Hertfordshire Partnership University NHS Foundation Trust

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Chair: Sarah Betteley
Date: 5 October 2023
Time: 11:00

Da Vinci Suite

NHS
Hertfordshire Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 5 October 2023
Da Vinci A,B & C
Time: 11:00am – 13:30pm

A G E N D A					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
1.	**Welcome and Apologies for Absence**	Chair - Sarah Betteley			11:00
2.	**Declarations of Interest**	Chair - Sarah Betteley	**Note**	Attached	
3.	**Shared Experience**				11:00
4.	**Minutes of Meeting held on 28 July 2023**	Chair - Sarah Betteley	**Approve**	Attached	11:30
5.	**Matters Arising Schedule**	Head of Corporate Affairs and Company Secretary - Helen Edmondson	**Review & Update**	Attached	
6.	**CEO Brief**	Chief Executive Karen Taylor	**Receive**	Attached	11.35
7.	**Chair's Report**	Chair - Sarah Betteley	**Receive**	Verbal	11.45
QUALITY & PATIENT SAFETY					
8.	**Report of the Integrated Governance Committee held: 27 July 2023**	Executive Director of Quality and Safety – Jacky Vincent	**Receive**	Attached	12:00
	a) Quarter One Integrated Safety Report	Executive Director of Quality and Safety – Jacky Vincent	**Receive**	Attached	
	b) Emergency Preparedness Resilience and Response Core Standards	Deputy CEO and COO - Sandra Brookes	**Approve**	Attached	
	c) Quarter one: Safe Staffing	Executive Director of Quality and Safety – Jacky Vincent	**Receive**	Attached	
	d) Guardian of Safe Working Update	Executive Director of Quality and Medical Leadership - Asif Zia	**Receive**	Attached	
	e) Quarter one experience report		**Receive**		
	f) Annual Infection Prevention and Control report	Deputy CEO and COO - Sandra Brookes		Attached	
	g) People Report	Executive Director of Quality and Safety – Jacky Vincent	**Receive**	Attached	
	h) WDES and WRES data	Chief People Officer – Jo Humphries	**Receive**	Attached d	

9.	**Patient Safety Incident Response Plan**	Executive Director of Quality and Safety – Jacky Vincent	**Approve**	Attached	12:35
	OPERATIONAL AND PERFORMANCE				
10.	**Report of the Finance & Investment Committees held: 25 July 2023.** **a) Quarter One: Performance Report** **b) Quarter One: Annual Plan**	Chief Finance Officer - Phil Cave Director of Innovation and Digital Transformation - Hakan Akozek Executive Directo, Strategy Partnerships - David Evans	**Receive** **Receive** **Recieve**	Attached Attached Attached	12:45
11.	**Finance Report**	Chief Finance Officer - Phil Cave	**Receive**	Attached	12:55
	STRATEGY				
12.	**Belonging and Inclusion Strategy**	Chief People Officer – Jo Humphries	**Approve**	Attached	13:05
13.	**Anti-racism charter**	Chief People Officer – Jo Humphries	**Approve**	Attached	
14.	**Sexual safety charter**	Chief People Officer – Jo Humphries	**Approve**	Attached	
	GOVERNANCE AND REGULATORY				
15.	**Report from Audit Committee held on 5 September 2023**	Head of Corporate Affairs and Company Secretary - Helen Edmondson	**Receive**	Attached	13:20
16.	**Board Assurance Framework**	Head of Corporate Affairs and Company Secretary - Helen Edmondson	**Approve**	Attached	
17.	**Fit and Proper Person Test Framework**	Chief People Officer – Jo Humphries	**Receive**	Attached	
18.	**Nominations & Remuneration Committee Terms of Reference**	Chief People Officer – Jo Humphries	**Approve**	Attached	13:30
19.	**Any Other Business**	Chair - Sarah Betteley			
	QUESTIONS FROM THE PUBLIC	Chair - Sarah Betteley			
Date and Time of Next Public Meeting: Thursday 2 November 2023					

ACTIONS REQUIRED

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

Chair: Sarah Betteley

Declarations of Interest Register

Board of Directors

5 October 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: 6 July 2023
Venue: The Colonnades

MINUTES	
NON-EXECUTIVE DIRECTORS	**DESIGNATION**
Sarah Betteley | SBe	Chair
David Atkinson | DA	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
Tim Bryson | TB	Non-Executive Director
Carolan Davidge | CD	Non-Executive Director
Diane Herbert | DH	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
Phil Cave | PC	Chief Finance 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
IN ATTENDANCE	
Jane Twelves | JT	PA to Deputy CEO & Chief Operating Officer and Executive Director Strategy & Partnerships (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
APOLOGIES	
Sandra Brookes | SBr	Deputy CEO and Chief Operating Officer
Hakan Akozek | HA	Director Innovation & Digital Transformation

Item	Subject	Action
084/23	**SU Experience** SBe thanked Sam Wells and Garikayi Teera for their frank and transparent update on the experience of staff at Forest House.	
085/23	**Welcome and Apologies for Absence** SBe welcomed all to the meeting with an extended welcome to Dipo Oyewole. Apologies for absence were received from Sandra Brookes and Hakan Akozek.	
086/23	**Declarations of Interest** The Declarations of Interest Register was noted. The Board noted that KT was now an NHS Providers Board Trustee. **NOTED**	
087/23	**Minutes of Meetings held 25 May 2023** The minutes were reviewed and approved as an accurate account of the meeting. **APPROVE**	

	The Board APPROVED the minutes	
088/23	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
089/23	**CEO Report** KT presented the CEO Report to the Board which was taken as read. Headline messages of note to the Board were: The BMA have announced a further mandate for Junior Doctors to strike. The industrial action will be over 5-days, the longest in the history of the NHS. KT advised that HPFT will respond accordingly and will step into EPRR. The result of the ballot for consultant strike action had reported overwhelming support for strike action. KT reported that planning was underway to ensure we continued to provide safe services. Nationally NHS England has confirmed that COVID-19 is no longer a Public Health Emergency of International concern and the NHS workforce plan has been published setting out plans for recruitment and retention and reshaping. It had been announced that the EPUT inquiry would now be on a statutory footing. It had also been announced that there would be a national review of mental health deaths, due to start in October, with providers expected to give evidence. KT reported the Trust's disappointment that the Trust had not been successful in its bid as part of the New Hospital Project. She set out that the business case is being reviewed and an alternative plan for beds for the East and North population is being developed. It was noted that PAH and WHHT had been successful, and the Trust would be working with them to ensure needs of services users were taken into account in the planning. Also, NHS England had published the Equality, Diversity and Inclusion Improvement Plan, which was aligned to the Trust Strategy. At a system level the Integrated Care Board (ICB) has set out the next stage of its development with a focus on articulating its operating framework for the ICB and "Place", including Health Care Partnerships and commitments for people with mental illness, learning disability, dementia and meeting neurodevelopmental needs. The Herts MHLD HCP board met on 20th June 2023. All partners are now embedded. There have been some leadership changes at the Region. The Trust will continue to work closely with Catherine Morgan. It was noted that Natalie Hammond has been appointed as the ICB Chief Nurse. The Trust's University Status has been confirmed for a further ten years, which is very welcome news. KT reported that demand for services continues to be high, but we have seen some really good areas of improvement in performance. There is particular focus on South-West quadrant, inpatient areas, Learning Disability where the teams are under pressure. KT confirmed that the final CQC reports for Warren Court and Oak had	

	have been published following focussed inspections that took place in the Autumn 2022, both services were rated good. There is positive progress in terms of our people, in particular vacancies and levels of retention. Trust Long service awards are taking place on 19th July 2023, a great event to celebrate those that have given so much. Year end for 2022/23 had been managed well. KT extended thanks to the Finance Team, AB as Chair of FIC and DA as Chair of Audit Committee. KT updated the Board on the recent Website incident. A full investigation into the events leading to the tools being attached to the website is taking place and will conclude in July. The Board will continue to be updated. SRS – Commissioners have awarded the contract to Avenues. Avenues have transformed other hospital services into Supported Living. The Trust will continue to work with partners to ensure an effective mobilisation and transition period. KT updated the Board on the range of celebration events held to mark the NHS 75th birthday. In response to SBe's question KT reported that it had been agreed that TUPE did not apply to SRS staff but that if they chose to join the new provider, they would be supported in this but also, they had been guaranteed employment at the Trust if they wanted to stay. In response to TB's question regarding the national workforce plan and how we are locally going to translate it into additional training requirements. The Board were updated on the University of Hertfordshire's work to become a Medical School and that the Trust would be updating its workforce strategy. **RECEIVED** **The Board RECEIVED the CEO Brief**	
090/23	**Chairs Report** SBe provided Board members with a verbal update on the work she had undertaken since the last Board meeting. SBe advised there had been a number of national events: NHS Confederation, Chairs and CEO event for the region and NHS Providers. The theme coming out of the events is a focus on recovery in acute services. Claire Murdoch confirmed that Mental Health needs to be kept on the agenda and that we need to continue to advocate. SBe reported that Bim Afalomi had been very impressed with quality of the facilities at Kingfisher Court following a recent visit and he was very keen to support our plans and ambition for a new building. SBe had recently visited Forest House and Swift ward with Governors. The visit to Swift was very positive and SBe was inspired by the care provided. Whilst visiting Dove the team were very proud to report that all service users have planned discharges. Following the recent Board Away Day lots of positive feedback had been	

	received and the team are moving forward as a Board. SBe particularly liked the opportunity to explore relationships. DA stated it was good to hear about Bim Afalomi's interest in mental health and asked what could be done to engage proactively with him. SBe highlighted the need to be more deliberate with our briefings for MPs, including particular areas. **RECEIVE** **The Board RECEIVED the verbal update.**	
	QUALITY & PATIENT SAFETY	
091/23	**Safe Staffing Annual Report** JV introduced the report providing an update on the challenges experienced with staffing over the year across inpatient services. The levels of acuity and complexity in a number of inpatient settings has increased resulting in an increase in the number and level of prescribed safe and supportive observations. The result of this has been an increased demand for temporary staff as well as Team Leaders and Clinical Matrons stepping down to support. Vacancies have also had an impact on the challenges with staffing. JV set out four key areas of action: • The process of observations is reviewed daily; if they continue beyond 7-days, a wider MDT review is held. The next step is to review the observation policy and practice as Trauma Informed Approach is adopted across services together with an increase in therapeutic activity and engagement as we enhance and embed our safety culture. • An initial nursing skill mix and establishment review across each inpatient service has been undertaken to review data, observations and additional duties. The next step is to review the wider establishment review of the MDT and to include Peer Support Workers to enhance the skill mix and service provision. • An increased level of scrutiny, governance and oversight of roster management. • Recruitment of Registered Nursing (RN) and Registered Nursing in Learning Disabilities (RNLD) continues to be a challenge. This has been impacted by the limited training providers and therefore we are support eight Health Care Support Workers (HCSW) to undertake RNLD training via the Open University. This has led to discussions at regional level about the training provision offered. In answer to AVD's question about the establishment mix and how this will feed into the financial position JV advised she is working with PC/JH to continue to review data. KT thanked AVD for his challenge stating that by reporting differently we will see clearer trends. There is a piece of work to take forward with Commissioners to review whether we are funded to run inpatient wards to the level of demand being seen. It was agreed that how the Trust benchmarks against other Trusts would be included in future reports. **RECEIVE** **The Board RECEIVED the report.**	**JV**
092/23	**Safeguarding Annual Report** JV reported that there has been an increase in reported incidents of child	

	safeguarding with the last quarter showing the highest in the past four years. Analysis shows that with the increased demand in CAMHS there has been more opportunity to identity and raise concerns. The types of risks identified all align with national data. The Safeguarding Children Datix form has been updated to capture additional information and deeper analysis in addition to the category of abuse. There has also been an increase in activity relating to adult safeguarding which reflects the increase in referrals into services, post-pandemic adjustment and cost of living crisis. Physical abuse remains the highest category for adult safeguarding. The Corporate Safeguarding team have undertaken a number of actions in response to the review and reported analysis: • Bespoke training with a focus on recording and decision making. • Attendance and presence in local practice governance meetings. • A Child Looked After (CLA) link person identified in each CAMHS team. • Domestic Abuse policy to support staff who may be experiencing domestic abuse. • Launch of the Weprotect App (as the first NHS organisation) allowing free access to initial legal advice to people at risk of domestic abuse. Following the annual Safeguarding Assurance visit in February feedback received in April highlighted a number of areas of good practice and demonstrated our commitment to ensuring safeguarding is embedded in all areas together with a culture of strong leadership, care compassion and innovative practice. In answer to AVD's questions JV advised that the HPFT has representatives on both the Herts Adult Safeguarding Board and Herts Child Safeguarding Board. Whilst there is an increased level of domestic violence, KT advised that there is more for interagency partners to take forward, with different partners responding differently. Internally, actions are followed up at the Safeguarding Joint Committees. In response to AB's question JV reported that recommendations for audits are followed up at the Safeguarding Committees where the actions are formally reported on. **RECEIVE** **The Board RECEIVED the report.**	
093/23	**CQC Inspection Update Report** JV presented the report which provided the Board with updates of the CQC published reports regarding Warren Court and Oak Ward inspections and the actions that have been taken forward. <u>Oak Ward</u> – Areas of positive practice were noted including regular safety audits of the environment, safe ward layout with risks well managed. Staff are knowledgeable, respectful and responsive to service users. The report noted concerns regarding continuous safe and supportive observation practice and access to clinical information. Areas of improvement and actions were identified which will be taken forward by Unplanned Care	

	senior leadership team. A Service Improvement Action Plan providing oversight and scrutiny reports to the Executive Team. The service has been re-rated by CQC as Good overall and Requires Improvement for safe. Warren Court – Positive areas of practice were noted by the CQC. The reinstatement of the Carers Forum was welcomed. The report also noted concerns related to redecoration of house five, there were few information notices for service users and the environment was not therapeutic. Senior leadership from SBU LD&F hold oversight of the actions. A detailed Service Improvement Action Plan provides further oversight and scrutiny and reports to the Executive Team. CQC rated the service as Good overall and Requires Improvement for safe. KT confirmed both ratings were final and that there is more work to be done in both areas. Board will be further updated. **IGC to receive report at its October meeting providing an update on the two Service Improvement Plans.** **RECEIVE** **The Board RECEIVED the report.**	**JV**
094/23	**Framework of Quality Assurance for Responsible Officer and Revalidation** AZ presented the report advising this is a national report and that the Trust has adopted the Appraisal 2020 model with a reduced requirement for preparation by the doctor and greater emphasis on reflection and discussion during appraisal meetings. The report provides quality assurance for the Responsible Officer (Executive Director Quality and Medical Leadership) of revalidation carried out at 31st March 2023 by 153 doctors due for appraisal. It was noted that 150 doctors completed their appraisals, two doctors missed their appraisal and one doctor had an approved missed appraisal. Those that missed their appraisals were either unwell or had well founded reasons resulting in the Trust achieving compliance of 98.04%. AZ confirmed there was positive feedback on the appraisals with learning coming back to Medical Education and Training and Clinical Directors. It was noted that the process works well and is an example of how the Trust supports medical staff. **RECEIVED** **The Board RECEIVED the report.**	
OPERATIONAL AND PERFORMANCE		
095/23	**Delivery of the Financial Plan** PC presented the report which provided the detail of the financial position for the period to 31st May 2023 (Month 2). At the end of Month 2 the Trust is reporting a £1.9 M deficit which is £1.5M off plan. This deficit is driven by an increase in private beds, increased costs in estates and high temporary staffing. The Trusts cash position at Month 2 is £53.8M which has decreased by £1.7M due to the reported deficit. Financial governance has been reviewed across the organisation, with	

	added controls in place in particular for agency and discretionary spend. PC advised there is an anticipated £200K coming into Month 3 relating to costs that were overstated at the end of Month 2, together with £3M income. The position will continue to be challenging however this is supported by the Executive Team and SBU Managing Directors. In answer to DH question about collective purchasing power related to temporary staffing, JH advised that it is more effective to approach a single provider which was being considered. There is some work to be completed around vacancy hotspots areas and to think about the recruitment pipeline. Whilst vacancies are improving there is a national and local gap which will take time to address across the organisation. AB reported that she is working closely with PC to monitor the financial position. PC reported that the budgets were currently with managers to be signed off, also confirming that the process for 2024/25 budgets would be more speedy. KT stressed that having a deficit of £1.9m was not where the Trust needs to be. Seeing a similar picture in system, regionally and nationally. In response to TB's question KT reported that expected EDT to be in place in September 2023. In answer to AVD's question about the cost of DTC's and whether the money would have been spent differently. PC advised that more recently a couple of service users have moved on to more suitable settings. **RECEIVED** **The Board RECEIVED the report**	
096/23	**People and OD Report** JH presented the Month 2 People and OD report to update the Board on progress against the key performance indicators. Improvements have been seen across all areas, however vacancies in registered nursing and AHP staff remain challenging areas for recruitment and retention. There are also 36 medical vacancies. Deep dives are being undertaken by the Recruitment and Retention group to ensure robust actions are in place to continue to address the challenges and this will be closely monitored by the Executive Team. Agency spend has increased and the Financial Recovery and Delivering Value Board are scrutinising all agency spend, developing a trajectory for improvement and monitoring the impact of actions. The Quarter One Pulse Survey had 839 respondents; the Quarter one survey results remain positive. However, WRES and DES colleagues continue to feel there is disparity between them and others. DH asked about the use of apprenticeships JH advised that HPFT currently has 114 apprentices and whilst we are growing our apprenticeships, we continue to not fully utilise the levy pot. Work is underway 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. The People and OD Group will continue to monitor and oversee plans to continue improvements against each of the workforce key performance indicators. **RECEIVE** **The Board RECEIVED the report**	
097/23	**Guardian of Safe Working Annual Report** AZ presented the report providing a review of Guardian of Safe Working for the period June 2022 to June 2023. AZ highlighted that the Integrated Governance Committee received quarterly updates throughout 2022/23. During the period there were 14 exception reports raised by the Trust's Junior Doctors. The main themes for the exception reports received relate to staying longer over the shift end. There has been an increase in type of exception reporting relating to service provision. On each occasion the clinical supervisor has been informed and support provided. A benchmarking exercise has been undertaken and the information indicates that the Trust has a lower rate of exception reports than its peers. **RECEIVE** **The Board RECEIVED the report**	
098/23	**Performance Report** DE introduced the report which provided the Board with an overview of the Trust's operational performance against the Single Oversight Framework, Access and Safe and Effective key performance indicators. The Board noted the areas HPFT continues to perform well and focused on the key areas for improvement: • South-West Quadrant – Staffing challenges continue and an improvement plan is in place. • Out of Area beds – continue to be challenging. There are delays in flow in Norfolk, Bucks and Essex. • EMDASS – there are delays in providing a diagnosis, we continue to provide additional clinical and have started transforming the diagnosis pathway. It is anticipated the service will recover performance in Quarter 3. • ADHD – the backlog remains; HPFT is supporting the system wide process. Challenges will come to the fore nationally. Conversations are taking place with Commissioners about the backlog and will be presented to the ICB at a future meeting. Members of the Board discussed the report considering what should be presented, the improvement journey and what are we commissioned for and whether it is feasible. AZ stated that we are still absorbing activity we are not commissioned for. Whilst there is better oversight across the organisation, we need to consider where the focus and attention needs to be.	

	RECEIVE **The Board RECEIVED the report.**	
	STRATEGY	
99/23	**Trust Strategy** DE presented the new Trust Strategy which sets out the strategic direction of the Trust for the next 5 years. The Team has worked with a design agency to create a final version of the Strategy. The final document sets out what HPFT stands for as an organisation summarising our values, mission and vision and how we will work in partnership with others. In addition to the main strategy document an easy-read version together with a range of material to promote the Strategy to ensure that staff, service users, carers and partners understand it. SBe welcomed the new Strategy setting out that to her it felt 'real' and completely in tune with Trust values and clearly sets out what the Trust wants to do. All Board members voiced their support and enthusiasm for the strategy. JV described how it had really connected with staff and had been positively received. JW highlighted the comprehensive approach to co-production. It was noted that the next phase would be its launch, commencing Monday 10th July 2023. This would be followed by a period of operationalising it throughout the Trust and system. It was noted that later in the year the Trust would be launching is Belonging and Inclusion Strategy and Commercial strategy which would be aligned to 'Great Together'. It was also noted that the BAF would be updated. DE expressed thanks to key members of the Team for their help, insight and development. **APPROVE** **The Board APPROVED the Trust Strategy**	
100/23	**Mental Health, Learning Disability and Autism Health Care Partnership Update** DE reported that since the last update to the Board in January 2023 the MHLDA HCP has developed its capacity and capabilities to deliver improved outcomes for people and communities in Hertfordshire. The HCP has overseen tangible improvements in local services including embedding mental health support in the Hertfordshire response to the cost-of-living crisis to supporting increased uptake of Annual Health Checks for people with learning disabilities. DE reported that the Hertfordshire Dementia Strategy has been successfully launched and the MHLDA Physical Health Strategy setting out ambitious objectives for the wider system. The MHLDA HCP Board now provides strategic leadership and oversight of a number of existing system partnerships. SBe added this is an exemplary example for collaborative working. **RECEIVE** **The Board RECEIVED the report**	

GOVERNANCE AND REGULATORY		
101/23	**Audit Committee Report meeting held: 22 June 2023** PC presented the report which sets out an overview of the work undertaken by the Audit Committee held on 22nd June 2023. The Committee meeting solely focussed on the review and approval of the Annual Accounts for 2022/23 and Annual Report for 2022/23 for recommendation for approval to the Board on met on 22nd June 2023. **RECEIVE** **The Board RECEIVED the report**	
102/23	**Trust Risk Register** HE presented the Trust Risk Register to the Board for consideration and approval. The risks on the Risk Register have been thoroughly reviewed by the Executive Team and reflect the current challenges faced by the Trust. The risk descriptors have been updated and the total number of risks has increased from seven to eleven relating to specific issues to ensure there is clear sight on the impact and the actions needed. KT advised that the Trust Risk Register has been updated to be separate from the Strategic risks in the BAF. AVD welcomed this piece of work and stated that it would be good to see the top SBU risks and how we are performing and managing risk environments. KT agreed that there was additional work to do to ensure the Trust Risk Register is robust and to review this in light of what the CQC would look for. Board members discussed and challenged the Risk Register scores noting the reputational impact on the organisation. **ASSURANCE** **The Board were provided ASSURANCE**	
103/23	**Mental Health Act Managers Annual Report** TB presented the report on the activity of the Mental Health Act Managers and the use of the Mental Health Act (MHS) in HPFT during 2022/23. TB highlighted that the report included an update in respect of the reform of the Mental Health Act. **RECEIVE** **The Board RECEIVED the report**	
104/23	**Any Other Business** No further business was put forward.	
105/23	**Questions from the Public** No questions were put forward.	
Date of Next PUBLIC Meeting Thursday 5 October 2023		

Close of Meeting

PUBLIC Board of Directors 7 September 2023

MATTERS ARISING SCHEDULE

Matters Arising from meeting held on: 6 July 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
091/23	**Safe Staffing Annual Report**	**JV**	Safe Staffing report at IGC to provide details on benchmarking	July 2023	
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	
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	July 2023	
Matters Arising from meeting held on: 2 February 2023					
Minute Ref.	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
007/23	**Chairs Report**	**SBr**	Schedule Board discussion regarding Learning Disability service and future model	To be confirmed	

PUBLIC Board of Directors

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

National update

The national activity is summarised below:

Letby Case Coverage

Board members will have followed the coverage of the trial of Lucy Letby, a nurse found guilty of the murder of seven babies and the attempted murder of six other babies while working at the Countess of Chester Hospital NHS Foundation Trust. The crimes have both shocked and sickened staff across the Trust, the NHS as well the public. The Department of Health and Social Care has announced that there will be an independent statutory inquiry into events at the Countess of Chester Hospital NHS Foundation Trust, chaired by the court of appeal judge Lady Justice Thirlwall.

The Trust has taken immediate steps and actions relating to: Freedom to Speak Up; support for whistle blowers; Fit and Proper Person requirements; indicators of responsiveness. We have communicated with our staff to offer support, publicised the routes to speaking up and have reinforced the importance of maintaining professional standards of practice and behaviour. A section later in my report details the work taking place across the Trust.

National Quality of Care/Incidents

Over recent weeks there has been high profile coverage of a number of safety incidents and practice issues across the NHS. This has included failure to listen patient and family concerns, responsiveness of organisations investigating incidents, charges made against organisations and individuals following patient safety incidents and failure to accurately track and record deaths in three mental health organisations. In addition, there have been a number Care Quality Commission (CQC) Inspection reports published that highlight the failures of organisations to adhere to regulatory standards.

At a recent national event, Chris Dzikiti, CQC Director of Mental Health has stated that mental health trusts should be naming the board member in charge of investigating and reducing restrictive interventions. The Trust regularly considers data on restrictive practice and is supported in this by the Integrated Governance Committee. The Trust already has a board member identified - Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse).

Industrial Action

In June a new ballot of Junior Doctors for further strike action opened, the outcome of which was 98% support for a six-month mandate for further strike action. Since the last report to public Board NHS Consultants have taken part in a two-day period of industrial action (24-25 August 2023), and further action took place involving junior doctors and consultants in September (19 -22 September). Further action is planned for 2-5 October when both Junior Doctors and Consultants will strike. During this time the BMA have committed to delivering Christmas Day levels of service.

Although the Trust has responded well to Junior Doctor and Consultant strike action, it is important to note that strike action is having an impact, not only on the morale of those staff affected, but also on Trust performance, finances and the running of services. It impacts on the Trust's ability to deliver on the wide

range of developments planned for 2023/4, with a material amount of clinical and operational management time being diverted to manage the planning, operational pressures and recovery arising because of the Industrial Action.

Winter Planning

In July 2023 NHS England produced its winter plan. The plan includes creating additional bed capacity, ensuring system coordination centres are open 24/7 across the country, offering financial incentives to trusts that exceed on key performance measures, expanding acute respiratory infection hubs to be in every part of the country. There are ten high impact interventions that each system is being asked to deliver on, with three of those interventions that mental health providers are expected to deliver including: Improving acute inpatient flow and length of stay, improving community bed productivity and flow; Single point of Access. Systems will also be closely monitored on the work being done to support their workforce in terms of wellbeing reduction in use of agency, management of Industrial Action and access to support.

As a Trust we have a detailed winter plan in place covering the ten interventions, surge capacity, workforce support, flu and Covid vaccination plans, our role within the system and the governance structure to support the system plan and maintaining our readiness to step up incident command as required. This will be monitored via the Trust Management Group. The Trust is due to start the Covid and flu vaccination programmes the first week of October for both services users and staff.

NHS England have announced £200m nationally to be available to help support services through the peak months of winter. Alongside this, £40 million is being invested to bolster social care capacity and improve discharge from hospital. It has been stated that the funding will ensure patients are seen as quickly as possible, while also driving forward plans to cut waiting lists.

Suicide Prevention in England: 5 year cross sector strategy

On 11 September the Government published the Suicide Prevention in England: 5 year cross sector strategy Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)

The strategy highlights that while overall the current suicide rate is not significantly higher than in 2012, it is not falling and there is much more that must be done to save more lives. The strategy identifies that this will require a national government effort, as well as continued action across the NHS, local government, the voluntary, community and social enterprise (VCSE) sectors, employers and individuals. The aim of the cross-government strategy is to bring everybody together around common priorities and set out actions that can be taken to reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner; improve support for people who have self-harmed and improve support for people bereaved by suicide.

Priority areas identified include: improving the data and evidence to ensure that effective, evidence-informed and timely interventions continue to be adapted; providing tailored, targeted support to priority groups, including those at higher risk; addressing common risk factors linked to suicide at a population level by providing early intervention and tailored support, promoting online safety and responsible media content to reduce harms, improving support and signposting, and providing helpful messages about suicide and self-harm; provide effective crisis support across sectors for those who reach crisis point; providing effective bereavement support to those affected by suicide; make suicide everybody's business so that maximise collective impact and support to prevent suicides.

Alongside the new strategy NHSE also published a national suicide prevention toolkit, to help organisations support the health and wellbeing of their staff and to understand and act on suicided risks. NHS England » Working together to prevent suicide in the NHS workforce

Reinforced Aerated Autoclaved Concrete (RAAC)

Following the recent publicity regarding RAAC in schools, trusts have been asked to assess their estate again based on updated guidance. The national RAAC programme team are collating information from these assessments, including where there are appropriate mitigation plans and the steps necessary to remove this material from use. The Trust has been asked by the NHS central team to review all buildings to identify if any contain Reinforced Autoclaved Aerated Concrete (RAAC). On a previous review no

RAAC was identified in either the Trust's owned or leased buildings however a further review is being undertaken. This review includes an age profiling of our properties using the services of an external company which will inform the plan for surveys if required. The Board are asked to note that our freehold properties are not constructed using RAAC methods.

Provider Selection regime

NHS England have published details of the Provider Selection Regime (PSR) NHS commissioning » NHS Provider Selection Regime (england.nhs.uk) which will replace the existing procurement rules for healthcare services. The aim of the Provider Selection Regime is to make it easier to integrate services and enhance collaboration, and to remove the rigidity associated with the current procurement rules, and the related bureaucracy and cost. However, under the Provider Selection Regime, the competitive tendering of health services can continue to have a role where this is in the best interests of patients, taxpayers, and the population. Current indications are that PSR will be introduced before the end of 2023 and Finance and Investment Committee will be advised in due course as further detail on the implementation becomes available.

Enforcement Guidance

NHS England (NHSE) has published the updated guidance NHS enforcement guidance (england.nhs.uk) together with their response to the enforcement guidance consultation, which was carried out in late 2022.

The revised enforcement guidance describes NHSE's enforcement powers and approach in relation to ICBs, NHS trusts, Foundation Trusts, licensed independent providers of NHS services, and licensed NHS controlled providers. It explains the regulatory and statutory processes in the event of enforcement action and subsequent rights of appeal. The guidance should be read alongside the NHS provider licence and the NHS oversight framework.

The main changes to the guidance are:

- Introduction of a two-tier approach to ICB enforcement, which ensures parity with NHS provider organisations. This means that undertakings would be used where there is reasonable suspicion of ICB failure to discharge its functions, while directions would follow where NHSE is satisfied there is a failure.
- Revisions to the language to reflect the change from Monitor to NHS England as the regulatory body for NHS foundation trusts.
- The extension of the provider licence to NHS trusts.

NHSE had planned to introduce new enforcement powers in relation to patient choice but, as changes to the regulations have not yet been made, the current procurement, patient choice and competition regulations remain applicable, with the adjustments from 1 July 2022 set out in the explanatory note on NHSE's website. NHSE's enforcement powers in relation to providers have not changed. The revised guidance, however, is aligned with the principles of the oversight framework, which state that NHSE will be working with and through ICBs wherever possible to encourage local resolution before escalation.

Drug and Alcohol Strategy

The new national Drug and Alcohol Strategy is due to be published within the next month. The Board will be updated following its publication.

Sexual Safety

On 4 September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. It is expected that signatories will implement all ten commitments by July 2024. The Board will later on the agenda be considering the Charter for approval and adoption across Trust.

Shadow Cabinet Reshuffle

Sir Keir Starmer has carried out a reshuffle of the shadow cabinet and ministerial team. Of the 31 shadow cabinet members, 15 are in a new job or have major new responsibilities. The reshuffle saw the return of

MPs with experience of being in government and brought the shadow cabinet roles in line with the current machinery of government.

Wes Streeting retains his role as Shadow Secretary of State for Health and Social Care. Karin Smyth, Andrew Gwynne and Feryal Clarke remain in the team. Andrew Gwynne and Karin Smyth have changed roles to become deputies to Wes, with Andrew taking on Social Care and Karin becoming Shadow Minister for Health. Abena Oppong-Asare, has joined the team as Shadow Minister for Women's Health. She is the MP for Erith and Thamesmead and her most recent role was Shadow Exchequer Secretary.

Workforce Disability Equality Standard

On 7 September NHS England (NHSE) published the annual Workforce Disability Equality Standard (WDES) data report. The data is split into ten metrics of workplace experience and opportunity for disabled and non-disabled staff in the NHS workforce. Additionally, for the first time, the report includes greater intersectional data and analysis. The Board later on the agenda will consider the detail of the report, however it is of note that for the first time the publication includes individual benchmarking reports for trusts. The benchmarking information for the Trust shows that the Trust is ranked 8th overall out of all 212 trusts in England. We are in the top 10% of all trusts for the following areas:

- disabled representation in the workforce (non-clinical)
- disabled representation in the workforce (clinical)
- relatively low levels of harassment, bullying or abuse from patients, relatives or the public in last 12 months.
- low levels of harassment, bullying or abuse from other colleagues in last 12 months
- career progression; presenteeism; feeling valued; reasonable adjustments and staff engagement.

Areas of focus for us as an organisation will me disabled representation in the workforce (medical/dental); disabled representation on the Board. The Trust WDES's action plan has been coproduced with our staff networks to address these issues as well as the areas that our staff feel are our highest priority.

Fit and Proper Person

NHS England published a new Fit and Proper Persons Test (FPPPT) Framework on 2 August alongside guidance for chairs and staff on implementation. The majority of the requirements echo those that already existed in the previous Fit and Proper Person Test guidance. Core elements that continue to be assessed are good character; possessing the qualifications, competence, skills and experience required; and financial soundness. These are in addition to standard employment checks such as CV checks, proof of identity and right to work.

The framework introduces a new standard Board member reference, and the Electronic Staff Record (ESR) will be used to store information related to FPPT checks and references. This will provide a standard way to record and report compliance internally. The collation of retrospective data is not proposed.

All Board members have received an email outlining the implications for them; and the details of the changes have been considered by the Nominations & Remuneration Committee (Rem Com) and the Appointments and Remuneration Committee (ARC). The Board will be considering a report later on the agenda to provide assurance regarding the implementation of the new Framework.

Review of section 75 arrangements

Pooled budgets are principally delivered through two sets of provisions in NHS Act 2006. Firstly, the joint working and pooled fund arrangements under sections 65Z5 and 65Z6 (inserted by section 71 of the Health and Care Act 2022). Secondly, the provisions relating to arrangements between NHS bodies and local authorities under section 75 (s75) which is the route through which the Better Care Fund (BCF) is delivered. The Department of Health and Social Care (DHSC) have reported that information from system leaders indicate that arrangements to pool budgets can be complex which can hinder more ambitious models of integration. In the integration white paper, and the Hewitt review the DHSC have committed to reviewing the legislation covering pooled budgets to consider simplifying and updating the underlying regulations where necessary.

As part of the review the DHSC have launched a review of section 75 arrangements and have called for evidence Review of section 75 arrangements: supporting document - GOV.UK (www.gov.uk) the review is asking for views on: whether the scope of s75 should be widened to include additional health related functions of local authorities and NHS bodies; whether to widen the range of organisations that can enter into these arrangements; how the governance of s75 can be strengthened or simplified; and whether there are barriers to further use that could be addressed via legislative changes. The Trust is considering the review and will respond to the request in line with the 31 October 2023 deadline.

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 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

At the ICB Board meeting that took place on 22 September it was reported that the pre-delegation assessment framework for the delegation of specialist commissioning by NHS England to the ICB was approved by Commissioning Committee. This framework sets out the joint proposal that East of England specialised services are managed through a multi-ICB partnership in 2024/25. Detail regarding the devolution of staffing resources to ICBs is being worked through.

System Financial Position

The Hertfordshire and West Essex Integrated Care System (HWE ICS) is working together on its agreed financial plan. The Trust is working closely with other local NHS partners in the system on six areas including the development of a medium term finance plan; how resources are distributed; controlling deficits (which are financial shortfalls); allocation of funds from the Sustainability and Transformation Fund (SDF); improving the reporting of the financial position and planning capital spend. The goal is to strengthen the financial health of the healthcare system and ensure its sustainability.

Hertfordshire Mental Health and Learning Disability and Autism Health Care Partnership

At its meeting on 8 September the HCP received an update on the activity of the Learning Disabilities and Autism Strategic Partnership Board, focussing on work the Board has undertaken in relation to the LeDeR Annual Report and the successful pilot of the Autism Health Checks. The HCP considered how, collectively, it can ensure that the issues identified through the LeDeR report can be taken forward across partner organisations and align with the HCP's Physical Health Strategy for people with serious mental illness, learning disabilities and autism.

The HCP received an update on the delivery of the NHSE Wave 4 Suicide Prevention initiatives, endorsing the business case and supporting the proposal that further funding should be sought from the ICB. Finally, the HCP was briefed on NHS England's inpatient quality programme and the activity that will take place locally to respond including a proposed clinical summit across Hertfordshire and West Essex.

The next MHLDA HCP Board scheduled for 13 October 2023 will focus on children and young people including an update on the work of the Emotional and Mental Wellbeing Board, the development of the Hertfordshire Neurodiversity model and the outcomes of the Hertfordshire SEND inspection.

Mental Health Urgent Care Centre

A business case has been developed to establish a Mental Health Urgent Care Centre (MHUCC) on the Lister site (The Glaxo building). The model proposed will be an enhanced specialist multidisciplinary team focused on improving the experience and outcomes for service users, carers, and staff presenting in crisis. It is anticipated the new service will also mean less presentations to acute hospital emergency departments in Hertfordshire and reduce the overall use of mental health beds by appropriately supporting people to access appropriate care and support in the community.

The service will operate 24/7 and will be a multi-disciplinary, cross sector service that is practitioner-led and supported by social care, voluntary sector partners and Lived Experience Workers. Once fully mobilised, referrals into the MHUCC will come via a number of routes; diversion from ED, direct referral from EEAST, the police and Street Triage, GP urgent referrals or self-referral via direct service user access (walk-ins).

During mobilisation, the service will adopt a phased rollout of the referral routes, with the first phase accepting diversions from the ED. Referrals from EEAST, the police and street triage, and then urgent GP referrals self-referrals/walk-ins will be accepted in the second and third mobilisation phases, respectively.

The model is based on a number of similar services across the country and has been developed by a multi-agency task and finish group. There will be a capital investment required of £1.35m required and the annual cost of running the new service will be £3m. The business case has been presented and approved by the ICB Executive Team, ICB Finance & Investment Committee and ICB Board. The ICB has been asked to underwrite the revenue costs part year effect 2023/24 and full year 2024/25 and support additional system capital for the Trust in 2024/25 to offset the trust capital prioritisation of this project in 2023/24.

East of England Provider Collaborative

Anna Hills, Chief Executive of Cambridgeshire and Peterborough Foundation NHS Trust has recently taken up the role of Lead Chief Executive of the Collaborative. In September the first ‘new style’ collaborative Executive Committee met. As well as considering a number of transformation schemes to recommend to the collaborative Board for approval, the Committee aims to support the clinical leadership model of the Collaborative accelerate transformation and unblock operational issues.

Feedback from the Andy Graham, Managing Director of the Collaborative suggests that each of the clinical workstreams continued to perform well over summer despite a number of challenges, such as a significant reduction in Children and Young People (CYP) beds in Essex Partnership University Trust due to medical staffing; suspension of services at the Phoenix CYP Eating Disorders unit in Cambridgeshire and Peterborough and emergent financial challenges in secure services.

The Collaborative’s ambition to commission perinatal services was not approved by NHSE to ‘go live’ in October. NHSE regionally has decided not to devolve perinatal commissioning at the present time. NHSE colleagues have reflected on the current commissioning arrangements and they will be facilitating a working group with the Collaborative, ICB, service users and family representatives, and other relevant stakeholders involved in the community element of the pathway. The purpose of the group will be to further develop model of care that includes joining up the whole commissioning pathway.

The East of England Specialised Mental Health Provider Collaborative; and other appropriate stakeholders have also been asked to undertake due diligence on the quality element of the mother and baby units (MBUs), including ensuring this service has been considered against the national Quality Maturity Framework (QMF).

Cambridgeshire and Peterborough Foundation NHS Trust and Norfolk and Suffolk NHS Foundation Trust have both developed business cases to recurrently fund community forensic services following the pilots.

The evaluation of the existing Intensive Community Service (ICS) pilot for Adult Eating Disorder has 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 is currently being considered for approval.

At the end of July the provider collaborative financial position remains in a net surplus position and is on plan year to date.

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

August has seen ongoing high levels of demand particularly within adult inpatient and community services compounded by Industrial Action and leave periods. Work has continued to reduce the number of inappropriate out of area placements and an improved position has been achieved. This is due to the ongoing focus on flow, and actions being taken as part of the acute pathway transformation programme. Delayed Transfers of care remain a challenge with ongoing work with system partners being undertaken.

South West community adult and crisis services remain under pressure with high levels of vacancies. Work is underway to fully understand our capacity to meet demand and consider alternative ways of working. East CAMHS team is also experiencing a high level of vacancies and a plan has been agreed to provide additional support to this team, whilst carrying out further work to reduce caseloads and respond to demand effectively and improve recruitment.

The Learning Disability & Forensic Strategic Business Unit has been placed under additional performance and support arrangements reflecting the previously highlighted workforce and cultural issues arising at Broadlands, Warren Court and Astley Court. Further detail will be provided at the next Integrated Governance Committee and at the Trust Board meeting itself.

Our People

In August, the number of staff we employ increased by 14 FTE and our turnover decreased to 11.3%, which resulted in our vacancy rate reducing from 12.2% in July to 11.7% in August. Our recruitment pipeline remains healthy, with a large cohort of soon-to-be newly qualified nurses joining the Trust over the coming months and our turnover has reduced to 11.3% which is the lowest it has been in two years.

Our appraisal compliance rate increased from 86% to 92% by the end of August because of our new appraisal window and Appraisal App, which was 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 met our target of 92% in August. We have now rolled out the Oliver McGowan eLearning package to all staff, and at the end of September our compliance has already reached 38%. We are also about to launch the face to face training, starting with our Learning Disability and Forensic Strategic Business Unit.

As part of our retention work, we continue to provide a robust health and wellbeing support offer. We celebrated Cycle to Work Day in August and have 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. We have also rolled out our new mental health support toolkit, which was developed in collaboration with our Staff Networks and is designed to help managers provide consistent, best practice support to staff. In August, our sickness absence rates remained slightly above our target of 4%, at 4.4%.

We are rolling out our programme of work for National Inclusion Week, Black History Month and ADHD Awareness Month. In addition, we are planning for the launch of the staff survey, which will run from early October to late November.

Finance 2023/24

The financial plan for the year for the organisation is a deficit of £1.8m, noting that to achieve this position the ICB recognised a further £1.8m risk to this delivery. This deficit target contributes to the overall breakeven financial plan for Hertfordshire and West Essex Integrated Care System. At month five the planned deficit was £1m, however at the end of August (month 5) the Trust's financial deficit will stand at £2.9m, exceeding the planned deficit by £1.9m YTD.

The main contributing factors to this deviation is the ongoing utilisation of independent sector beds and the reliance on agency staffing in the inpatient areas. The Trust has a cost reduction programme in place and has enhanced financial governance in place, whilst continuing to prioritise safety and quality of care. The Board will be receiving a detailed report on financial performance later on the agenda.

Learning from national incidents

As a learning organisation, the Trust has been actively reviewing the learning from national incidents and reports, identifying key themes and learning to further inform our own approach to safety and responsiveness. As part of this, a deep dive has taken place into the key indicators of responsiveness for the Trust through the Executive Team and an exceptional assurance report will be provided into the Integrated Governance Committee taking place in October. At the end of September:

- All Serious Incident Investigation have been investigated within the 60 day standard.
- The median time for complaint response is 38 days, with 11 complaints exceeding the standard of 35 days response time (13%).
- Of 32 open Freedom to Speak Up cases, 1 case has been opened longer than 5 months and there is a plan to resolve and address the issue raise.
- There are currently 7 open grievances. 70% (5) have been open less than 4 months and a clear plan is in place to expedite the investigations underway for all 7 cases,

Website Incident

The Trust has been informed that the Information Commissioners Office (ICO) has completed its investigation in relation to the Trust’s use of a meta pixel on its website. The ICO has closed the case with no regulatory action. The Board is asked to note that the ICO will be issuing guidance on the use of meta pixels in the upcoming months, and the Trust will review and ensure it implements any requirements.

Annual General Meeting

The Trust held its Annual General Meeting on 21 September. It was a well attended event and provided an opportunity for the Trust to set out what its performance across, quality, experience and finance in 2022/23. The Annual Report and Auditors report are now available on the Trust website.

Chair and Non-Executive Director re-appointment

We are delighted to be able to formally report that the Council of Governors have approved the re-appointment of Sarah Betteley as Chair of the Trust for a further three years. The Council of Governors considered the recommendation from the Appointment and Remuneration Committee (ARC) and the feedback from NHS England following the application to them regarding the proposed re-appointment. The application was made to NHS England in line with the new guidance on the length of time Chairs and Non-Executive Directors can be in post at the same Trust, and the feedback was supportive of the re-appointment.

We are also delighted that at the same Council of Governors meeting the recommendation from ARC to re-appoint Tim Bryson and Anne Barnard as Non-Executive Directors for a further three-year term each was also approved.

Awards

We are delighted to report the shortlisting of our teams and people for a number of prestigious national awards:

- Enhanced Rehabilitation Outreach Service + team has been nominated for two Nursing Times Team Award and a Royal Collage of Psychiatrists award.
- Trust doctor has been nominated as Speciality Doctor/Associate Specialist of the Year for Royal College of Psychiatrists awards.
- Norfolk Forensic Community Learning Disability Team shortlisted for Psychiatric team of the Year: Intellectual disability, Royal College of Psychiatrists
- Expert by Experience has been shortlisted for Patient contributor of the Year award, Royal College of Psychiatrists.
- Carer associated with the Trust has been shortlisted for Carer contributor of the Year, Royal College of Psychiatrists.
- Trust social worker has been shortlisted as Approved Mental Health Practitioner of the Year, at Social Worker of the Year awards.
- Fishing for Health, shortlisted HSJ awards, under the innovation in mental health category.

To be shortlisted and recognised against national fields is a real credit to the teams and the work they do. At the Health Service Journal Patient Safety Awards ceremony held on 18 September the Simulation Suite was highly commended at the Health Service Journal Patient Safety Awards.

The Trust has been awarded One NHS Finance Towards Excellence Accreditation, at level 1, by the NHS Finance Leadership Council. This is in recognition of the Trust following best practise in finance in terms of culture, skills and processes. The accreditation follows an assessment process that involved answering questions on a variety of themes ranging from culture and values to technical finance aspects.

Our internal staff awards have also been launched with thirteen categories covering all teams, services and geographies. The awards ceremony will take place on 29 November 2023, always a joyous occasion, a celebration of all that is great about our people.

NHS England Chief Executive Visit

On 22 September 2023 Amanda Pritchard, Chief Executive of NHS England visited the Trust. She spent time at Saffron Ground meeting teams on site, she was particularly interested to hear how our services supported service users across all age groups and needs. A focus for the visit was CAMHS services and Amanda heard how the CAMHS North team work with some of the most deprived and densely populated communities, with large numbers of looked after children. The Team were also able to talk about the roll out of Mental Health Support Teams in schools.

Karen Taylor
Chief Executive Officer

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 8
Subject:	Report of the Integrated Governance Committee held on 27 July 2023	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting on 27 July 2023.

Action required:

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

Summary and recommendations to the Board:

Summary

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

Recommendation

The Board are asked to note there are no matters for formal escalation to the Board.

Board to note that a number of quarter one reports would be considered by the Board at this meeting and that the EPRR compliance statement would also be ratified at the meeting.

Relationship with the Business Plan & Assurance Framework:

List specific risks on BAF – 3 and 4

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

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

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

There are no implications arising from this report.

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Integrated Governance Committee held on 27 July 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 27 July 2023, in accordance with its terms of reference and was quorate. In the absence of Diane Herbert, Non-Executive Director and Committee Chair, Tim Bryson, Non-Executive Director chaired the Committee.

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

2. Deep Dive

2.1 The Committee received a deep dive presentation into Trauma Informed Approach (TIA). The presentation provided insight into trauma and its impact and what trauma informed approaches in practice aims to do. Also, how the Trust has piloted the approach on Robin ward and the outcomes seen, which have informed the plan to roll out the approach across the Trust.

2.2 Committee members explored the long-term consequences of experiencing trauma and the need to move from asking “what is wrong?”. It was reported that TIA is being adopted globally and they are a fundamental element of the Long-Term Plan and Trust Great Together strategy.

2.3 The Committee discussed the national and local evidence of the impact of adopting a TIA, including reduction in restrictive practice, improved staff retention and vacancy levels.

2.4 Members of the Committee identified the opportunity to work with third sector providers to ensure support for TIA. Also, the need to consider how TIA is embedded in core training.

3. Quality

3.1 The Committee considered the quarter one Integrated Safety report, welcoming the new format. The report provided an analysis of safety related incidents, identifying themes and contributory factors and also provided an overview of the plans in place and actions being taken to address the issues identified.

3.2 Committee members noted that the top two themes regarding the reported incidents were violence and aggression and self-harm. That the increase in Absent Without approved Leave seen in quarter four had continued in quarter one. The report included analysis of this the action taken.

3.3 The number of Serious Incidents (SI) during the quarter had remained relatively stable and was a similar trend to quarter four of 2022/23, but was a significant reduction compared to quarter one of 2022/23. The themes of SI cases remained unchanged, with unexpected death or avoidable death being the most prevalent.

3.4 The Committee discussed the implementation of Positive Behavioural Support (PBS) plans and the positive impact this was having on levels of prescribed Safe and Supportive Observations.

3.5 The Committee were updated on the progress with the implementation of the Patient Safety Incident Response Framework (PSIRF), noting there was Board workshop taking place on 1 August 2023 on this topic.

3.6 It was reported that the Trust remains on track for the transition to PSIRF in October 2023. Noting that there is likely to be further changes to the process as the transition happens.; this is line with intelligence from early adopter organisations.

3.7 The Committee were informed that the Trust has a draft Patient Safety Incident Response Plan (PSIRP), is reviewing Patient Safety Incident processes/methods and finalising governance and monitoring processes, so that are aligned with annual cycle of business.

4. Quality - Effectiveness

4.1 The Committee considered a report that detailed the six Commissioning for Quality and Innovation (CQUIN) goals for 2023/24, progress to date and mitigating actions for goals which are not on track. It was noted that the themes of the CQUIN goals for 2023/24 are flu, outcomes, and restrictive practice. It was noted that five of the six goals are a continuation from 2022/23. It was reported that of the five goals that require a quarter one submission three are on target.

4.2 The Committee considered the Research and Development Annual Report 2022/23. The report detailed the close work with National Institute of Health Research (NIHR) and Clinical Research Network East of England (CRNE) and the collaboration with Higher Academic Institutions (HEIs) including The University of Hertfordshire (UoH), University of Warwick, University of East Anglia and University College London.

4.3 It was reported that in 2022/23, the Trust had supported recruitment to 20 NIHR Portfolio studies, with an additional nine registered and awaiting recruitment to start. And across those studies, 263 service users, carers and staff were recruited. It was noted that by April 2022 the Trust was no longer supporting any of the urgent public health (UPH) COVID-19 surveillance studies. The report included a full list of the portfolio studies.

4.4 The Committee considered a report that described the activities undertaken by the pharmacy department and Trust staff to support the safe and effective use of medicines in 2022/23.

4.5 The report set out the performance across procurement, dispensary, medication safety, Electronic Prescribing and Medicines Administration (ePMA), COVID vaccination programme, education, and training.

4.6 The Committee were updated on the roll out of ePMA and the positive feedback from wards and that there was great staff engagement. It was noted that the Pharmacy and Medicines Optimisation Strategy 2023-2026 is due for production in quarter three of 2023/24.

5. Our People

5.1 The Committee considered the quarter one 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.

5.2 The Committee were updated on the roll out of Oliver McGowan training and the Trust's aim of 100% compliance.

5.3 Committee members raised what the impact of industrial action was. It was noted that Unite had recently balloted regarding industrial action and that Junior Doctor strike action was continuing.

5.3 The Committee discussed the Guardian of Safe Working quarter one reporting noting that there had been two exception reports in the period, a figure well below the national average.

5.4 The Committee considered the quarter one Freedom to Speak Up report that detailed the number of cases received in the period, and that the majority involved an element of worker safety or wellbeing. It was noted that the number of cases continued to rise but that the number of anonymous was very low.

5.4 It was noted that some concerns had different elements but the four main categories for the concerns received in the quarter were: element of service user safety/quality; element of worker safety or wellbeing; element of bullying or harassment and an element of other inappropriate attitudes or behaviours. The Committee were updated on the progress with resolving the concerns and identifying learning. It was reported that an internal audit would be taking place in quarter two of Freedom to Speak Up at the Trust.

6. Experience

6.1 The Committee considered the quarter one Experience report. It was reported that the figures for compliments and complaints had remained static but had seen an increase in Friends and Family Test (FTT) score.

6.2 It was reported that work was underway to review and amend the approach to *Having Your Say,* reducing the length of the questionnaire and concentrated on high quality feedback from more targeted work.

6.3 Committee members expressed their interest in the new approach to involvement and it was agreed that the next meeting would have an update on this.

7. Governance

7.1 The Committee received and approved the updated Trust Risk Register. It was noted that the risk descriptions had been updated and the total number of risks had increased from seven to eleven. The increase in the number of risks was as a result of the identification of the specific risks, to ensure there is clear sight on the impact, and the actions needed. It was noted that the Trust Risk Register would be reviewed and updated for discussion at the October Committee meeting.

7.2 The Committee received a report that provided an overview of the Trust's performance in relation to the Emergency Preparedness, Resilience and Response (EPRR) Core Standards expected by NHS England for 2023/24. The report also set out the assurance in place regarding the Trust's annual position statement for EPRR.

7.3 It was reported that the annual assurance process has four stages, the first of which is 'self-assessment'. It was noted that following the self-assessment of the core standards and the deep dive standard the Trust would be reporting full compliance, including compliance with statutory training requirements. It was noted that the there was also an internal audit being undertaken which was reporting a positive opinion.

7.4 It was noted that that Trust Accountable Emergency Officer (Deputy CEO) would have a review meeting with the Integrated Care Board EPRR officers, following which NHS England will have the opportunity to raise any issues or further clarity around the Trust's submission before it will be formally ratified.

8. Matters for Escalation to the Board

8.1 There were not matters for formal escalation to the Board. It was noted that a number of quarter one reports would be considered by the Board at its' meeting on 5 October and that the EPRR compliance statement would also be ratified at the meeting.

Appendix One: Integrated Governance 27 July2023, agenda items

DEEP DIVE
Trauma Informed Approach
QUALITY SAFETY
Quarter One: Integrated Safety Report
PSIRF
QUALITY EFFECTIVENESS
Quarter One: CQUIN Update
Research and Development Annual Report
Annual Pharmacy and Medicines Optimisation Report
PEOPLE
Quarter One: People & OD Report
Quarter One: Guardian of Safe Working Report
Quarter One: Safe Staffing report
Quarter One: Freedom to speak Up Report
EXPERIENCE
Quarter One: Experience of Care Report
GOVERNANCE
Trust Risk Register
Emergency Preparedness Resilience and Response
TO NOTE **Reports taken as read and only questions to be taken**
QRMC Update Report May and July 2023
PODG Update Report June and July 2023
IMGS Update Report June 2023
Annual Infection Prevention and Control report
Integrated Governance Committee Planner
ANY OTHER BUSINESS
Any Other Business
Matters for escalation
Date and time of future meetings: 24 October 2023

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 8a
Report Title	Quarter 1 Integrated Safety Report	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Priscilla Chikwanha – Interim Head of Safety Bina Jumnoodoo, Deputy Director, Nursing and Quality	
Approved by:	Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse)	

Executive Summary

This report is for quarter one 2023/24. It provides the Board with an analysis of safety related incidents, identifying themes and contributory factors and also provides an overview of the plans in place and actions being taken to address the issues identified. Of note in this report are the following areas:

- The top two themes regarding the reported incidents were violence and aggression and self-harm
- Absent Without approved Leave increased over Quarter 4 and Quarter 1 and this report includes the analysis undertaken and actions taken to address
- Serious Incidents numbers remain relatively static, and this have been reviewed with similar trends to quarter 4
- Three Serious Incidents resulted in fractures (Older People's Services), with immediate learning already actioned and a full review being undertaken.

The report details the actions that have already been implemented and those in progress, as an outcome of the learning and analysis of the safety incidents and data. It also identifies other areas of focus during quarter 1 and into quarter 2, in line with our MOSStogether Strategy.

Recommendations

The Board is asked to receive the report, noting key themes and actions.

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 One 2023/4
27 July 2023

1. Introduction

1.1 This is the Integrated Safety Report for quarter 1 2023/24. In the report, there is an analysis of safety related incidents, identifying themes, contributory factors and an overview of the plans to address the issues identified.

1.2 From the analysis of the data during this period, the top two reported incidents related to violence and aggression and to self-harm, which this report will discuss, as well as providing more detail regarding Absent Without approved Leave (AWOL), following what looks like an increase.

1.3 This report also discusses Serious Incidents (SI), highlighting trends for the quarter, addressing three incidents that resulted in fractures.

1.4 Actions already implemented and those in progress are included, as an outcome of the learning and analysis of the data.

1.5 This is a new style of reporting, recognising the need to provide greater analysis and clarity of the actions taken. This will be further developed during quarter two.

2. Serious Incidents

2.1 Whilst the number of SIs are relatively static, there is a slight reduction compared to the previous quarter. However, there is a significant reduction compared to the same quarter last year, as detailed in *Figure 1.* The overall themes of the SI cases remained unchanged, with unexpected or avoidable deaths being the most prevalent theme.

Category	**Q1 22/23**	**Q4 22/23**	**Q1 23/24**
Unexpected or avoidable deaths	12	11	10
Apparent, actual or suspected self-inflicted harm	10	4	3
Disruptive, aggressive or violent behaviour	5	1	1
Slip, trip or fall	1	2	3
Sub-optimal care of deteriorating patient	2	2	3
Incident threatening organisations ability to continue to deliver an acceptable quality of healthcare services	0	1	0
Unexpected/potentially avoidable injury causing serious harm	0	2	0
Apparent, actual or suspected homicide	1	0	0
TOTAL	**31**	**23**	**20**

Figure 1

2.2 In quarter 1, there were three service users in older aged adult inpatient services who sustained a fall, resulting in fractures. Whilst the numbers remain low, it is important that we review the practice, and a detailed investigation has been

commissioned to identify contributing factors, learning and areas for further development, which will be shared in the next report.

2.3 Initial learning has already identified the need to ensure all service users have a physical health examination on admission, including the use of soft measures such as individual behaviours, signs and symptoms observed, discussed and recorded. A learning note and follow up discussions in the teams have already taken place.

2.4 There has also been a sustained reduction during quarter 1 in the number of those SIs relating to *disruptive, aggressive or violent behaviour*, and *apparent, actual or suspected self-inflicted harm*. That said, these two categories remain the top two themes reported from all safety-related reported incidents, which will be discussed later in this report.

3. Safety Related Incidents

3.1 *Figure 2* provides data from quarter 1 2022/23 to quarter 1 2023/24, which demonstrates that *low* and *no harm* remain the highest number of incidents reported. It also shows that the number of reported deaths and incidents of *severe* and *moderate harm* remain static. Further analysis to understand the correlation between the number of reported incidents, against the acuity and activity levels will be provided in the next report.

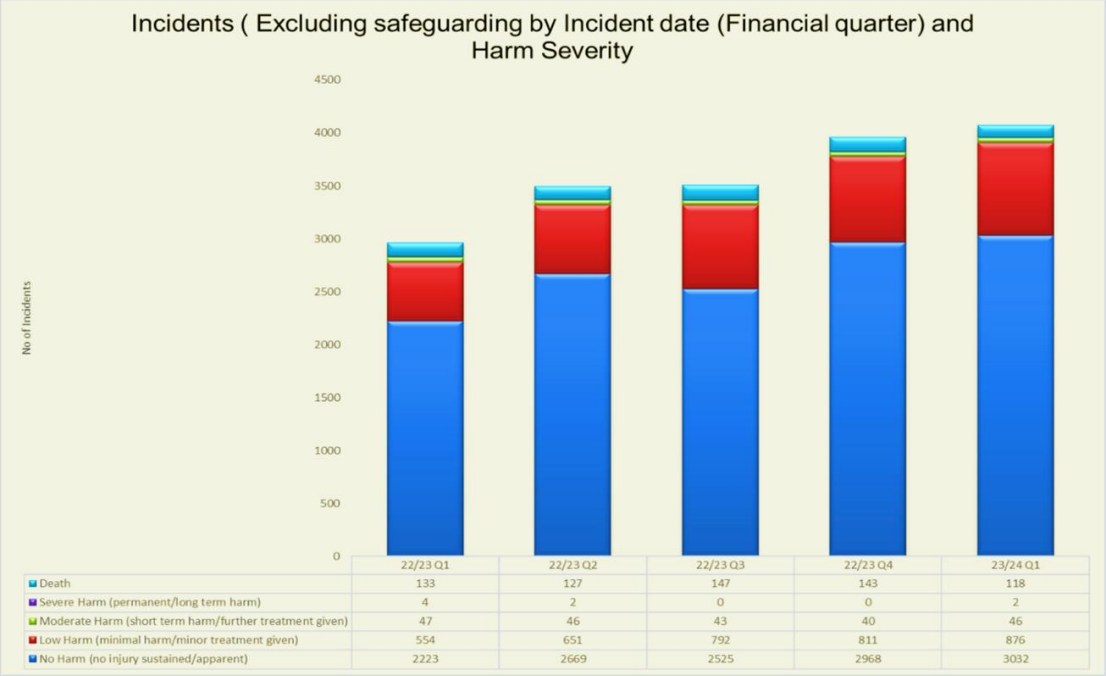

Figure 2

3.2 The highest categories of reported safety-related incidents are *violence and aggression*, and *self-harm*. The section below examines trends, contributory factors and actions, as an outcome of the learning and analysis from the data.

3.3 **Violence and aggression**

Figure 3 provides a breakdown of the number of incidents by subcategories of *violence and aggression*, which shows there were 349 reported incidents under the subtype of *violence and aggression* from *service user to staff*, with the highest reporting services in the Learning Disability and Forensic Strategic Business Unit (SBU).

3.4 Reviewing this in more detail, Dove Ward had 85 incidents, Astley Court 49 incidents, and Lexden 33 incidents. The majority of the incidents are attributed to five individual service users across the three service areas, all of whom who are clinically ready for discharge and awaiting an appropriate social care placement. All incidents continue to be reviewed regularly within the multi-disciplinary teams (MDT), informing both risk assessment and care plans.

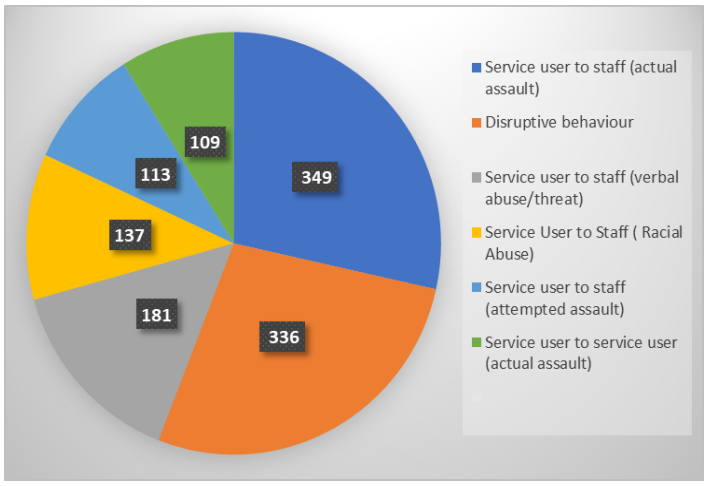

Figure 3

3.5 We have been using Continuous Quality Improvement (CQI) methodology to look at violence and aggression and the work has identified three key areas for focus - service user engagement, staff support and staff training. The following are being taken forwards:

- Ensure sufficient substantive staffing levels, through SafeCare, to reduce workload and stress
- Increase the use of de-escalation techniques and managing aggressive behaviour content in training
- Improve effective communication between staff and service users
- Provide more meaningful activities and therapeutic interventions for service users.

3.6 Although the other *violence and aggression* subcategories (*disruptive behaviour*, *service user to staff verbal abuse/threat*, *service user to staff racial abuse*, *service user to service user actual assault*) have not been individually addressed in this report, the CQI workstreams are considering all data and learning.

3.7 Further areas which are in progress include:

- **Inpatient establishments** - reviewed with finance and Human Resources (HR), to ensure correct staffing levels, in line with guidance from the National Quality Board and analysis of staffing levels, in response to acuity and complexity over the past year, and to ensure we have the right staff with the rights skills to deliver safe care
- **Reducing Restrictive Practice Regional Project** - Dove ward and Lexden are participating in the Reducing Restrictive Practice Regional Project, employing bespoke interventions tailored to individual service users' needs, which include increasing engagement with meaningful activities. This is reported to the Restrictive Practice Committee, with an anticipated outcome to have a system wide approach to ensure the least Restrictive Practice
- **Using Trauma Informed Approaches (TIA - f**ollowing the positive outcomes seen on Robin ward as an initial pilot, including a reduction in violence and

aggression towards staff, reduced length of stay and improved staff morale, we are now planning the roll out across all inpatient services. In line with the Annual Plan, the use of TIA is to be embedded across all inpatient services, and then community services.

3.8 **Self-harm**

Figure 4 highlights a consistent increase in *actual self-harm incidents* over the last twelve months. This section provides an overview and an analysis of the data, as well as implemented interventions, and recommendations for further actions.

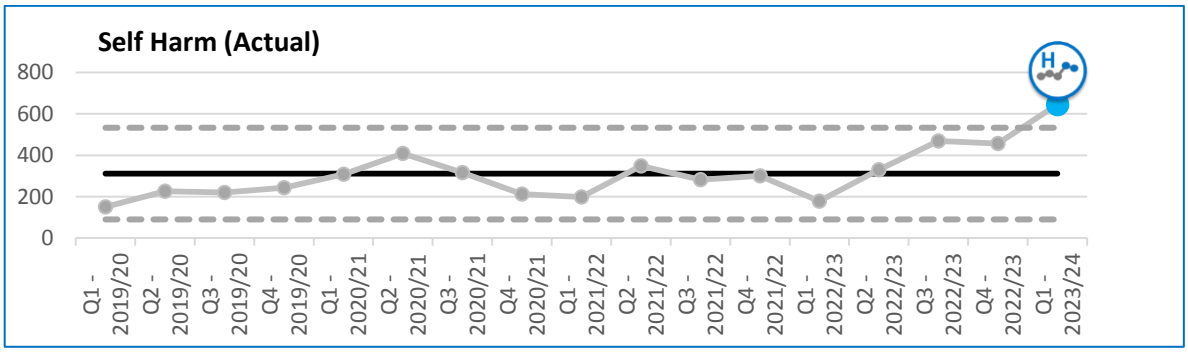

Figure 4

3.9 Overall, 795 incidents of *actual self-harm* were reported in quarter 1. Forest House accounted for the highest number of incidents (303), followed by Albany Lodge (135) and Aston ward (68). The analysis of self-harm incidents revealed that the two main types of self-harm on the inpatient service areas wards were headbanging and non-anchor ligatures (use of clothing).

3.10 The incidents relate to a small number of service users in the inpatient services. For example, at Forest House, 78% of the incidents involved four young people; at Albany Lodge 80% of the incidents involved three service users and on Aston Ward, 71% of incidents involved two service users. Whilst the majority of the incidents resulted in *low* to *no harm*, 14 were recorded as *moderate harm* and two incidents as *severe,* which were *actual self-harm* (*ingestion of object* and *deliberate self-harm*) and needed medical treatment.

3.11 All incidents are reviewed daily within the MDTs, informing both risk assessment and care plan reviews, to ensure that individuals receive the appropriate support to meet their needs whilst displaying behaviours which are complex and challenging.

3.12 Following immediate learning, an audit on search training was completed, owing to the number of incidents involving service users using contraband items to self-harm. The audit identified further training and development on search practice and bespoke training with services is planned to commence in September.

4. AWOLs

4.1 Following what looks like an increase in the number of reported AWOLs in quarter 4 2022/23 and quarter 1 2023/4 (see *Figure 5* showing the number of AWOLs over the past three years), a Task and Finish Group (the Group) was established. Chaired by the Clinical Director for Unplanned Care, the Group analysed the data, and identified areas of learning, informing changes in policy and practice and collaborative working with the police.

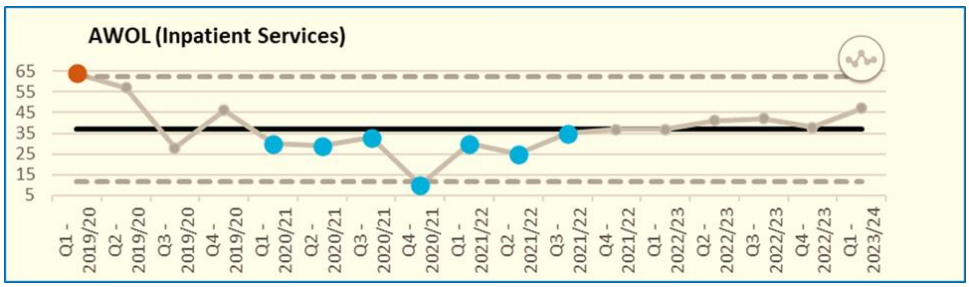

Figure 5

4.2 The Group concluded the following analysis:

- The majority of the AWOLs were reported to the police, regardless of risk level
- A high number occurred on the acute treatment and rehabilitation wards
- A high number of AWOLs involved service users who have been an inpatient for a long time
- The AWOLs often occurred during unescorted leave.

4.3 The Group identified that, overall, the number of AWOL incidents is low for all Trust inpatient services, compared to the number of leave (escorted and unescorted) granted from all the wards on a daily basis.

4.4 The Group concluded that services are managing the leave procedure and following existing guidelines. However, there remained areas requiring further improvement around the proactive identification of high AWOL risk, communication and having mitigation plans.

4.5 The Group considered themes around absconding, with, as mentioned above, the majority of incidents related to service users with a long length of stay. Reasons for AWOL are currently not always explored by staff when a service user returns to the wards, which is being addressed. Below are the main themes the Group identified:

- Need of social engagement with family/friends (one service user went on a date and spent the night in a hotel room)
- Personal needs – having haircut, picking up personal belongings; going to a synagogue
- Boredom, wanting a "change of scenery"
- "Wanting to have a drink" - use of alcohol while AWOL – but no heavy intoxication or serious harm under influence during this period
- Drugs – in three incidents there was evidence of drug use documented; most urine drug screens (UDS) on return were negative when documented
- Two resulted in self-harming and one death
- One was related to an argument with the family who accompanied them and absconded
- Leave for smoking (often recorded as leave for "fresh air").

4.6 The Group have identified actions in response to the above, which are due to be completed by the end of quarter 3, including:

- Review of the Trust's AWOL Policy, and separated from the Managed Entry and Exit Procedures (MEEP) Policy and Leave for Informal Leave Policy
- Clarity on roles and responsibilities of Trust staff and the police in responding to AWOLS and when to escalate

- Risk assessment/AWOL management flow charts, to guide three levels of risk categories
- Review of the guidance on Section 17 leave for smoking and use of Nicotine Replacement Therapy (NRT)
- Review of the Trust's Smoking Policy
- Development of an electronic Section 17 Leave form on the Electronic Patient Record (EPR).

4.7 A further update will be included in the next report on the above actions and further data analysis.

5. Areas of Focus/Other Actions

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

5.2 **Trauma Informed Approach (TIA) and Behavioural Support Plans**
Learning from the successful pilot on Robin ward, both a TIA and Behavioural Support Plans will be implemented across all services, to reduce self-harm over the course of the year. An update will be provided in the next report.

5.3 **CQUIN**
Forest House is participating in the Clinical Quality and Innovation Network (CQUIN) initiative, specifically focusing on reducing the use of restrictive practices. Quarterly reports provided to the Restrictive Practice Committee will include the number of restrictive practice interventions and the reason.

5.4 **Positive Risk-Taking**
Albany Lodge is taking a positive risk-taking approach in supporting service users who self-harm, by implementing Positive Behavioural Support Plans (PBS) instead of prescribing continuous Safe and Supportive Observations (SASO). This approach is being regularly reviewed by the team and a full evaluation will be discussed in the next report. Early indications suggest that we have seen a reduction in the use of SASO prescribed and an improved staff experience.

5.5 **Safety Measures and Audits**
As an outcome of an increase in self-harming behaviour at Albany Lodge, the MDT have been undertaking daily reviews regarding the use of safety measures, including anti-ligature clothing, safety pods and cushions, to safely support individuals, as per individual risk assessment and care plans. Ligature audits continued to be conducted and reviewed on a weekly basis by the Head of Nursing

5.6 **Learning and Quality Improvement**
Incidents, where prohibited items were brought in by service users or carers, led to the implementation of the Pro Screen 200 Ultra device in the Section 136 Suites, Forest House and Thumbswood. This device effectively detects ferrous metal on or in the body, including mobile phones, razor blades, lighters, needles, and knives. The effectiveness of this device will be evaluated in quarter three.

5.7 **NHS England adult inpatient guidance**
NHSE published new guidance on 18 July, and this is currently under review by services and the safety team. Whilst focused on 'effective inpatient care' we will

ensure any key learning and requirements regarding safety and the delivery of inpatient care is reviewed. An update will be provided in the next report.

5.8 **Mortality Governance**

As part of good practice, we regularly scan what is happening in other Trusts, from the Care Quality Commission (CQC) and other national publications. On 28 June 2023, the Health Service Journal (HSJ) published an article about an independent review, raising concerns about Norfolk and Suffolk NHS Foundation Trust reporting systems, and highlighted a number of service user deaths shortly after leaving the Trust's care since 2012. This included nearly 300 service users who died on the day they were discharged.

As a Trust, we are undertaking a review of all deaths across the Trust within 30 days of discharge, and this will be shared in due course with the Integrated Governance Committee. This work will also align with the work we anticipate taking place in the Autumn as part of the Health Services Safety Investigations Body (HSSIB) national investigation into mental health inpatient care settings.

6 Conclusion

6.1 This is the Integrated Safety Report for quarter 1, 2023/24, providing an analysis of safety related incidents, identifying themes, contributory factors and an overview of the plans to address the issues identified. The report has also identified actions for quarter 2.

7 Recommendations

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

NHS
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PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 8b
Report Title	EPRR Annual Report	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Caroline Mills, EPRR Lead Fiona McMillan Shields, Managing Director	
Approved by:	Sandra Brookes, Deputy Chief Executive/Chief Operating Officer	

The Integrated Governance Committee is asked to: (please choose which one(s) apply)
Approve: To formally receive and discuss the report and approve its recommendations or decide on a particular course of action. **Assurance:** To take assurance that effective systems of control are in place.

Executive Summary
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. This paper provides an overview of the Trusts performance in relation to the EPRR Core Standards expected by NHS England for 2023/24 and assurance regarding the Trust's annual position statement for EPRR. The process is in four stages and this report details the outcomes of the first stage of a 'self-assessment'. All 58 core standards and the 1 deep dive standards have been reviewed, and evidence to support performance against identified. The deep dive standards do not contribute to the overall assurance rating for the trust. This year the deep dive is regarding training. The Trust is reporting full compliance in the assurance process with all systems and processes remaining effective. This includes compliance with statutory training requirements. After the Accountable Emergency Officer's review meeting with the Integrated Care Board EPRR officers, NHS England will have the opportunity to raise any issues or further clarity around the Trust's submission before it will be formally ratified. The Trust has an EPRR Group of senior managers that meets monthly to routinely oversee and operationalise the annual plan for EPRR.

Recommendations
The Board is asked to APPROVE the report.

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.	

EPRR Annual Report: July 2023

1. Introduction

The purpose of the report is to provide assurance to the IGC on the annual Self-Assessment programme and the work of the Emergency Preparedness, Resilience and Response (EPRR) Team.

The Report is being presented for approval and assurance that the Trust is meeting its statutory requirements under the Civil Contingencies act (2004).

2. Background

The purpose of the EPRR annual assurance process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR core standards. The Trust was assessed last year as 'Substantially compliant" in the assurance process of 2022/23 and following local ICB commissioner assurance meetings, this final rating was confirmed. It is, perhaps, worth noting the assurance process last year was extremely rigorous following on from 2 years of lighter touch assessments during Covid, and that of the 9 organisations in the Herts and West Essex ICB Assurance process, only 1 organisation was rated as fully compliant, 1 provider was 'non-compliant', and the remainder achieved 'substantially compliant'.

3. EPRR Report

3.1 NHS England has a statutory requirement to assure itself of NHS EPRR readiness including through individual Provider Trusts. This is actioned through the EPRR annual assurance process. Assurance is a four-stage process.

1. EPRR Self-assessment for Trusts
2. Local Health Resilience Partnership (LHRP) confirm and challenge
3. NHS England regional EPRR team confirm and challenge
4. NHS England national EPRR team confirm and challenge

There are 74 core standards and 58 of those apply to Mental Health Trusts in 2023/24. The table below demonstrates self-assessment of compliance for the Trust for 2023/24. The latest draft version with the detail for submission is submitted alongside this report for information.

Table 1: HPFT's Self-assessment Compliance again Core Standards

Compliance level	Number of Standards
Not compliant	0
Partially compliant	0
Fully compliant	58

The Core Standards cover 10 Domains:

1. Governance
2. Duty to Risk Assess
3. Duty to Maintain Plans
4. Command and Control
5. Training and Exercise
6. Response
7. Warning and Informing
8. Co-operation
9. Business Continuity
10. Chemical, Biological, Radioactive, and Nuclear (CBRN) risk

The applicability of each domain and core standard depends on the organisation's function and statutory requirements. The Trust will submit a Self-Assessment stating that we are "Fully Compliant" in all the Domains. The Core Standards assurance and our known areas for improvement inform the annual EPRR Work Plan for the Trust, managed through the EPRR Group.

Each year, a 'deep dive' review is conducted to gain additional assurance into a specific target area. In 2023/24, the topic is EPRR Training. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating; these should be reported separately.

Following last year's assessment, the domain on Business Continuity was one area assessed as 'requiring improvement', to that end, a new Trust Business Continuity Management Strategy document has been developed to outline the roles and responsibilities of individuals within the Trust in respect of Business Continuity planning. The processes and procedures are also outlined within the document HPFT Business Continuity Management Strategy

This year, business continuity has been a focussed area for corporate and operational team training. A formal external audit of the Trust's approach to Business continuity management has been conducted in the past month to assess compliance with regulatory and NHS assurance requirements with a full report due from the auditors imminently. This is expected to highlight any areas of good practice and areas where services will need to improve their completion and recording of business continuity processes. Any areas for improvement coming out of this audit will be incorporated in to the EPRR annual work plan.

3.2 <u>EPRR Audit</u>

An audit of Emergency Planning and Business Continuity was as part of the Trust's agreed internal audit plan for 2023/24. The objective of the review was to allow management to take assurance over the business continuity arrangements in place across the Trust to ensure critical functions are able to operate in the event of disruptions.

To ensure the Trust continues as usual in the event of localised or Trust-wide disruptions, it has a Trust Business Continuity Plan (BCP) whilst service areas and sites within the Trust are also required to have BCPs and Business Impact Assessments (BIAs) using standard Trust templates. The Trust has 110 service areas/sites which are required to have BCPs, which require an annual update. Business continuity is governed by a Business Continuity Management Strategy (BCMS), which covers the roles and responsibilities of staff in relation to business continuity.

The audit found that adequate guidance was in place for staff with regards to business continuity. Standard templates for BCPs and BIAs were used by service areas and sites within the Trust. A Business Continuity Management Strategy was established to govern business continuity processes. The Trust organised business continuity training provided by third parties to key staff. The Trust was also compliant against the business continuity domain of the EPRR Annual Assurance Framework with a report provided to the Trust Board on this, we verified the accuracy of a sample of these assessments.

However, a number of areas were identified that required further actions including ensuring all service delivery teams have both a business continuity plan and a business impact assessment and that annual testing for business continuity plans takes place. An action plan has been developed taking noted of these areas identified.

Internal audit opinion:

The auditors concluded an overall a rating of Reasonable Assurance. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risks.

3.3 EPRR Policy

All NHS funded organisations are asked to provide evidence of their compliance and for their Board to issue a *Statement of EPRR Conformity* to their commissioners. The EPRR Group has developed and approved a new EPRR Policy that provides evidence for this purpose.

It is vital that the Trust is prepared and can respond to any major incident, providing a coordinated range of emergency, mid- and long-term services to those involved, including patients, relatives and friends, and our own staff. As such, robust and comprehensive emergency planning is a priority for the trust and compliments the safe and effective governance structures that work 24 hours a day and 7 days a week.

The Policy document is a concise document covering governance and areas of work covered by EPRR to fulfil our statutory duties under the UK Civil Contingency Act as a 'category one responder' and as a member of the Local Resilience Forum, which means the Trust is cooperating with other local health and public sector organisations to coordinate responses to emergencies. Category 1 responders are those organisations at the core of an emergency response and are subject to the full set of civil protection duties including to assess the risk of emergencies occurring and use this to inform contingency planning, to put in place emergency plans and to put in place business continuity management arrangements.

The policy covers the duties and responsibilities of the Trust's Chief Executive and Accountable Emergency Officer and Directors and senior managers. It describes the command and control structures and processes and how emergency preparedness is managed.

3.4 Incident Command

The Trust's incident response team has had to address other new stressors on the Trust's business throughout the past year including the death of The Queen, winter pressures, network outages, a water pipe leak at Kingsley Green and Industrial Action. The national and local Trust Covid incident command response was only de-escalated in Q1, 2023/24.

The Trust's incident command response has continued to flex up and down, to meet the needs of the Trust and provide assurance that all actions are being addressed. We have continued to use MS Teams as the preferred medium for the meetings and it has proved very efficient and meant we can have a full Tactical group meeting within a very short time of an incident being declared, as was the case for a recent water leak at Kingsley Green.

Full incident command and the incident command centre (ICC) was mobilised multiple occasions to oversee and manage the implications of Industrial Action within the Trust. During one spell of Junior Doctor Industrial Action, we had a concurrent Network Outage Incident. In addition, ICC was mobilised in response to a major water pipe leak at Kingsley Green affecting most of the HPFT services on site. The incident was managed in a timely and effective way minimising impact on service delivery. Debriefs are routinely held after each incident with learning identified.

The Trust has this year also identified Waverley Road as a secondary incident command centre (ICC) hub to be used if The Colonnades building is impacted or is unavailable. We will continue to use a virtual meeting format where that is appropriate and efficient.

3.5 Working with Partners

The Trust has continued to be responsive and support local Herts and West Essex ICB and wider organisation system calls and meetings. The ICB set up very regular system calls which were attended by the Managing Directors in normal working hours and the Director on Call for meetings out of hours. The frequency of the meetings reflected the pressures on the system, sometimes happening several times a day, during the Industrial Action for example.

We have responded to the local Tactical health response for Afghan and Sudanese evacuees, Industrial Action and extreme bed pressures across the system

The Trust continues to contribute to the Local Resilience Forum to access training and have also used the UK Health Security Agency (UKHSA) facilitated training.

HPFT participated in several ICB EPRR exercises. EPRR officers attended "Exercise Lemur", this was based on the scenario of a total national, power outage and its impact on the local health economy. The lack of generators at HPFT Trust sites for community and mental health providers continues to be flagged as a Trust risk that is difficult to mitigate against.

HPFT has joined a regional Resilience Mental Health Partnership, working with, and supporting regional EPRR leads from other trusts across the East of England.

3.6 EPRR Group

The Trust EPRR group meets monthly to oversee a robust annual work plan designed to achieve full compliance with the NHS England Emergency Preparedness, Resilience and Response Framework and the NHS Core Standards for EPRR. This group oversees holiday planning and winter and surge escalation planning.

The EPRR group also coordinates and commissions EPRR-focused training and exercises. We had a particular focus on Business Continuity Training this year, the ICB provided some very good, virtual training sessions and we held a face-to-face session at The Colonnades, which included Tactical Crisis Management.

As previously mentioned, the EPRR Group approved a new EPRR Policy, which supersedes the EPRR Policy Statement. The policy outlines the Governance, expectations and function of EPRR within HPFT and as part of the Local resilience Forum, during an incident or during business as usual.

The Group approved the updated Adverse Weather Plan, this was updated following the launch of the UKHSA Heat Health Alert system, on 1st June 2023. Further update will be made when the Winter/Cold Weather Health Alert plan is launched.

The Group has co-ordinated several Business Continuity Exercises. We ran a large face to face exercise based on the loss of the Electronic Patient Record. Operational Staff and colleagues from IM&T discussed the planning for and recovery from this sort of incident. The scenario was based on a 'ransomware' scenario but were focused on the events earlier in the year where other organisations did lose their EPR over a prolonged period. The report from this exercise went to the EPRR Group and several actions were followed up on afterwards, including the proposal of a cloud-based solution and there is currently a review of the current EPR underway subject to procurement options and the review of business continuity plans for all services which have been completed.

Power Outages were a real threat last winter and the EPRR team attended briefings from the UK Power Networks who were warning of possible scheduled power outages due to the demand outweighing the supply, made worse by the invasion of Ukraine. With the threat of the power outages, EPRR ran some exercises, engaging administration staff in the discussions on planned and unplanned losses of power and what they needed to think about in terms of business continuity and service delivery in such circumstances. Mitigating actions continue to be followed by teams including retaining local word documents and each team having USBs of basic patient records.

EPRR Team, alongside the Fire Compliance Officer, ran a Fire and Evacuation Exercise with a scenario following a fire on one of the wards at Kingfisher Court. The exercise was in the format of a tabletop evacuation and shelter discussion.

3.7 Winter Planning

The winter plan supports the Trust approach in terms of support for staff, support for service users and carers and business continuity. Winter planning encompasses support for the system, including response to surges in demand and changes in capacity alongside improved use of technology. The organisation adverse weather policy is also included.

As part of the Winter Planning, the EPRR team worked with Bed Management colleagues to create an "Live" bed management document on an MS Teams channel. Meetings were held 3 times a day to oversee the bed demand and flow. This winter saw very high demand for Mental Health Beds and this document was visible to all HPFT staff who may need sight of it or had any situational updates so that we had a real time view of where the beds were available and where the demand was coming from. This approach has now been incorporated into business-as-usual approaches to manage capacity and demand and flow across the trust.

The organisation continues to feed into the local system groups participating in any system wide winter planning that includes funding winter schemes.

3.8 Training

To meet National Occupational Standards for EPRR and monitor compliance, executive directors and senior leaders need to undertake several training courses in EPRR. The EPRR team continue to seek support from management teams to encourage team members to attend mandatory training and so make HPFT compliant with training requirements. The Trust can confirm that it carries out training in line with a training needs analysis to ensure staff are current in their response role and the organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. In addition, individual responders and key decision makers are supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role.

4. Summary/Conclusion

The EPRR Group has used the outcome of the EPRR self-assurance report from last year to inform the 'Work Plan' for this year, we have focused on the areas where we were found to be not meeting full compliance and have put policies and plans in place to enhance our assurance for this year.

5. Recommendations

For the Board to accept the *Statement of EPRR Conformity contained* within the EPRR Policy and to acknowledge the Trust self-assessment of the 2023/24 NHS Core Standards for EPRR. For the Board to note the outcome of the audit of EPRR and that there is an action plan in place to address areas for improvement.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 8c
Subject:	Quarter 1 Safer Staffing Report	**For Publication:** Yes
Authors:	Jinu Joseph, eRoster SafeCare Lead Bina Jumnoodoo, Deputy Director of Quality and Safety	**Approved by:** Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse)	

Purpose of the report:

This paper is presented to the Board to provide details regarding safer staffing and actions for Quarter 1 2023/24.

Action required:

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

Summary and recommendations to the Board:

This report informs the Board with an update on the safe staffing across all SBUs within the Trust, discussing key areas and actions taken as well as those in progress. This report was presented to the Integrated Governance Committee with the analysis of months 1 and 2 only from quarter 1. An update to include month 3 has therefore been included.

This report notes the increased acuity and complexity of service users, the number of prescribed safe and supportive observations, Registered Nurse vacancies and staff sickness which resulted in a continual increase in staffing across services, including the use of agency.

The CHPPD data shows a number of wards with a significantly higher fill rate over 120%. Following the completion of the phase 1 inpatient skill mix and establishment review, the SBUs commenced implementation and the updating of the HealthRoster. The analysis of this will be reviewed in the quarter 2 report, including a narrative of the CHPPD data and the impact on the fill rates, following the implementation of the revised establishment.

During the quarter, progress was made with the offer of over 100 Registered Nurse posts to the student nurses due to qualify during quarter 2, which will again be updated in the next report.

Relationship with the Business Plan & Assurance Framework:

Relation to the Trust Risk Register:

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

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

Relation to the BAF:

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

2. We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support, and treatment.

Summary of Implications for:

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

Equality & Diversity and Public & Patient Involvement Implications:

There are no implications arising from this report.

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

Safe staffing will support compliance with regulatory requirements

Seen by the following committee(s) on date:

QRMC 13 July 2023. IGC 27 July 2023

1. Introduction

1.1 This report provides an analysis of safe staffing across all inpatient services for quarter 1 2023/24. This report also provides detail regarding bank and agency usage and e-rostering across the Trust.

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

1.3 Where the skill mix and number of staff who work is lower than planned, there is an agreed escalation process for reporting. If a shift remained unfilled, this is reported to the Heads of Nursing and recorded as a safety incident. Staffing cover is often mitigated by an increase of staff from a different band, cross cover from co-located services and by the Team Leaders and Clinical Matrons.

2. Summary of findings

2.1 CHPPD Fill Rate data, is provided in **Appendix 1,** and reflects the staffing utilised across the services. CHPPD is a measure of workforce deployment that can be used at ward level and service level or be aggregated to Trust level.

2.2 The CHPPD fill rate is an indication on the staff utilisation for the month for each of the wards. When the fill rate is below 80%, it highlights high number of unfilled hours. When the fill rate is above 120% indicates creating additional duties to assign to staff. Continuous occurrence of fill rate outliers may indicate a requirement to review the establishment.

2.3 The analysis of the fill rate for this period indicates that NRN (Non-Registered Nurses - HCSWs) fill rates exceeded 120% for a number of wards with Aston Ward, Astley Court, Lexden, Swift ward, Robin ward, Forest House, and Oak ward as hotspot areas. The NRN fill rate for Aston ward exceeded 300% for both day and night, indicating the high number of additional duty hours created. This data is reviewed at the monthly SBU Safer Staffing meetings; increased prescribed SASO and high acuity was highlighted as the reason for the increase in the fill rate.

2.4 The fill rate analysis for RN highlights that day fill rate for Astley Court and Warren Court was close to 50%, which is an indication of nursing hours not filled. Again, this was discussed in the monthly SBU Safer Staffing meetings, citing the RN vacancies as having the impact. All the other wards are working withing the threshold fill rates for RNs.

2.5 With the revised establishment review and the increase in the RN numbers, we expect the CHPPD fill rate to achieve the optimum level. This will be analysed and reported in the quarter 2 report.

2.6 Phase 2 of the establishment review will commence in quarter 2 and look at the wider multi-disciplinary team (MDT) workforce and include Peer Support Workers.

3. SBU key headline updates

3.1 **Unplanned Care SBU**

RN vacancies and acuity and activity were the main reason for the use of bank and agency. A Resourcing Project Lead and additional admin support was identified to support clinical staff with recruitment; 31 student nurses due to qualify in the autumn were offered posts.

The estimated cost of SASO reduced by approximately 10% reduction during May, as an outcome of increased oversight and scrutiny of all prescribed SASOs and as part of Continuous Quality Improvement (CQI) project. There has also been a reduction in reported sickness, following additional support and training provided to the ward Team Leaders.

3.2 **East and North SBU**

There was an increase in the number of substantive nursing staff employed, which showed a positive impact on the use of agency. The SBU has also seen an improvement in the management of annual leave and reduction in lost contracted hours, as a result of increased scrutiny of roster and the associated Key performance Indicators (KPI).

There were nine Health Care Support Workers (HCSW) in the SBU who completed their Registered Nurse Associate (RNA) training and to supprot them on the pathway to qualify as an RN.

3.3 **Learning Disability and Forensic SBU**

The SBU saw an increase in the number of reported incidents of safer staffing from 18 to 31, owing to the challenges with covering shifts considering the number of prescribed SASO, and level of complexity and demand.

RN in learning disability (RNLD) vacancies are particularly high in the SBU and remained on the Risk Register. During the quarter, approval was received for eight HCSWs outside of Hertfordshire to undertake their RNLD training via the Open University. Work continued working at a regional and national level, supported by the Trust's Chief Nursing Officer, to explore options for hybrid and flying faculty RNLD training, owing to the limited number of universities now providing the training.

A time in motion study for Clinical Matrons and Operational Managers was undertaken which identified a high percentage of time spent on administrative tasks. The findings were being explored to identify ways to release time to care.

4. Finance

4.1 The quarter saw positive improvements in the reduction of agency and bank spend in some wards, as an outcome of the increased scrutiny and oversight of agency usage, roster monitoring and governance.

4.2 Pay costs continued to increase and were above plan, reflecting significant bank and agency costs. The pay award was accounted for in line with National Planning guidance, with some further funding expected to bridge the gap to the full award.

4.3 The aforementioned phase 1 establishment and skill mix review was completed and updated in ward establishments. The impact on this will be analysed in the quarter 2 report in consideration of the CHPPD data and the use of temporary staffing.

5. Bank and Agency

5.1 The reliance on temporary staffing was high across the wards, with approximately 50% shifts covered by temporary staff. On average, 90% of the total shifts requesting temporary staffing cover were filled. A reduction in the use of agency was shown, compared to the previous quarter, from 22% to 16%.

5.2 The top five reason codes requested for the use of temporary staffing were vacancies, SASO, training, ward activity and sickness.

5.3 A number of wards over recruited to nursing posts where able following recruitment processes and additional hours used to ensure staff have a robust induction onto the wards.

5.4 Loss contracted hours continued to be checked each week during the roster scrutiny meetings, ensuring staff completed their substantive contracted hours before working bank shifts.

5.5 During the quarter, the Trust procured Allocate Insight Reporting, which will support the Trust to benchmark the Rostering performance with national figures against six KPIs: Roster Approval, Unavailability, Temporary Staffing, Additional Duty, Unfilled Duty, Net Hours Balance. More detail will be provided in the quarter 2 report.

6. Conclusion

6.1 This report provides some additional data form the report presented to the Integrated Governance Committee, as it includes month three of quarter 1.

6.2 The use of temporary staffing has shown improvement although continues to be a challenge in some areas, owing to vacancies, and level of acuity and activity predominantly.

6.3 The SBUs completed the phase 1 nursing establishment reviews; the revised establishment will be updated in HealthRoster, and an analysis on the impact provided in the quarter 2 report.

6.4 The Trust actively recruited to RN posts, with the offer of over 100 newly qualified nurses. An update with the numbers will be provided in the next quarterly report, as a majority are due to commence employment in the autumn.

6.5 The Board are asked to note the content of this paper.

Appendix 1 – CHPPD Data

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

May 2023		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	100%	103%	-	-	102%	99%	-	-
	Hampden House	105%	135%	-	-	100%	122%	-	-
	Astley Court	60%	216%	-	-	86%	180%	-	-
	Warren Court	53%	90%	100%	-	65%	86%	100%	-
	4 Bowlers Green	96%	105%	-	-	97%	104%	-	-
	Beech	111%	101%	-	-	98%	131%	-	-
	Dove	122%	163%	100%	-	96%	214%	100%	-
	The Beacon	100%	101%	-	-	97%	206%	-	-
	Broadland Clinic	105%	96%	-	100%	103%	120%	-	100%
	Lexden	105%	300%	-	-	100%	195%	-	-
	SRS	96%	93%	100%	-	99%	100%	100%	-
West	Albany Lodge	101%	135%	100%	-	98%	159%	-	100%
	Aston	99%	305%	-	-	100%	287%	-	-
	Swift	105%	259%	-	-	96%	181%	-	-
	Robin	127%	191%	-	-	105%	220%	-	-
	Owl	101%	157%	-	-	98%	162%	-	-
	Oak	89%	361%	-	-	95%	253%	-	-
	Thumbswood	95%	120%	-	-	98%	144%	-	-
East & North	Logandene	96%	104%	-	100%	96%	133%	-	-
	Wren	95%	98%	-	-	100%	108%	-	-
	Lambourn Grove	117%	99%	100%	-	56%	121%	100%	-
	Seward Lodge	109%	101%	-	-	100%	114%	-	-
	Forest House	136%	140%	-	100%	139%	173%	-	-
	Victoria Court	119%	114%	-	-	100%	100%	-	-

June 2023		Day				Night			
SBU	Service	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate	RN Fill Rate	NRN Fill Rate	RNA Fill Rate	NRNA Fill Rate
LD&F	Gainsford House	96%	104%	-	-	100%	99%	-	-
	Hampden House	102%	153%	-	-	100%	130%	-	-
	Astley Court	45%	229%	-	-	93%	140%	-	-
	Warren Court	55%	91%	100%	100%	75%	85%	-	100%
	4 Bowlers Green	101%	91%	-	-	100%	100%	-	100%
	Beech	88%	115%	-	100%	98%	133%	-	-
	Dove	110%	150%	100%	-	98%	201%	-	-
	The Beacon	98%	111%	-	-	98%	224%	-	-
	Broadland Clinic	92%	103%	-	100%	99%	113%	-	-
	Lexden	100%	314%	-	-	102%	201%	-	-
	SRS	94%	97%	100%	100%	100%	100%	-	-
West	Albany Lodge	78%	124%	100%	100%	93%	140%	-	100%
	Aston	94%	446%	-	-	100%	388%	-	-
	Swift	103%	236%	-	100%	96%	168%	-	-
	Robin	90%	197%	-	-	100%	207%	-	-
	Owl	101%	145%	-	-	100%	149%	-	-
	Oak	93%	258%	-	-	90%	206%	-	-
	Thumbswood	88%	122%	-	-	100%	140%	-	-
East & North	Logandene	98%	104%	-	100%	100%	117%	-	-
	Wren	98%	109%	-	-	90%	181%	-	-
	Lambourn Grove	106%	100%	100%	-	75%	120%	-	-
	Seward Lodge	114%	112%	-	-	103%	142%	-	-
	Forest House	91%	165%	-	100%	100%	157%	-	-
	Victoria Court	101%	107%	-	-	100%	101%	-	-

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 8d
Subject:	Guardian of Safe Working Hours Quarter One Report	**For Publication:** Yes
Author:	Dr Dinal Vekaria, Guardian of Safe Working	**Approved by:** Professor Asif Zia, Executive Director Quality and Medical Leadership
Presented by:	Professor Asif Zia, Executive Director Quality and Medical Leadership	

Purpose of the report:

To share with the Board the Guardian of Safe Working Hours Update Report.

Action required:

Receive.

Summary and recommendations to the Board:

This is the quarterly Guardian Report, covering Quarter 1- April to June 2023.
During this quarter there were 2 exception reports raised by our Junior Doctors.

Overall, there has been a slight increase in bank locum spend since the previous report- mainly the impact of industrial strike action.

The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of exception reporting process. All junior doctors including Trust doctors can submit exception reports.

To raise awareness around Exception reporting, a joint presentation by medical staffing and the Guardian was carried out at the induction for new doctors.

Relationship with the Business Plan & Assurance Framework:

BAF Strategic risk one, two and three

Summary of Implications for:

This report does not have any financial or clinical implications

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

An EIA has not been completed and is not necessary, there are no Public and Patient Involvement Implications.

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

Assurance regarding Guardian of Safe Working will support compliance with regulatory standards

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

QRMC 13 July 2023, IGC 24 July 2023

Hertfordshire Partnership University NHS Foundation Trust

Guardian of Safe Working Hours Quarter 1 Report

1) Executive summary

- This is the Guardian of Safe Working Quarter 1 Report, covering April to June 2023.
- During this period there were 2 exception reports raised by our Junior Doctors.
- Overall, there has been a slight increase in bank locum spend since the previous report, due mainly to the impact of industrial strike action.
- The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of exception reporting process. All junior doctors including trust doctors have the ability to submit exception reports.
- To raise awareness around Exception reporting, a joint presentation by medical staffing and the Guardian was carried out at the induction for new doctors explaining the process. In addition, the Guardian has attended the monthly Junior Doctor Forums to highlight Exception reporting, and also asked for trainee reps to circulate information on Exception reporting to their colleagues.

2) Junior Doctor posts Numbers

- The table below gives the number of trainees of different grades working for the organisation. There are separate arrangements between HPFT and local trusts around core trainees rotating through psychiatric posts in Buckinghamshire, Norfolk and Essex.
- There are currently 116 doctors of different grades in training in the trust (see below for breakdown). Most of the trainee posts are in Hertfordshire. International Medical Fellows (IMF) posts have been recruited from overseas against posts that were left vacant after national recruitment however the number of IMFs have reduced due to the increase in trainee doctors.

Type of doctor	**Number of doctors in the trust**
Foundation Year 1	13
Foundation Year 2	8
GP Trainees	25
Honorary doctors	6
Maternity leave	2
Core Trainees	35
Speciality Trainees	20
International Medical Fellows	6
TOTAL	**116**

3) Exception reports (in regard to working hours)

- There were 2 exception reports raised by the junior doctors during Quarter 1.
- The two exceptional reports raised were in General Adult Psychiatry by core trainees.
- One Exception reports was due to staying late to manage a clinical emergency which was entirely appropriate.
- The other was around service cover and provision (sickness and cross cover as the ward doctor was on nights)
- All exception reports from previous quarters have been reviewed by the Guardian of Safe Working. Given the issues around liaising with the supervisors and the reasons for extra cover, we have not managed to fully resolve them all yet, but this will be completed soon.
- HPFT has one of the lowest numbers of exception reports in the region.

4) Benchmarking

EPUT: 132 doctors (annual average)

Exception reports Trainees via the Allocate reporting system from April 2021 to March 2022 raised 21 exception reports.

HPFT: 100 doctors (annual average)

Exception reports Trainees via the Allocate reporting system from Jan 2022 to December 2022 raised 9 exception reports.

5) Work schedule reviews

- During April to June 2023 there were no recorded requests for work schedule reviews by either trainees or clinical supervisors.

6) Fines

- No fines were issued during April to June 2023.

7) Rota Gaps and Cover

- The main issues were caused by the doctors' Industrial Action. There were 32 gaps in the rota in April and 24 in June. There were vacancies in the rota with 16 in April, 12 in May and 7 in June night shifts.

- Most of the cover has been provided by Bank locums- we aim to use our own internal locums, when possible, to maintain safety and quality of care.

- Primarily due to Industrial Action, there has been an increase in external locum spending, with some slightly higher sickness absence cases.

- All doctors doing locums completed the 48-hour opt out declarations.

8) Locum spend

Locum Cover

Apr 2023

Rota	Grade	Shifts	Hours	Cost
1st on call	CT =	9	112.5	£4,725
	F3 =	10	125	£5,250
2nd on call	SAS =	6	67	£3,190
	ST=	1	4.5	£214.29

May 2023

Rota	Grade	Shifts	Hours	Cost
1st on call	FY3 =	24	300	£12,600
	CT =	3	37.5	£1,575
2nd on call	ST=	10	109	£5,190
	SAS=	4	42	£2,000

June 2023

Rota	Grade	Shifts	Hours	Cost
1st on call	CT =	5	62.5	£2,625
	F3 =	12	150	£6,300
2nd on call	ST =	6	67	£3,190
	SAS =	3	34	£1,619

9) Locum work by HPFT doctors for other NHS Trusts

There were no other shifts that we are aware of declared at different organisations.

Summary

- This report provides data on the safe working hours for junior doctors.
- The 1st on call rota frequencies were all 1 in 12 and 1 in 13. The 2nd on call rota was 1 in 13 with 4 SAS doctors supporting the rota.
- There have been 2 exception reports, we are finalising resolution for them.
- In relation to sickness absence medical staffing have a robust system in place to ensure accurate reporting as well as return to work interviews are taking place. Covid19 risk assessments are also being completed to ensure junior doctors are supported, this has shown some improvement.
- Most of the gaps have been covered by internal bank locums or doctors providing cross cover.
- The Guardian of Safe Working attends and co-chairs a monthly Junior doctor forum that is run virtually. In addition, there are also meetings held with Junior Doctor Reps, Guardian of Safe working, DME's and Medical Staffing for any concerns or questions to be raised and resolved in a timely manner.

Dr Dinal Vekaria, Sept 2023

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 8e
Subject:	Experience of Care Report: Quarter 1	**For Publication:** Yes
Authors:	Lara Harwood, Interim Deputy Head of Experience	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Sandra Brookes, Deputy CEO and Chief Operating Officer.	

Purpose of the report:

This summary report provides the Integrated Governance Committee with information on feedback received from service users and carers, i.e. compliments, PALS contacts, complaints, Having Your Say and other local surveys including the Friends and Family Test, and other experience feedback during Quarter 1, 2023-24.

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

Action required:

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

Summary and recommendations:

Summary

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

This summary report provides an overview of feedback: local surveys, national surveys, compliments and complaints, actions and learning from SBUs and the involvement programme during quarter one 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.

Headlines for quarter one 2023-24

In the quarter the Trust received:

- 518 compliments (512 in quarter four)
- 1,973 surveys (Having Your Say (HYS), Friends and Family Test (FFT), Attend Anywhere) (2,180 in quarter four)
- 79% FFT Score (80% in quarter four)
- 252 PALS contacts (253 in quarter four)
- 118 complaints (139 in quarter four)
- 34 survey responses so far have been received for the Inpatient Survey Project asking how safe people felt on inpatient units. Please note that this current project is still running and will be completed mid-July.

Key Performance Indicators

- 81% service users feeling safe on adult and CYP inpatient units – compared to 72% in quarter four.
- 85% service users know how to get support and advice at a time of crisis – compared to 71% in quarter four.
- 82% service users have been involved as much as they want to be in discussions about their care – compared to 81% in quarter four.

- 92% of carers feel valued by staff as a key partner in care planning – compared to 80% in quarter one

The most significant changes when compared with the previous quarter?

Positive
- An increase in compliments received compared to quarter four.
- Decrease in complaints.
- Increase in carers saying they feel valued as partners in care planning.
- Increase in service users feeling safe on inpatient units as reported through HYS.
- Increase in service users knowing how to get support at a time of crisis.

Areas for improvement
- 9% decrease in surveys received.
- Continued low numbers of feedback surveys from carers.
- Number of days to respond to complaints

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

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

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

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

Financial implications with financial remedy recommended to acknowledge distress and inconvenience caused by failings in service delivery and complaints handling. Also claims for property that is lost while in the safe-keeping of the Trust.
Mandated acknowledgement of complaints within three working days.
Mandated Friends and Family Test monthly submission to NHS England

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

The Trust must continue to learn from the lived experiences of those using HPFT services (NHS England Five Year Forward for Mental Health 2016), by working collaboratively with stakeholders, staff, service users and carers to ensure that we consistently deliver services that are representative of the people using services.

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

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

Seen by the following committee(s) on date: IGC 24/10/2023

Experience of Care Report – Quarter One, 2023-24

1. Introduction

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

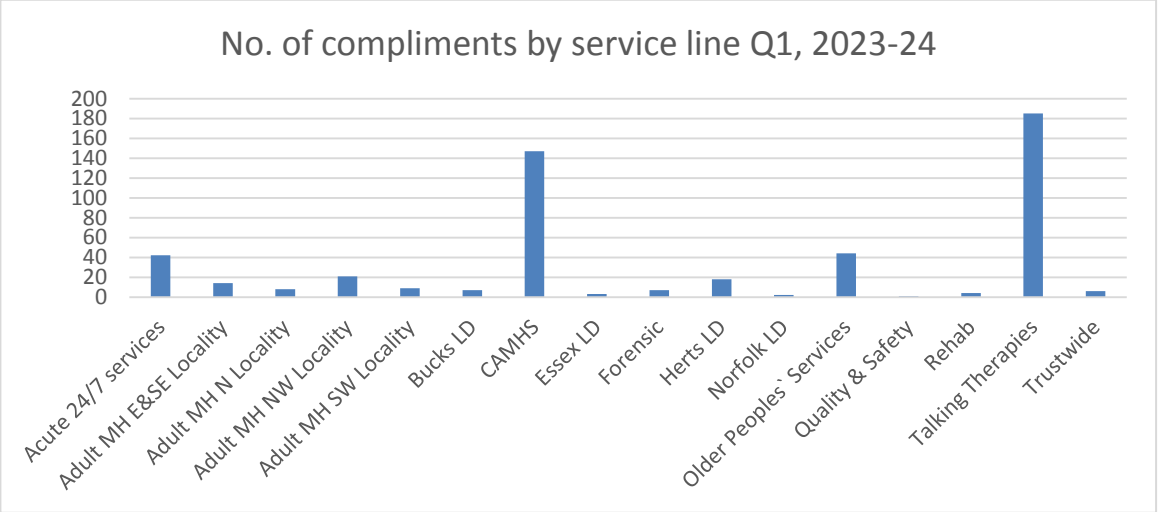
1.2 This includes local surveys, national surveys, compliments and complaints, actions and learning from SBUs and the involvement programme during quarter one 2023-24.

2. Compliments

2.1 In quarter one 2023-24 we received a total of 518 compliments compared to 512 in quarter four. The majority of compliments were received for Talking Therapies with a total of 185 compliments, this was followed by CAMHS with 147.

2.2 Compliments are shared with staff through The Hive and "compliment of the week" in the staff bulletin. An increase in compliments is now a Key Performance Indicator for 2023-24. Promotional work will be ongoing in quarter two to encourage teams to record any compliments received.

Graph 1



2.3 Compliment Themes: Words such "amazing" and "excellent" were used frequently.

Thank you for everything you have been amazing, you have always advocated for X and given her a voice.

Forest House

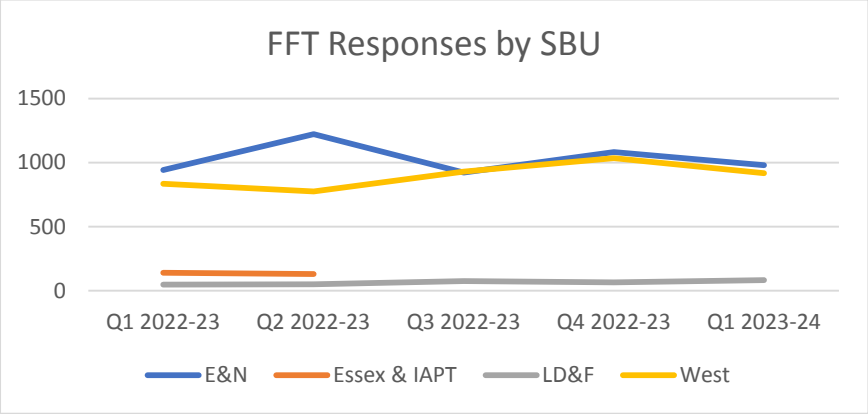
I think my therapist Tom was fantastic. He listened very well and provided appropriate strategies for me that mirrored my moods and emotions each week.

Talking Therapies East

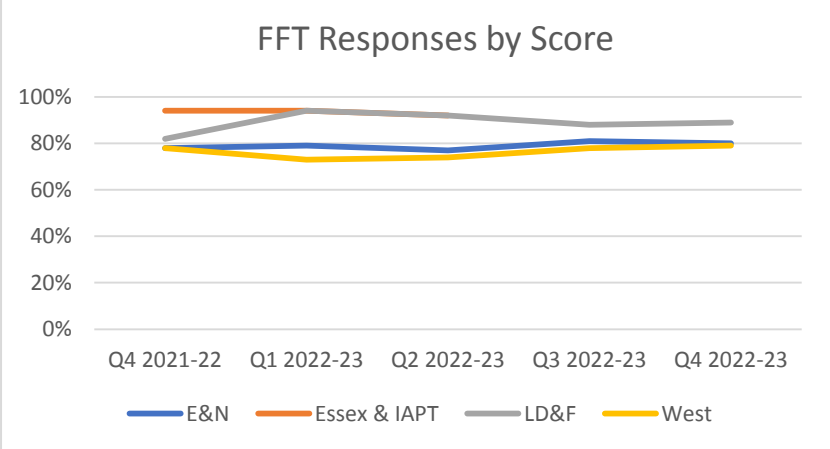
3. Surveys

3.1 During quarter one we received 1,973 responses to local surveys compared to 2,180 in quarter four. The FFT score dipped slightly to 79% from 80% in quarter four. The graphs below show the response and scores by SBU.

Graph 2

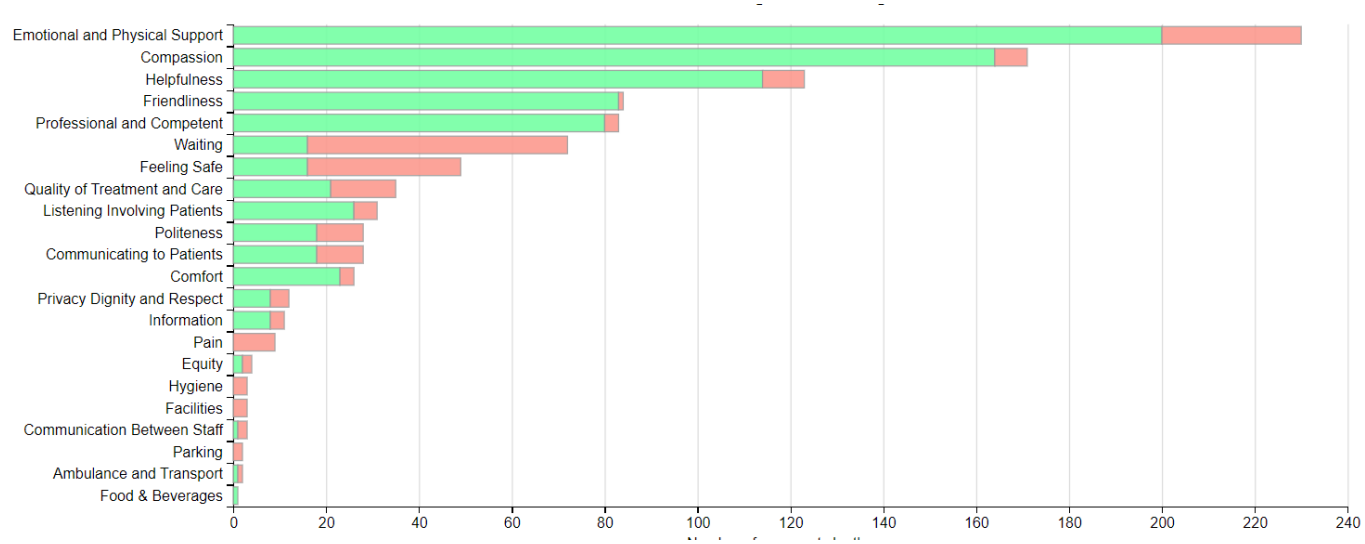


Graph 3



3.2 The majority of comments given through local surveys were positive and were categorised under the theme “Emotional and Physical Support”. “Excellent”, “supportive” and “impressed” were words mentioned frequently. Responses also spoke about feeling “comfortable” to share without judgement. “Waiting” and “Feeling Safe” showed the highest number of negative comments. Responses stated that people are waiting for care coordination, psychiatry appointments and prescriptions. Frustrations about cancellations were also mentioned. Among the negative comments given the words “anxiety”, “crisis” and “rude” were mentioned. The diagrams below detail the themes from local surveys.

Graph 4 - all survey data



Word Cloud 2

3.3 The Having Your Say (HYS) review findings have been approved by the Executive Team with a proposal to slowly phase out HYS. The FFT surveys will remain as mandated by NHS England. This will be monitored over the year to ensure that we continue to gather feedback in other ways such as targeted time limited surveys, e.g. feeling safe, peer listening and peer observation projects. Key Performance Indicators relating to HYS have been changed to align with current areas of focus.

3.4 Following a procurement project, the experience survey platform will change provider from 1st September 2023. This means that all experience anonymised survey data will move to a new system called IQVIA. The new platform will offer all the benefits of the old, real time reporting for experience surveys for all staff, plus statistical process control (SPC) charts and benchmarking across the Integrated Care System (ICS). Work is underway to ensure a smooth transition.

4. Shared Experience Stories

4.1 One service user shared their experience at the Board meeting in May of the Enhanced Primary Care Mental Health Service (EPCMHS). They thanked the service for supporting them out of a mental health crisis and valued the impact of the peer support group that the service offered. The service user had never experienced issues with their mental health until this point

in their mid 50's and felt that EPCMHS helped to keep them alive and able to continue. The story had a powerful impact at the meeting with attendees thanking the service user for their candour in sharing their experience.

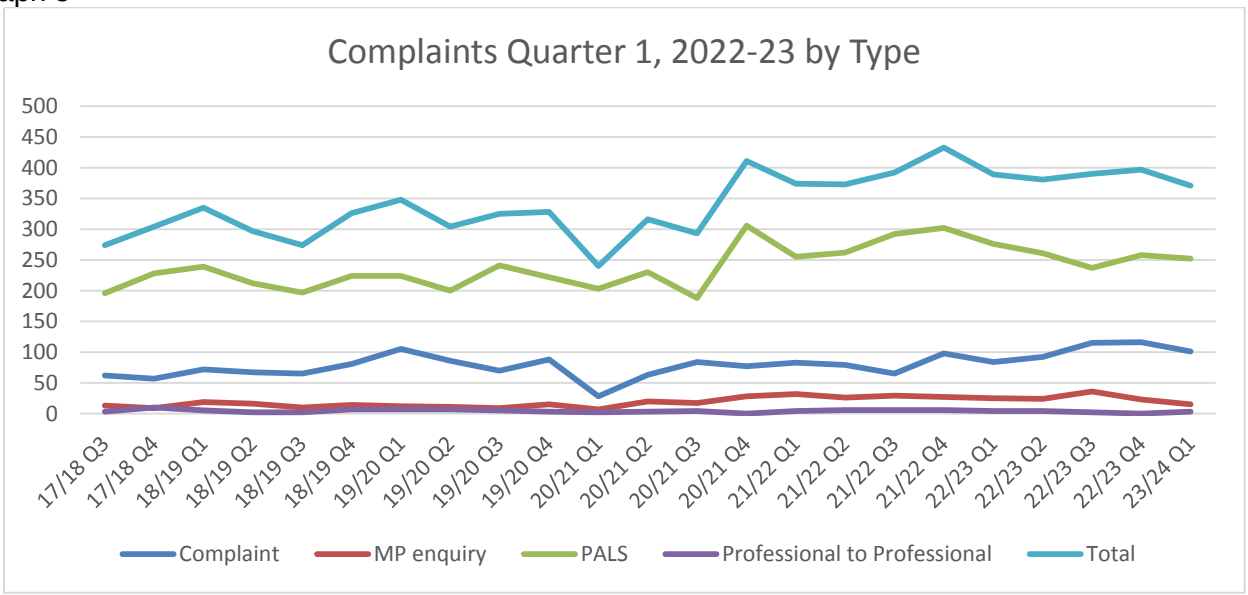
5. Complaints and PALS

5.1 In quarter one, 2023-24 we received 118 complaints compared to 139 in quarter four. This is the second quarter in a row where complaint numbers have decreased. Included in this figure are 15 MP enquiries, which was a decrease compared to 23 in quarter four. There were three professional to professional complaints, we did not receive any in the previous quarter.

5.3 There were 252 PALS enquiries in quarter one compared to 253 in quarter four. 64 of the PALS enquiries received were not related to HPFT compared to 43 in the previous quarter.

5.4 In the quarter one 123 complaints were closed compared to 123 complaints quarter four; 8 were upheld, 41 partially upheld, 65 were not upheld, 5 were withdrawn, 2 complaints were closed as the concerns did not fall within the remit of HPFT Complaints Procedure. (Please note that complaints closed during quarter 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 are that in the quarter, 49% of all complaints received were for **Adult Community Mental Health Services** (ACMHS), this is a decrease compared to 55% in quarter four. Patient care was again the main theme followed by communication. Complainants mentioned a lack of support which is impacting on deteriorating mental health, poor communication, issues with medication and inaccuracies in reports.

5.6 There was a decrease in complaints from **CAMHS** (21 compared to 25 in quarter four). The main concerns relate to a lack of support and access to medication. Families expressed their frustration about the wait for treatment and access to treatment with no explanation about why they are not being taken on by HPFT CAMHS.

5.7 In **Unplanned Care**, care and treatment and communication were the main themes of the concerns raised. Several concerns have been raised this quarter about service user's access to their mobile phones on the wards. Staff attitude has also been raised on occasions.

5.8 In **Forensic Services** there has been a number of persistent complaints received from one service user at the Broadland Clinic. As part of the CQC's new approach to resolution, the Complaints Team and clinical staff are working with the CQC and service user to ensure we are responding to the concerns and that CQC are supportive of the approach being taken.

5.6 With regard to the key performance metrics for complaint management, the average number of days taken to acknowledge complaints in quarter one was three (3.3) working days, it was three 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 40 days, this compares to 42 in quarter three. 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 118 complaints received in quarter one, we received 6 completed equality monitoring forms. There were no complaints in quarter four that mentioned equality as a concern.

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

5.9 In the quarter one, seven complaints evaluation surveys were received. 66% of those who responded said that their complaint had not been resolved and was ongoing. All respondents said they were either seeking legal advice or would be contacting the Ombudsman. The team are working with the SBUs to use the action planning module on Datix to monitor actions taken, it is hoped that this will enable improved local ownership of complaints and a cycle of feedback to the complainant.

5.10 In quarter one the Parliamentary and Health Service Ombudsmen (PHSO) requested the casefiles for one complaint. One case with the Local Government Ombudsmen (LGO) returned initial findings relating to a service which is sub-contracted via HPFT.

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.

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

6.5 Following completion of Peer Listening interviews at Warren Court and the Broadland Clinic and Peer Observation visits at older peoples' inpatient units, draft reports are now being written with the findings. Teams will be asked to review the reports and its recommendations and compile an action plan.

7. Involvement

7 .1 There were 480 hours of involvement activity in quarter one compared to 655 in quarter four.

7.2 42% (equivalent to 203 hours) were allocated for specialist participation in Trust meetings. Additionally, 29% (equivalent to 139 hours) were devoted to Service User and Carer Council meetings, while 9% (equivalent to 42 hours) were dedicated to CQI projects. A further 13.5% (equivalent to 65 hours) were utilised for conducting interviews.

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

8. Volunteering

8.1 39 volunteers are currently registered with HPFT in various roles across services including, administration, meet and greet, PAT dogs, gardening and music activities, etc.

8.2 Two volunteers were recruited during quarter one and nine applicants are currently going through the recruitment process.

9. SBU Updates

9.1 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:

9.2 **CAMHS**: Work to centralise and streamline access to treatment is ongoing using an MDT approach due to increasingly complex cases. **Neurodiversity** work with the Anna Freud Centre, Autism and Eating Disorders from the National Autistic Society to understand more about the specific challenges of people with neurodiverse needs and how to adapt treatment in a person-centred goals/needs/strengths led approach. **Eating Disorder Team** parent/carer skills group continue with themes this quarter including: psycho-education about eating disorders, meal planning/nutrition, using parental skills, communication, understanding change and managing behaviours. **CCAT** a survey has been sent out to service users to inform of future improvement work. The team are working to start a parent/carer group. **Mental Health Support Teams** have reviewed their pathways and processes to reflect learning and changes to improve the experience. A new “wait list” pathway has been introduced and a new referral process has reduced the burden on schools to complete paperwork. Parent/carer coffee mornings continue. **Forest House** host an Involvement Group weekly giving the young people an opportunity to speak and feel heard. Introduction of coping/communication cards to help young people communicate their emotions and PBS (Positive Behaviour Support) plans to help address individual behavioural needs. Reflective Leave was introduced to give young people the opportunity to disengage from treatment and allow time for self-reflection and decision making.

9.3 **Older Peoples’ Inpatient Units**: Frail functional and assessment and treatment wards are working to ensure that any actions from their mutual help meetings are followed up in a timely way. “You said, we did” posters are being completed regularly and are available for service users and carers to view on the units. DIALOG+ was piloted on Wren Ward and has now been added as a care document on PARIS. This will improve our care planning and the treatment we provide for our service users as a coproduced care document. Carers and relatives will be involved particularly if the service user lacks capacity. There has been positive feedback from staff regarding this. The Crisis Function Team is continuing to work on the community transformation programme.

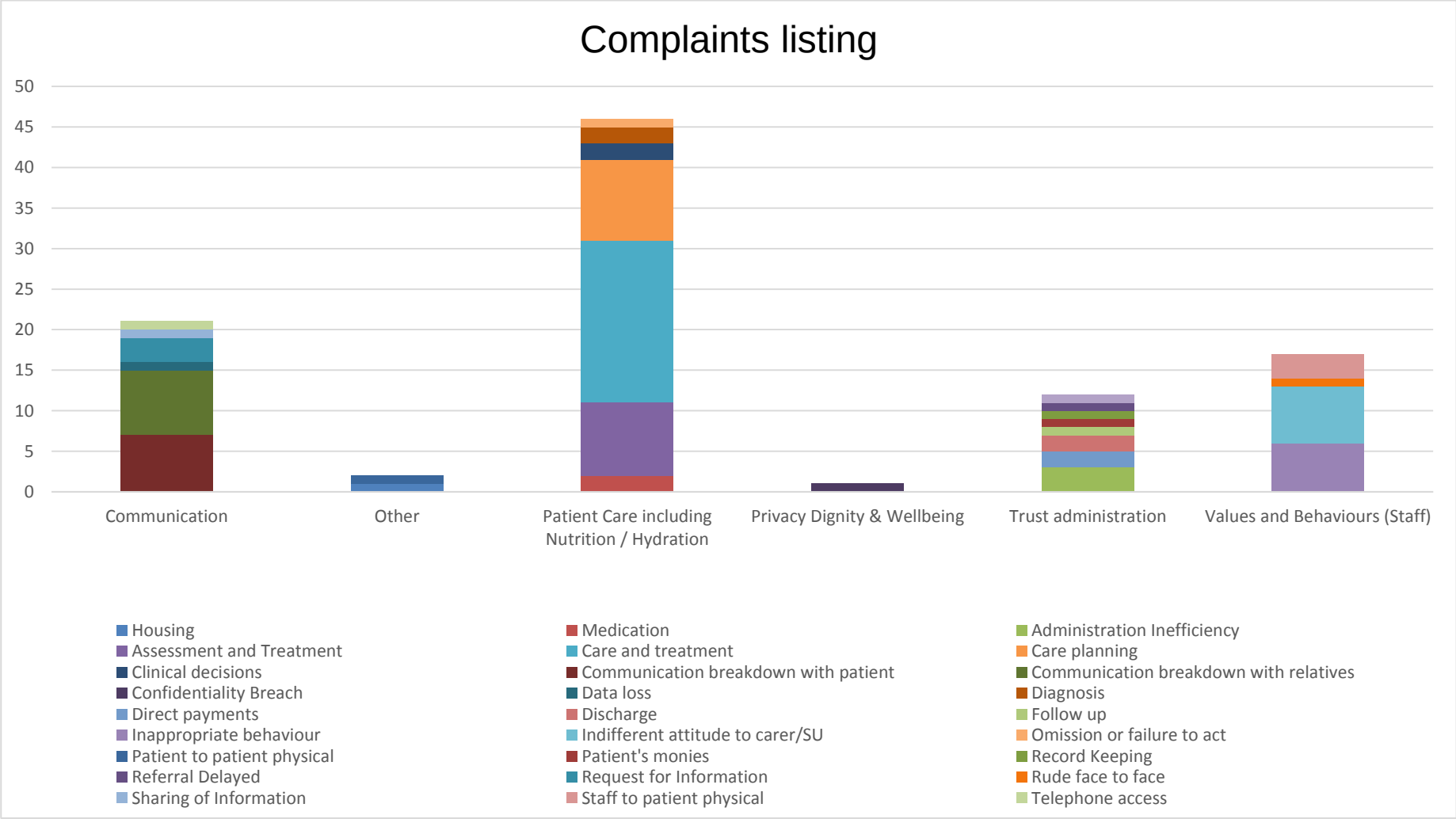
9.4 **Unplanned Care**: As part of the Trust wide agenda around engagement and activity, and improving the experience of people using our wards, making their admission purposeful, a CQI project was commenced on **Owl Ward**. A questionnaire was completed with people on the ward to establish their satisfaction with engagement and activities on the wards. Feedback told us that service users felt that there is not enough to do on the ward. Service users commented positively about staff engaging with people on the wards and the range of activities on offer. A 'Needs and Feelings' document is held in a folder on the ward for staff to use with people which helps identify their interests. Equipment such as table tennis set and table football have been ordered for the ward. Work continues with the **Acute Pathway Improvement Programme** to improve service user experience of the acute pathway, improve management of service users and their care needs, reduce delays in transfer of care and a reduction in out of area placements. **Carer** drop in sessions continue at Kingfisher Court covering carer support in the community, discharge planning and peer support. Carer Champions have been identified on inpatient wards**.** Carer Welcome Letter has been developed and will be adapted for the Inpatient Wards and Crisis Resolution Home Treatment Teams (CRHTT) to be given to the Carer once they have been identified.

9.5 **Planned Care**: **Talking Therapies** have developed a range of culturally sensitive interventions with skills training and supervision for staff. The **Community Perinatal Team** are using the Peers Support workers who help facilitate group sessions and one to one sessions with service users. They have just developed partner self-assessments. Alongside this they have also just developed a signposting and support document/leaflet for dads/partners. The 'Adjustment to Motherhood' group is being redesigned to include a session for partners/family members. It is hoped the team can recruit part-time male peer support worker to work with dads/partners. The team have started a Healthier Lives Group which gives service users information around making healthy choices. **SW Adult Community Mental Health Services** (ACMHS) held an away day to create joint working with partners for improved collaboration. This will offer service users a smoother pathway between teams and ensure referrals are made to the right team. A CQI Project has started to reduce waiting times for assessment in **Watford ACMHS**. A duty CQI Project has started with our EbEs to streamline the duty box process. The Teams are planning to invite service users and carers in to talk about their experience of service following a complaint resolution. **Enhanced Primary Care** are developing a First Contact Assessment process to better recognise information and conversations at first contact to inform interventions. There is also a money advice project to ensure key signposting, for financial support, during the assessment in primary care.

9.6 **LD&F**: **Making Services Better Group** have continued to support the physical health team in the development of an accessible leaflet for people with asthma. They have also participated in reviewing the Trust Mission Statement. They have provided their input into creating an easy read property disclaimer for inpatients, developing a resource for creating visual positive behavioural support plans, reviewing the easy read feeling safe survey and the semi-structured interview questions for service user feedback from being on safe and supportive observations. They have also provided their insight into the challenging behaviour and dementia pathways work. Three **Health Access Champions** have completed their CQI Leaders adapted course. They supported the CQI team to adapt the course to meet the needs of experts by experience including those with a learning disability and have now gone through the course themselves. **Carers Engagement** Herts Secure services celebrated Carers month with carers events in all three units and have spent time reviewing their support for carers and setting out a draft carers charter which will be shared at the next carers events to co-produce the end result. **Learning Disability Week** was celebrated with events involving staff, service users and carers. Work has commenced on the **SBU business plan objectives** which include coproduction with service users and carers at its heart. Meetings with teams have taken place to establish how they will meet the objectives and provide further opportunities for co-production for service users and carers in their local areas. A new piece of software

developed by the University of East London is being used to create bespoke easy read surveys with the ability to read out questions. This will help us to provide more opportunities for our service users and carers to give their feedback and for us to use this to improve services.

Appendix 1 – Complaints Themes



Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 8f
Subject:	2022/23 Infection Prevention and Control Annual Report and 2023/24 Infection Prevention and Control Programme	**For Publication:** Yes
Author:	Sarah Mantle, Consultant Nurse Infection Prevention and Control	**Approved by:** Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director, Quality and Safety (Chief Nurse)	

Purpose of the report:

To give assurance to the Board in relation to Infection Prevention and Control requirements.

Action required:

To RECEIVE

Summary and recommendations to the Board:

Summary

The IPC annual report provides detail of progress the Trust has made in relation to minimising the risks of healthcare associated infections.

The report also identifies the IPC priorities for 2023/24, required to implement to ensure that the risk of service users, staff, and visitors, acquiring a healthcare associated infection is kept to a minimum and IPC practice is applied consistently.

Recommendation

The Board is asked to RECEIVE the report.

Relationship with the Annual Plan & Assurance Framework:

This report speaks to and provides assurance in relation to clinical safety of service user, staff and the wider public in relation to infection and the key priorities for 2023-2024

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

No Equality and Diversity and Public & Patient Involvement Implications

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

Safety KLOE for CQC

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

QRMC 13 July 2023 IGC 27 July 2023

2022/23 Infection Prevention and Control Annual Report and 2023/24 Infection Prevention and Control Programme

1. Introduction

1.1 This report outlines the activities of the Trust relating to infection prevention and control (IPC) for 2022/23.

1.2 The report gives an overview of the reported healthcare associated infections (HCAIs), outbreaks declared in year, the audit programme, training compliance as well as IPC incident reporting.

1.3 The report also demonstrates how the Trust has the relevant practices and procedures in place to ensure the prompt identification of service users and staff with infections. Ensuring appropriate actions are taken to limit spread to others. It also explains the accountability arrangements, audit, surveillance, education and training, policies and procedures relating to IInfection Prevention and Control (IPC).

2. HCAI, Alert Organism and Outbreak Surveillance – Performance

2.1 Monthly data has been collected on the incidence of Meticillin resistant *Staphylococcus aureus* (MRSA), Meticillin sensitive *Staphylococcus aureus* (MSSA) and E-coli bacteraemia cases and *Clostridioides difficile* Infection (C. difficile).

2.2 There were no cases of MRSA or MSSA bacteraemia and two reported cases of MRSA colonisation/infection (not bacteraemia), the same as last year. The MRSA care pathway was implemented for both cases and the decolonisation treatment prescribed.

2.3 There were no cases of E-coli bacteraemia reported and no reported cases of service users with *C difficile* infection. Two service users were identified to be colonised with *C. difficile*, and both reviewed with treatment prescribed as directed by Consultant Microbiologist. The cases were not linked and recently had courses of antibiotics, which is a risk factor. There have been no reported cases of service users with Carbapenamase producing *Enterobacteriacaea.*

2.4 Other alert organisms/conditions reported during the year included:

- Ringworm
- Shingles/Chickenpox
- unexplained rashes
- Scabies
- headlice
- Diarrhoea and/or vomiting.

The IPC team (IPCT) investigated each incident and found no evidence of onward nosocomial transmission in any case. Learning and training was shared and provided with the IPC link practitioners.

2.5 The Trust continued to see Covid 19 cases in service users and staff, as detailed in *figure 1*. Increases were noted with the advent of new subvariants of Omicron in quarters 2 and 4, with an increase in outbreaks. At the same time nationally, testing requirements for admissions and staff were amended to pause regular asymptomatic Covid19 testing.

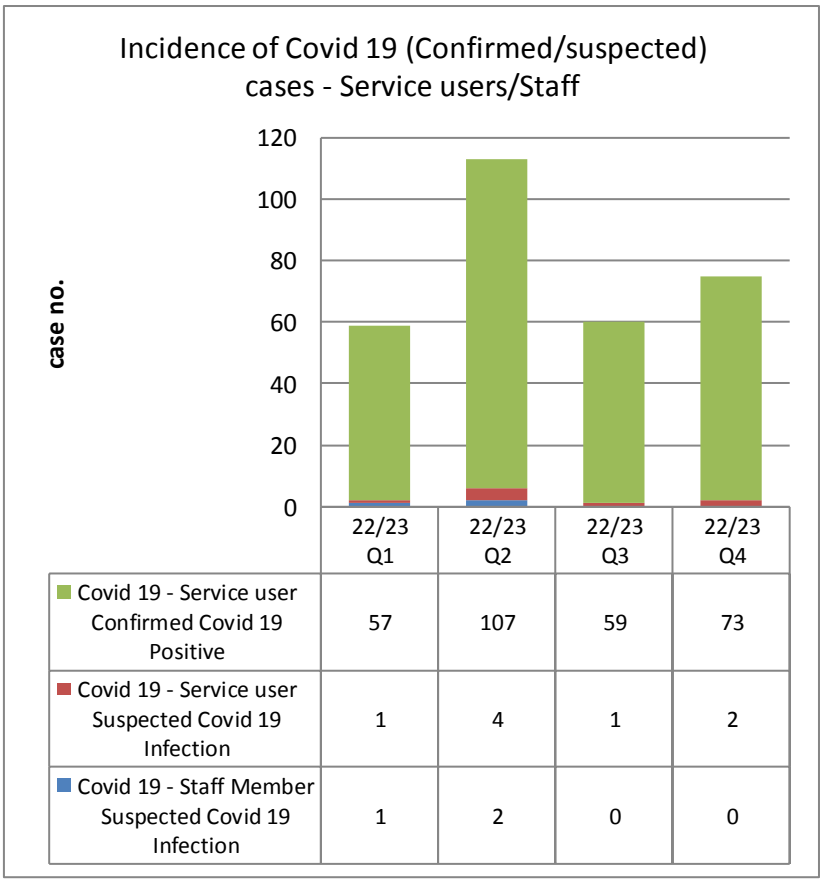


Figure 1

2.6 Ten service users were confirmed to have died from Covid 19; all were in the community and not linked to the outbreaks in the inpatient services. This is a reduction to the previous year and there has been a reduction in deaths from the 195 reported, as detailed in *figure 2*.

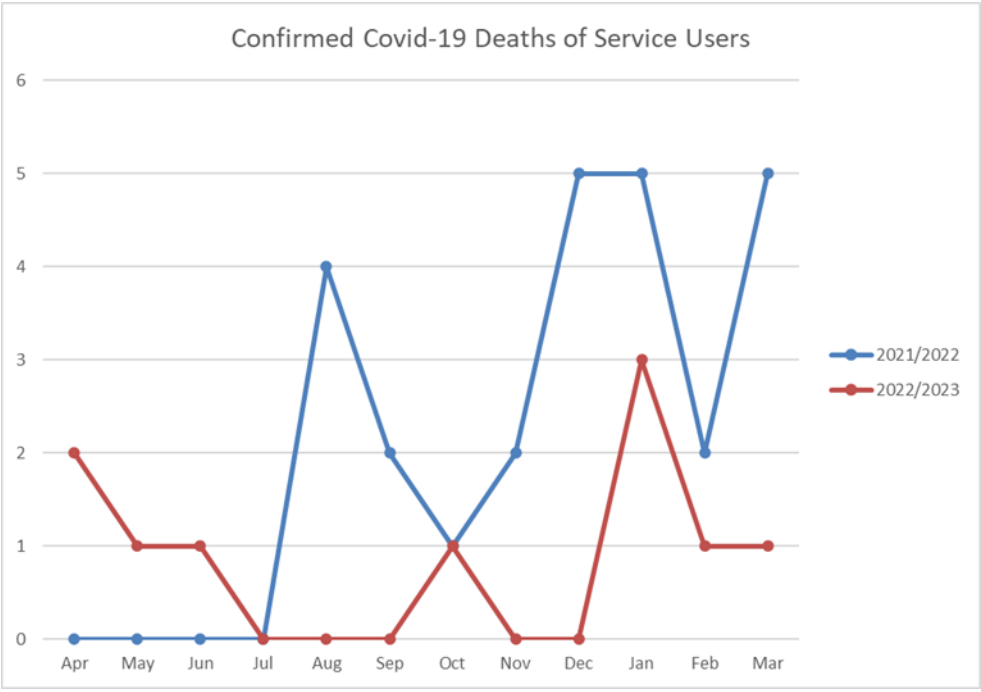


Figure 2

2.7 The year saw 63 confirmed outbreaks of Covid19 (*figure 3*), an increase compared to the previous year.

2.8 At the start of the year, the government set out a revised plan for managing and as a transition to living with Covid19. Less testing by the general population and requirements to self-isolate controlling the exposure for staff and service users impacted on the level of cases who were generally asymptomatic.

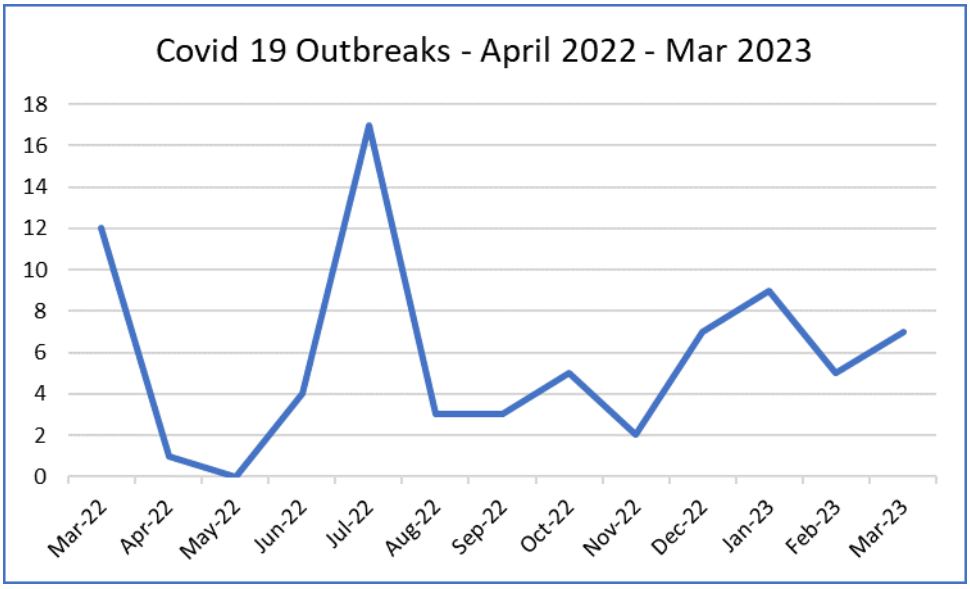


Figure 3

2.9 All outbreaks were investigated and monitored through regular Outbreak Control Team (OCT) meetings and there continued to be good working relationships between the Trust and external organisations including UKHSA, ICB and NHS England. 37% (n= 23) of the outbreaks related to staff only outbreaks (office areas or inpatient teams without transmission to service users). No outbreaks required escalation as a serious incident (SI).

2.10 IPC practices and procedures were implemented in line with the national guidance. Root cause analysis reports and risk assessments were developed and implemented for staff and service users who were identified as being Covid19 positive, to support with identification of learning.

2.11 Learning from the outbreaks included prompt recognition of when to test; supporting service users to isolate for the required period; complying with best practice in IPC; completing outbreak deep cleans to appropriate standards; and improving the surveillance of staff cases through local reporting processes.

3 Assurance – IPC practice

3.1 The IPC Committee (IPCC) continued to meet quarterly. The Trust also continued to be represented at the ICS IPC Strategic Group; ICS IPC Networking Forum and ICS Urinary Tract Infection (UTI) Workstream. During the year, the ICS came together with the IPCT ICB leading to draft the ICS IPC 5-year Strategy.

3.2 The IPC Board Assurance Framework (BAF), published by NHS England, requires the Trust to self-assess against national IPC guidance and identify risks to address. This has been completed regularly in year and shared with the Board via local governance procedures.

3.3 The Trust incorporated the criteria from the Health and Social Care Act, 2008 and the IPC BAF into its Annual IPC Programme 2022/23, approved by the

Trust's IPCC and the Board. Progress of the programme has been monitored on a quarterly basis at the IPCC.

3.4 *Figure 4* identifies the overall compliance achieved; the actions that were either non-compliant or partially completed will be incorporated into the IPC Programme for 2022/23.

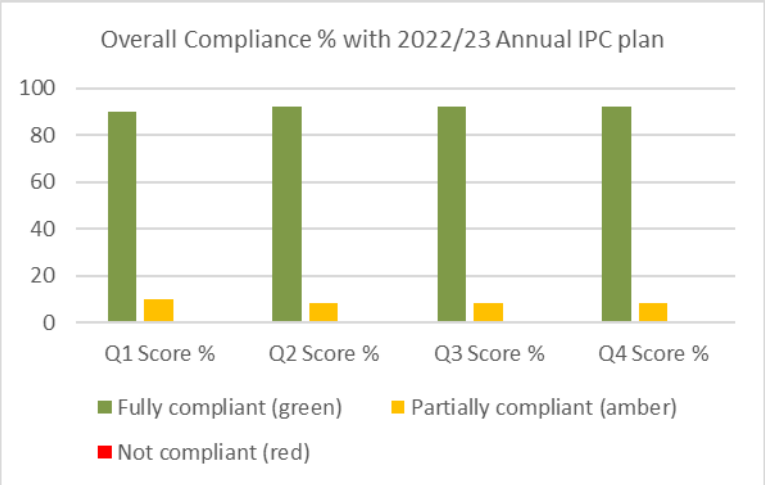


Figure 4

3.5 Within the annual IPC plan, the areas identified for improvement include:

- IPC training uptake compliance
- IPC training module (national) to include the training on personal protective Equipment (PPE) donning and doffing
- Capacity within the IPCT to undertake five IPC environmental audits
- Implementation of the 2021 national cleaning standards
- IPC doctor resource Trust wide
- Covid19 outbreaks included on the risk register and reviewed at IPCC
- Estates risk register regarding evidence relating to flushing of little used outlets

3.6 IPC policies are in date and reviewed, considering the national IPC manual and changes to guidance on Covid19. Rapid guidance changes (specifically for Covid19) were approved via Clinical Professional Advisory Committee (CPAC) and now picked up through the IPCC.

3.7 Audit tools were used to ensure quality assurance regarding the IPC practice within the Trust against the expected practice and standards. Work has started on moving the audits to an inhouse digital application launched during 2023/24.

3.8 The IPCT have been undertaking focused IPC practice audits to support staff with safe sharps practice, dealing with body fluid spillages and decontamination of patient equipment.

3.9 Regular sharing of information and learning via internal newsletters and through the link practitioners' meetings, where external/specialist speakers attended, provided staff with education on key areas, such as cleaning products, hand hygiene products and management of spillages.

3.10 Auditing of IPC practice evolved over the year, with the following undertaken:

- Hand hygiene
- IPC practice audits including:
  - Environmental
  - PPE
  - Catheter care
  - Decontamination of equipment

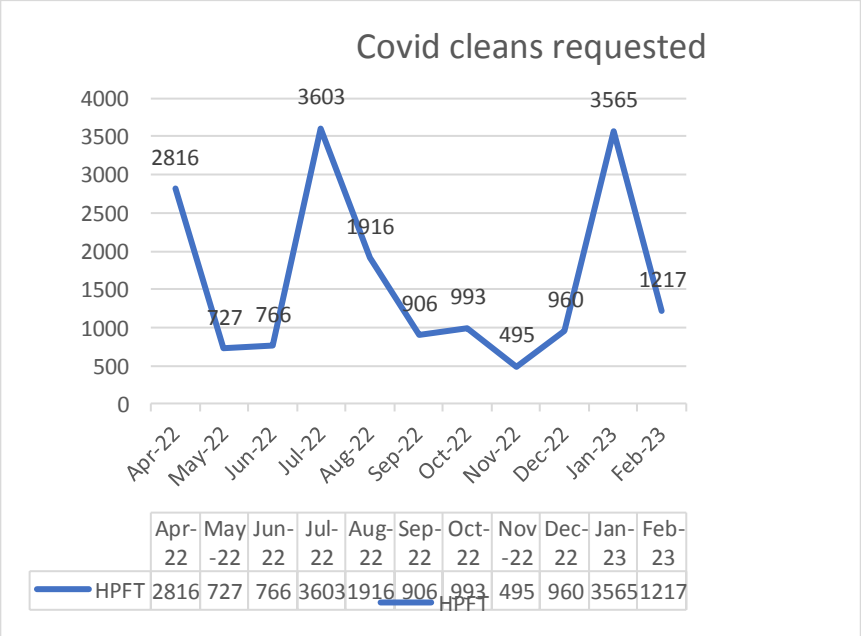
- Mattress
- Clinical Matron walkabouts.

- Clinical Matrons (community settings)
- Antibiotics prescribing.

4. Clean Environment

4.1 The Trust teams worked closely with the cleaning service provider, who continued to utilise specialist trained cleaning teams to conduct all Covid-19 related cleaning, separate to regular site cleaning teams with all cleaning conducted in line with national guidance. Enhanced cleaning of high touch points/usage areas continued within site cleaning schedules across the Trust's estate. The Covid-19 waste standard operating procedure (SOP) was updated in compliance with renewed national NHSI/E guidance.

4.2 *Figure 5* tracks the number of area cleaning requests for Covid-19 and the pressure placed on the cleaning services to deliver on the extra requirements which is out of scope of the contracted cleaning service.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
HPFT	2816	727	766	3603	1916	906	993	495	960	3565	1217

Figure 5

4.3 Annual periodic cleans here carried out across all sites and the schedule amended to allow for Covid-19 outbreak areas to be fully deep cleaned, once the outbreak was over.

4.4 Overall cleaning audit scores remained high and all above the national cleaning standards compliance rating. *Figures 6* and *7* show the cleaning audit results split quarterly and the overall annual cleaning scores, against the 95% high risk category.

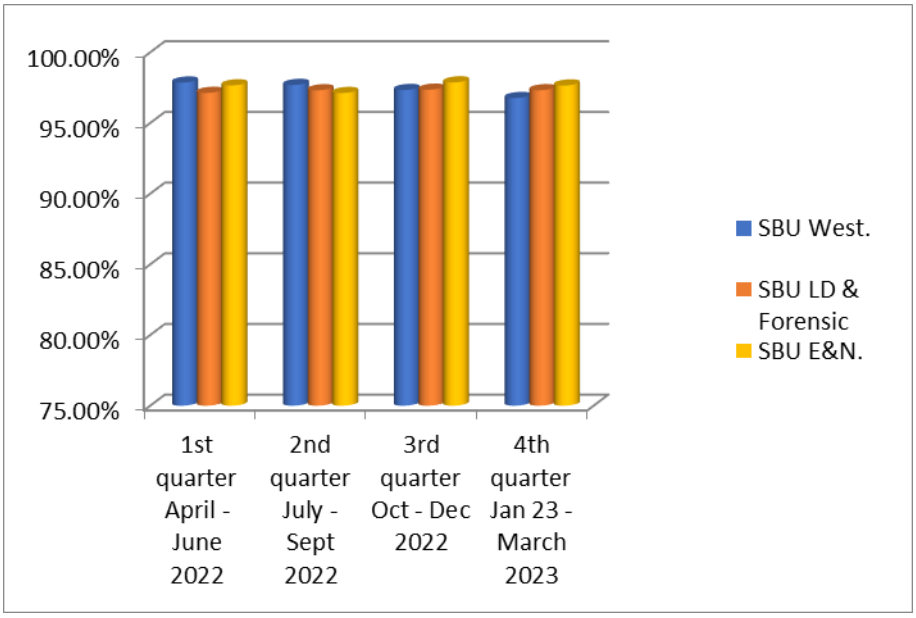


Figure 6

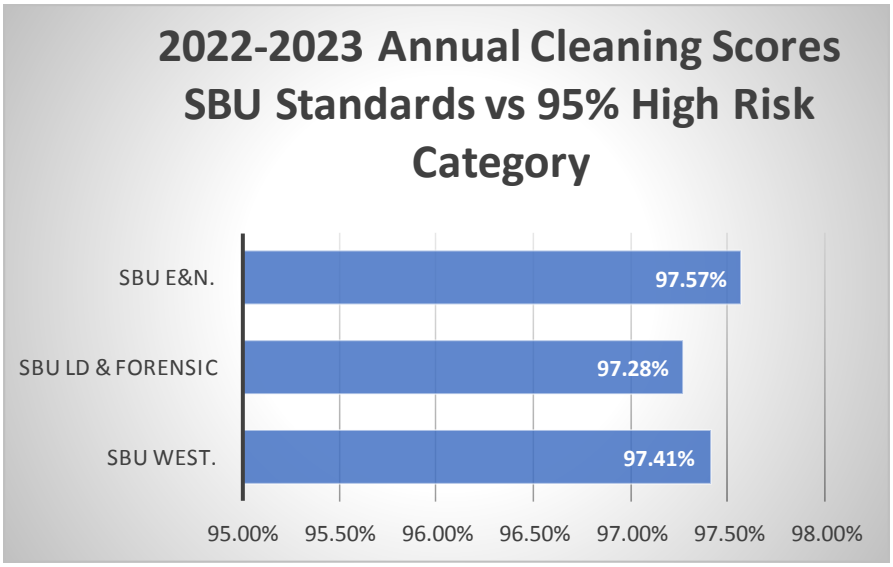


Figure 7

4.5 To ensure a consistent approach and joint working, clinical and Mitie staff completed joint monthly cleaning audits with the Estates and Facilities team. Close monitoring of this collaborative approach to assessing cleaning standards will continue to be monitored via the IPCC.

4.6 The *National Standards of Healthcare Cleanliness 2021* applies to all healthcare environments to encourage continuous improvement, combining mandates, guidance, recommendations, and good practice and the need for a collaborative approach. The process introduces efficacy audits, widening the audit function to include the cleaning process, as well as measuring the technical cleaning outcome.

4.7 The *Commitment to Cleanliness Charter*, to promote the ethos of the 2021 standards, has been signed off by the Trust Board and displayed in areas alongside the cleaning schedule. The Estates and Facilities team, in collaboration with the IPCT and Mitie, developed the processes required to comply with the new standards, approved in March 2023 and implemented, with the revised auditing mechanism.

4.8 The Patient Led Assessment of the Clinical Environment (PLACE) programme commenced in September until December, with 170 assessments across 13 sites, comprising of 30 wards and four outpatient units. Owing to the Covid 19 guidelines, it was agreed to keep the assessment teams to a maximum of four per group ensuring the patient (service user) representatives were the priority. 36 patient (service user) assessors were trained, resulting with 24 supporting the Trust with this year's collection.

4.9 Owing to the ongoing Covid-19 outbreaks across the Trust, NHS Digital authorised deadline extensions to ensure as many Trusts as possible were able to participate, with the final completion date as 4 January 2023. All assessments completed by the Trust were uploaded in December. *Figure 8* outlines the Trust's average scores, which show a good percentage for all sections.

Measurement	Cleanliness	Food / Hydration	Privacy, Dignity & Wellbeing	Condition, Appearance & Maintenance	Dementia	Disability
HPFT Score	**96.90%**	**90.24%**	**93.56%**	**93.73%**	**93.97%**	**90.67%**

Figure 8

4.10 The Estates and Facilities team developed site specific action plans and held ownership of the recommendations, ensuring completion/rectification of the elements detailed.

5. Education and Training Awareness raising

5.1 All Trust staff are required to have successfully completed level 1 or 2 mandatory training for IPC at induction, and then every two years. In year, there has been a measured increase and sustained overall commitment to reach the threshold of 92%, as detailed in *figures 9* and *10.*

Strategic Business Unit (SBU)	%Compliance Rates				
	2021/22 Q4	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4
SBU Learning Disability & Forensic	87%	96%	98.9%	96%	95%
SBU MH East & North Herts	85%	94%	96.3%	94.3%	94.5%
SBU MH West Herts	82%	91%	92.5%	94.4%	93.4%
Essex and IAPS	79%	91%	92.3%	96%	93%
Corporate	86%	90%	95%	92%	94%

Figure 9

Strategic Business Unit (SBU)	%Compliance Rates				
	2021/22 Q4	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4
SBU Learning Disability & Forensic	89%	91%	94.4%	96.7%	96%
SBU MH East & North Herts	89%	95%	95.3%	95%	95%
SBU MH West Herts	87%	87%	90.7%	91.4%	91.3%
Essex and IAPS	89%	94%	94.9%	94%	93%
Corporate	86%	91%	95.7%	93%	93%

Figure 10

5.2 Since categorised in 2021 as essential for nurses, prescribers and pharmacy staff, compliance for the training module *Antimicrobial Resistance – An Introduction* has seen a steady increase completed and exceeded the target of 92%, as detailed in *figure 11.*

Antimicrobial resistance – An Introduction	% Compliance rate				
	Q4 2021-22	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23
	93.32%	95.7%	96%	96.04%	96.61%

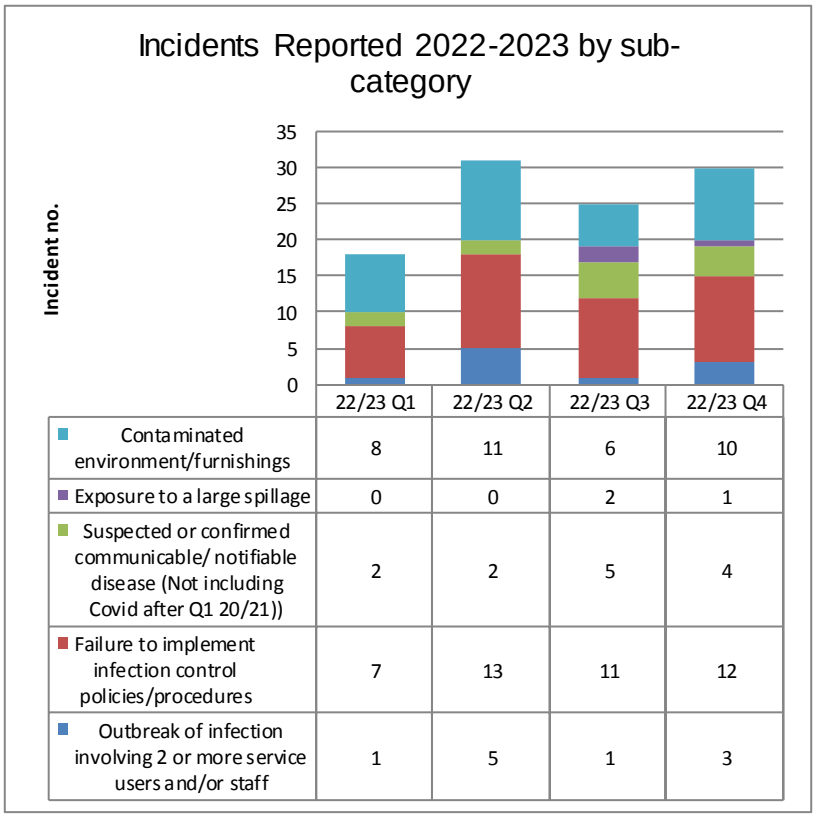
Figure 11

5.3 The Trust continued to promote key awareness programmes and include sessions on emerging infections, including Monkeypox, scabies and water safety. The IPCT led on celebrating IPC awareness week in October and also World Antibiotic Awareness week in November.

5.4 The profile of IPC and the IPCT continued to be raised internally, regionally contributing to the ICS strategy, and nationally contributing to the BAF.

6. Incidents

6.1 There were 104 IPC categorised incidents reported via Datix and to the IPCT, an increase compared to 62 in the previous year, as shown in *figure 12*.



	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4
Contaminated environment/furnishings	8	11	6	10
Exposure to a large spillage	0	0	2	1
Suspected or confirmed communicable/ notifiable disease (Not including Covid after Q1 20/21))	2	2	5	4
Failure to implement infection control policies/procedures	7	13	11	12
Outbreak of infection involving 2 or more service users and/or staff	1	5	1	3

Figure 12

6.2 Accidental inoculation injuries are reported through Health, Safety and Security and discussed at the IPCC, along with all IPC incidents, where trends/themes and any lessons learnt are shared and directly influence the work of the IPCT to support teams or policy changes are made.

6.3 Categories of incidents related to:

- Suspected/confirmed outbreaks of infection
- Periods of Increase in incidence of infection
- Poor environmental cleaning
- Suspected/confirmed communicable/notifiable/reportable infection

- Failure to implement IPC policies.

6.4 Learning from incidents over the year, for which support, audit, training, and guidance have been provided, has included:

- staff awareness of testing guidance
- challenges in service user compliance with isolation
- general IPC practice related to access to own hand rub and being bare below elbows
- audits of practice not completed
- post outbreak deep cleans not thorough
- sharps injury and awareness of temporary closure devices
- management of body fluid spillages
- management of MRSA.

7. Water Safety

7.1 The Trust's Water Safety Policy is compliant with HTM 04-01 and will be due for revision in 2024. The Water (legionella) risk assessment programme was reinstated by Inviron, with the Estates and Facilities Compliance Manager accessing the risk assessment programme and risk assessments. All deficiencies identified are rectified as per the Trust Water Safety Plan and where required will be supported by the appointed Authorising Engineer (Water).

7.2 Clinical teams are required to assess and submit evidence of regular flushing of the little used outlets which have been variable and on the risk register. An electronic system providing live data of the flushing compliance is being explored.

7.3 Refurbishments at Aston ward, Warren Court and Kingfisher Court have ensured compliance with HTM 04-01. All ventilation and cooling systems received scheduled Planned Preventative Maintenance and testing.

8. Flu and Covid 19 Vaccination campaign

8.1 The 2022/23 flu vaccination campaign and the Covid19 booster campaign was available to staff from quarter 3. Staff had access to vaccination clinics across the Trust in various locations. The national average for NHS Trusts was 60.5%; uptake from the end of February 2023 was lower than the aspirational target:

- 52.6% staff presented for their Covid 19 booster
- 49.1% staff presented for the annual Flu vaccination

8.2 A feedback session will be implemented to learn from the campaign and to improve the overall compliance for 2023/24 flu campaign.

8.3 All eligible inpatient service users were offered both flu and covid vaccinations, with multiple visits to facilitate discussions regarding the benefits of vaccination and also support individuals with needle phobia.

9. Occupational Health

9.1 The Trust's provider is with East and North Hertfordshire NHS Trust, compliant with the key lines of enquiry for the BAF, ensuring a robust service for staff.

9.2 A 24-hour needlestick injury helpline service is provided, with sharps and splash injury support included within the Service Level Agreement (SLA) as well as a telephone advice line to support the management of occupational exposure to infection.

10. Summary of Key progress and Challenges

10.1 Key progress noted over the year include:

- No MRSA/MSSA blood stream and *Clostridioides difficile* infections, IPC related SIs or influenza outbreaks (despite government predicted impacts with both viruses circulating between October and January, and ICS partners reporting high level of cases and associated outbreaks)
- Despite the high incidence of Covid19 outbreaks, no inpatient deaths due to Covid19 complications
- Ongoing changes to Covid-19 guidance maintained
- Fully established IPCT
- Sustained improvements in mandatory IPC training
- Increase in IPC awareness at several promotional events
- Increase in frequency of local SBU IPC meetings

10.2 Key challenges noted over the year include:

- Covid-19 reported incidence in service users and staff remain high and level of outbreaks increased further compared to previous years
- Inconsistent audit and associated action plan implementation
- IPC doctor resource
- Flu vaccination uptake

11. Priorities for 2023/24

11.1 Following the review of 2022/23 performance and the national priorities and the latest IPC BAF (NHS E Mar 2023), the priorities were set for 2023/24. The IPC programme will be agreed at the IPCC in quarter 1 and discussed and approved, on behalf of the Board, by the Integrated Governance Committee (IGC).

11.2 The key priority areas of work for 2023/24 include:

- Maintain a high profile of IPC, with visible leadership from the IPCT
- Embed the revised audit programme and reporting process
- Review and rationalise all IPC policies and embed the national IPC manual developing local implementation guidance for staff
- Ensure appropriate resource and provision of an SLA IPC doctor
- Sustain completion of level 1 and 2 IPC training
- Collaborative review of cleaning standards to support the *National Healthcare cleaning standards (2021*)
- Collaborative work with the ICS to achieve the initiatives HWE 5 Year IPC Strategy
- Continue to promote antimicrobial stewardship
- Address standards in UTI prevention, diagnosis and management
- Optimise uptake of vaccination amongst service users and staff

12. Conclusion

12.1 There have been challenges faced within all NHS organisations during 2the year, and the Trust has continued to make progress in the prevention and control of HCAIs.

12.2 The Trust continues to have high standards in IPC owing to strong working relationships between the IPCT and key colleagues and services across the Trust.

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PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 8g
Report Title	Month 4 People & OD 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:
Receive and discuss, in depth, noting the implications for the Board or Trust without formally approving it.

Executive Summary

The attached report sets out the Trust's Month 4 performance in relation to key People and OD metrics that support our annual plan.

The key headlines from Month 4 are as follows:

- Vacancy rates have remained at 12.2%. This is as a result of fewer staff traditionally commencing work over Summer months. However, turnover has improved to the lowest rate in two years and we continue to have a healthy pipeline of 712 FTE posts, 58% of which (416 FTE) are in the firm offer/starting phase. This means we are confident we will see a net positive impact 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 nurse recruitment pipeline and the potential increase of international nursing.
- Agency use mapped against recruitment activity is being scrutinised by the Agency Panel and Financial Recovery Board to generate clear trajectories to achieve the 2023/4 Trust targeted agency spend.
- The co-produced Belonging and Inclusion Strategy is being finalised and the supporting action plan will be implemented with ambitious targets for improvement across all workforce metrics which will be further developed to identify difference between our different staff groups through Q2.
- Formal employee relations cases remain low and we are seeing the impact of our action plan to re-set the approach to ER matters start to have an impact, albeit that some legacy cases will continue to be reported.
- Appraisal rates are at a record high level, albeit that they are 4.6% lower than our 95% target. Work will continue to achieve full compliance.
- Mandatory training rates have recovered to meet our 92% target, following the introduction of two new training modules nationally. 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.

Recommendations

The Board is asked to receive this report.

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.	✓

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Trust People and OD Report
Month 4 (July 2023)

as one

Our values
Welcoming Kind Positive Respectful Professional

Contents

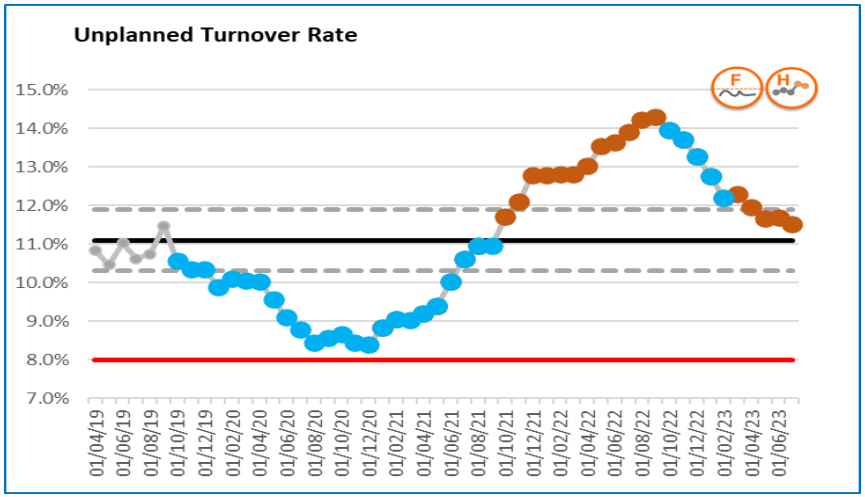
1. Overview

Metric	Previous Months											Current Month		Trend	Variation	Assurance
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Trust Target			
Staff in Post - Headcount	3774	3842	3887	3921	3935	4012	4052	4083	4100	4121	4120	4122				
Staff in post - FTE	3409.92	3462.08	3501.28	3542.65	3562.67	3636.30	3664.79	3702.91	3715.75	3743.59	3739.10	3741.66				
Budgeted Establishment FTE	3940.89	4029.56	4037.67	4147.96	4162.15	4157.99	4186.74	4198.26	4230.50	4245.48	4257.85	4263.57				
Vacant FTE	530.97	567.48	536.39	605.31	599.48	521.69	521.95	495.35	514.75	501.89	518.75	521.91				
Vacancy Rate	13.5%	14.1%	13.3%	14.6%	14.4%	12.6%	12.5%	11.8%	12.2%	11.8%	12.2%	12.2%	10%			
Total Turnover Rate	18.6%	18.6%	18.3%	17.7%	17.4%	16.7%	16.0%	15.8%	15.5%	15.3%	15.5%	15.4%	14%			
Unplanned Turnover Rate	14.2%	14.3%	14.0%	13.7%	13.3%	12.8%	12.2%	12.3%	12.0%	11.7%	11.7%	11.5%	8%			
Starters Headcount	77	120	85	49	46	90	65	63	77	51	42	55				
Leavers Headcount	69	78	48	37	41	43	33	67	50	43	56	57				
Stability Rate	83.6%	83.3%	83.0%	84.0%	83.9%	84.4%	84.5%	86.0%	85.2%	85.3%	86.5%	86.1%				
Sickness Rate	4.7%	4.6%	4.9%	5.4%	5.7%	5.0%	4.9%	5.0%	4.4%	4.4%	4.4%	4.2%	4%			
Training Compliance Rate	93.1%	92.3%	92.5%	92.7%	93.0%	92.7%	92.9%	87.6%	89.0%	90.0%	91.0%	92.0%	92%			
Appraisal Rate	84.6%	83.8%	85.1%	85.5%	85.0%	85.6%	84.7%	85.9%	86.3%	85.1%	86.0%	90.4%	95%			
Bank Spend	£2,192,616	£2,658,620	£2,304,492	£2,159,196	£2,136,852	£2,226,630	£2,272,368	£2,226,165	£2,216,972	£2,502,377	£2,749,160	£2,464,320				
Agency Spend	£1,246,626	£1,260,585	£1,265,116	£1,346,138	£1,287,560	£1,340,857	£1,080,570	£1,869,589	£1,075,919	£1,059,957	£908,385	£943,314				

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

- Our establishment increased again in Month 4. However, the number of staff in post has increased slightly due to recruitment of new staff compared to those leaving, which means that our vacancy rate remains stable and our turnover rate has reduced further to the lowest it has been in two years.
- However, registered nursing, medical 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 £35k, whilst Bank spend has reduced by £300k since June. However, both Bank and agency spend remains higher than planned for. The Financial Recovery Board and Agency Panel are proactively reviewing all agency use to ensure this ceases where possible.
- Mandatory training rates increased again in Month 4 and we are now meeting 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 from Q3.
- Whilst overall absence rates are lower than we have seen for a year, 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
15.0%
14.0%
13.0%
12.0%
11.0%
10.0%
9.0%
8.0%
7.0%
F
H
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
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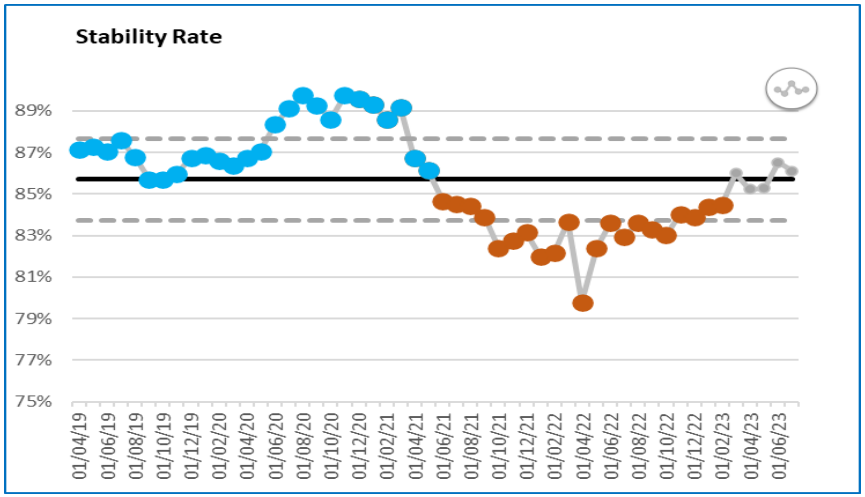
Stability Rate
89%
87%
85%
83%
81%
79%
77%
75%
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
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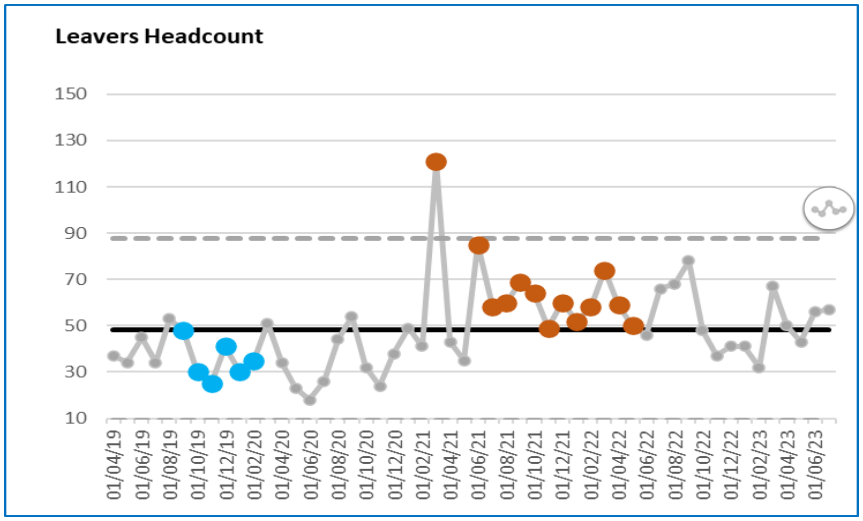
Leavers Headcount
150
130
110
90
70
50
30
10
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
01/10/20
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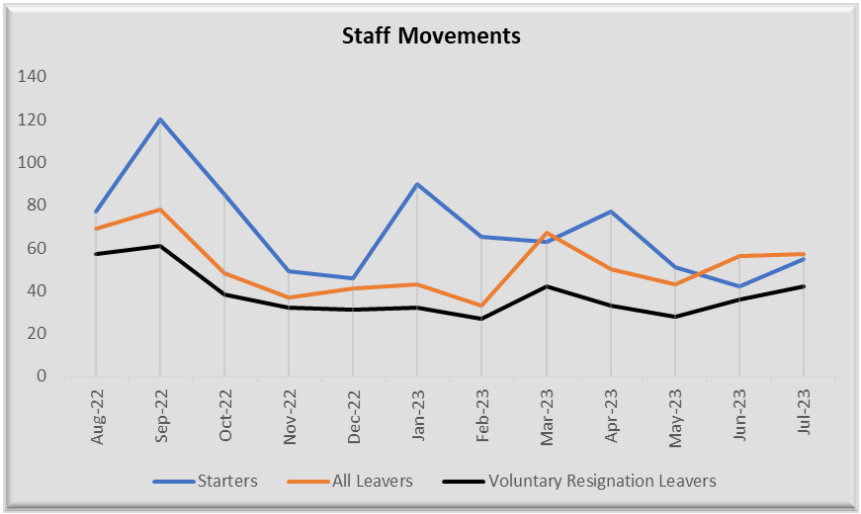
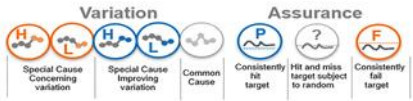
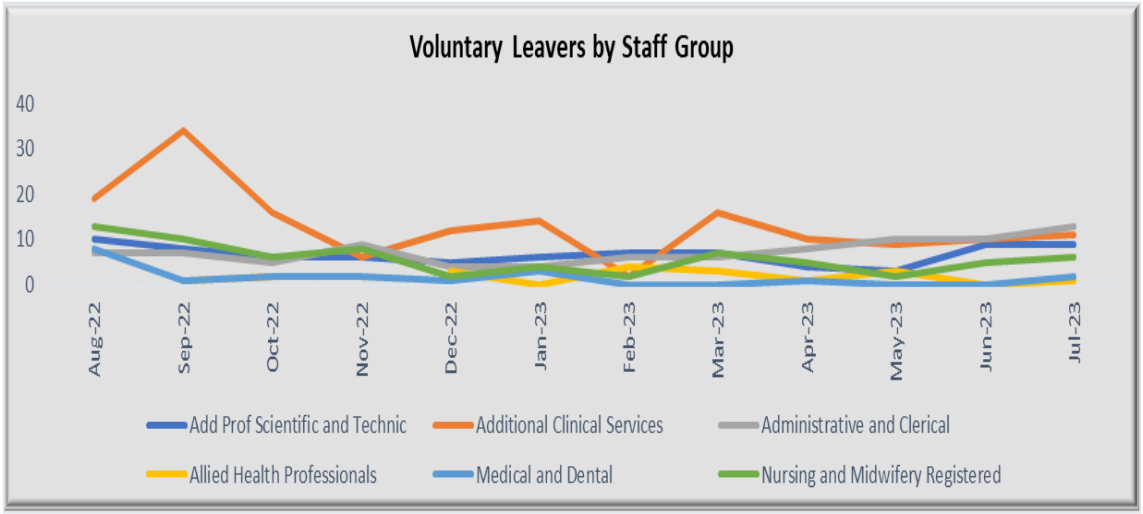
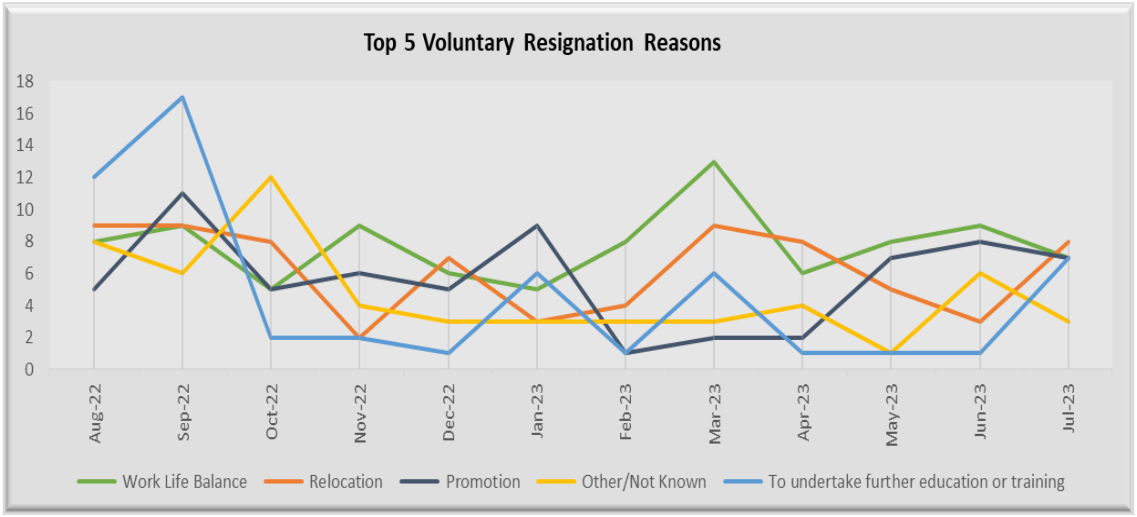

Staff Movements
140
120
100
80
60
40
20
0
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Starters
All Leavers
Voluntary Resignation Leavers


Variation
Assurance
Special Cause Concerning variation
Special Cause Improving variation
Common Cause
Consistently hit target
Hit and miss target subject to random
Consistently fail target

2. Retention





Turnover has remained at the lowest point for over a year in Month 4, improving by 0.8% since the end of Q4 of 22/23.

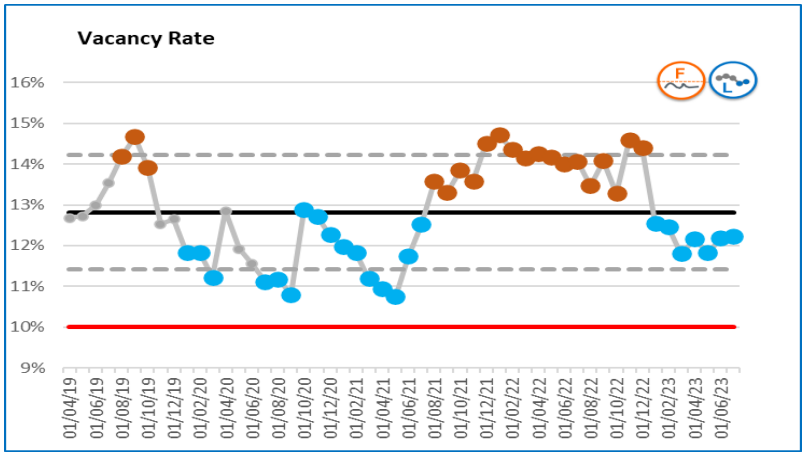
At the end of Q1 our turnover rates were 2nd best among the 12 trusts in the Herts and West Essex (H&WE) and Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Systems (ICSs), where the lowest was 10.2% and the average was 14.5%.

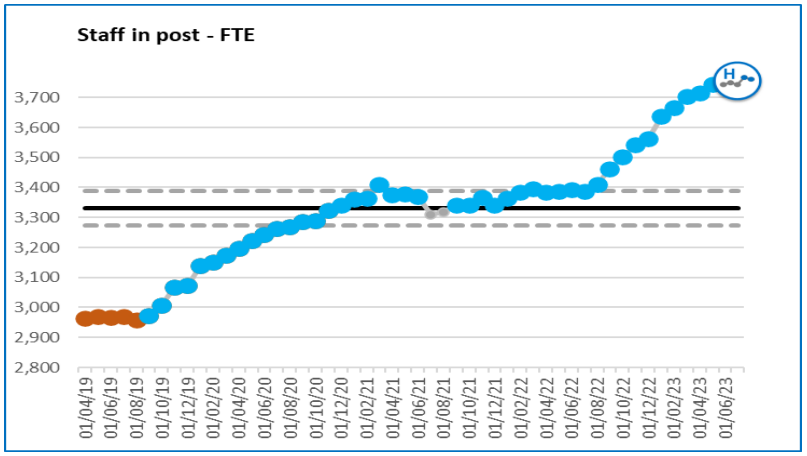
The People and OD Group and Recruitment and Retention Group have refreshed retention plans for 2023/4, centring around the Trust's annual plan key areas of:

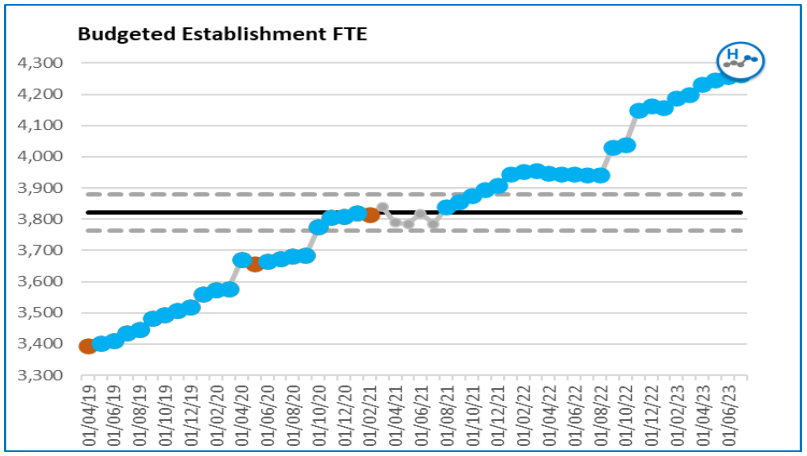
- Belonging and inclusion
- Talent management
- Collective leadership
- Resetting our fundamental standards of people management

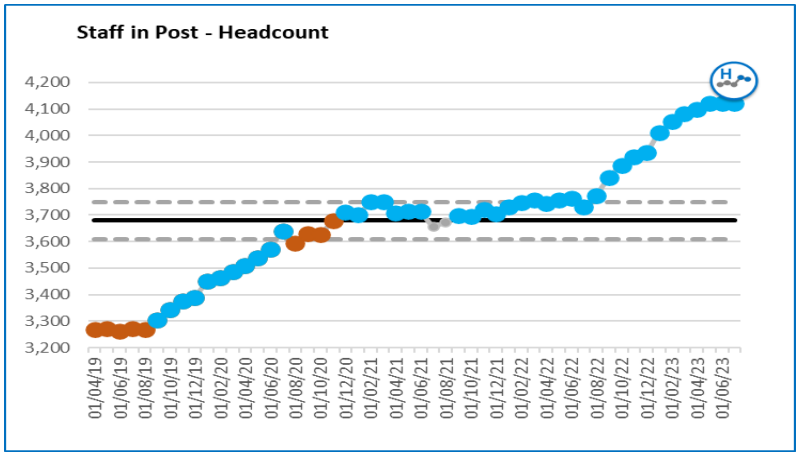
These are supported by our ongoing engagement with staff, together with our wellbeing offer, benefits and staff reward and recognition.

3. Recruitment

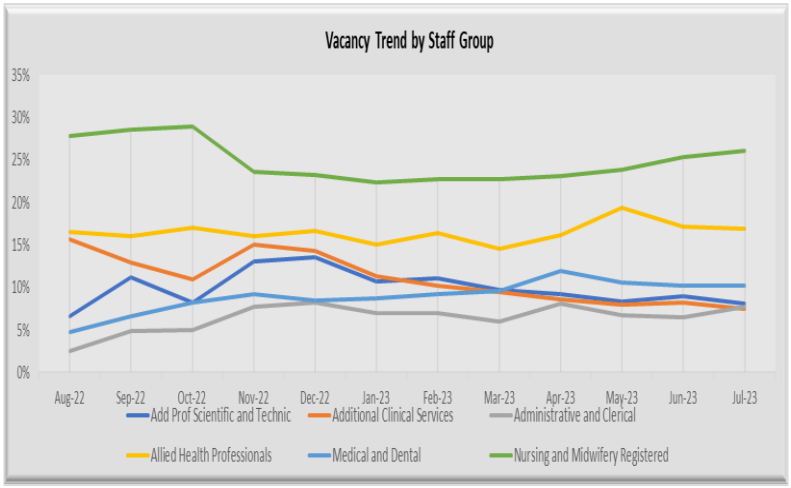








3. Recruitment



The net impact of new starters, leavers and an increase in establishment has resulted in our vacancy rate remaining stable at 12.2%. The SPC chart shows a continuing improving statistical trend.

Vacancy rates in our key staff groups are:

- Registered nursing – 26.2% (up from 25.4% in June). Staff in post reduced by 8 FTE as a result of more staff leaving than joining and the establishment increasing by 0.4 FTE . We are actively recruiting to 256 nursing roles against 257 vacancies, with a cohort of 105 newly qualified nurses due to join us by the end of Q2. International recruitment remains a key part of our recruitment strategy, which requires further investment to ensure its success. 2 internationally recruited nurses are joining our Norfolk services in August and 13 more are in the pipeline.
- AHPs –16.9% (reduced from 17.2% in June). Although establishment increased by 0.9 FTE, staff in post increased by 1.3 FTE, as a result of fewer staff leaving than joining.
- HCSWs – 1.3% (reduced from 3.4% in June). Although establishment increased by 0.4FTE, staff in post increased by 14 FTE, as a reuslt 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.

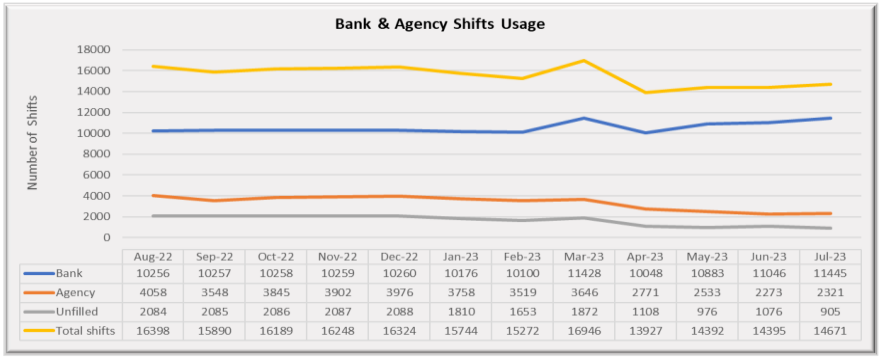
Our key recruitment metrics are as follows:

- Recruitment pipeline of 712 FTE posts, 58% of which (416 FTE) are in the firm offer/starting phase.
- Our time to hire has reduced from 58.4 days in June (when there was an issue with the Trac software system) to 49.7 days in July, which is below our target of 52 days. A further process review has taken place to streamline processes, the recommendations from which were approved at PODG in July. These changes will become increasingly visible in our time to hire as legacy recruitment episodes are concluded.

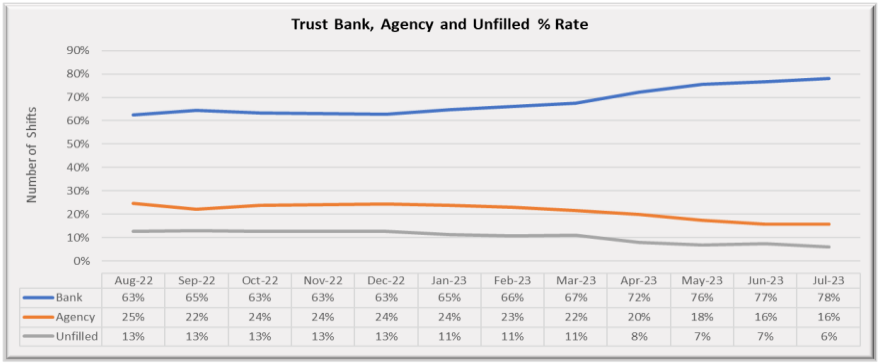
At the end of Q1 our vacancy rates were 7th best among the 12 trusts in the H&WE and BLMK ICSs, where the lowest was 6.2% and the average was 11.2%.

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

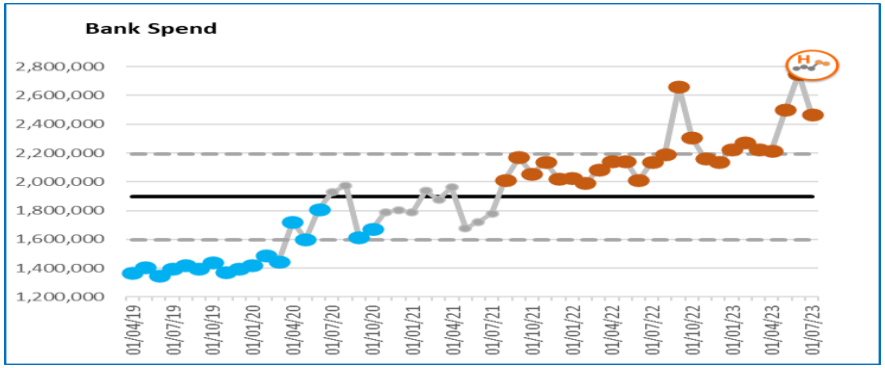
4. Temporary Staffing

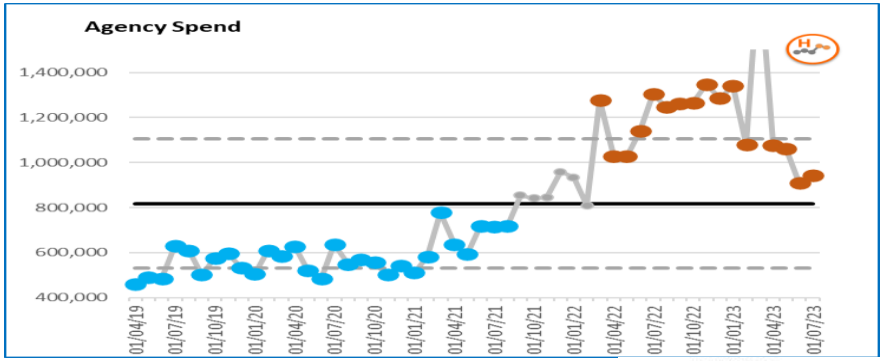


	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Bank	10256	10257	10258	10259	10260	10176	10100	11428	10048	10883	11046	11445
Agency	4058	3548	3845	3902	3976	3758	3519	3646	2771	2533	2273	2321
Unfilled	2084	2085	2086	2087	2088	1810	1653	1872	1108	976	1076	905
Total shifts	16398	15890	16189	16248	16324	15744	15272	16946	13927	14392	14395	14671



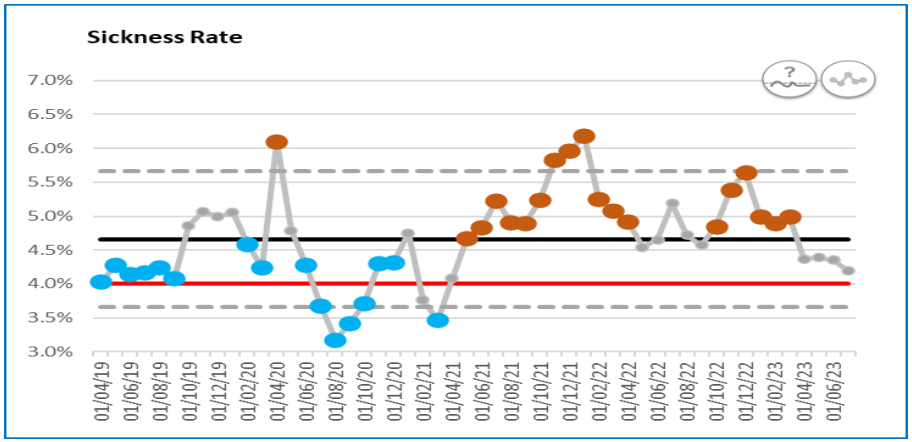
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Bank	63%	65%	63%	63%	63%	65%	66%	67%	72%	76%	77%	78%
Agency	25%	22%	24%	24%	24%	24%	23%	22%	20%	18%	16%	16%
Unfilled	13%	13%	13%	13%	13%	11%	11%	11%	8%	7%	7%	6%

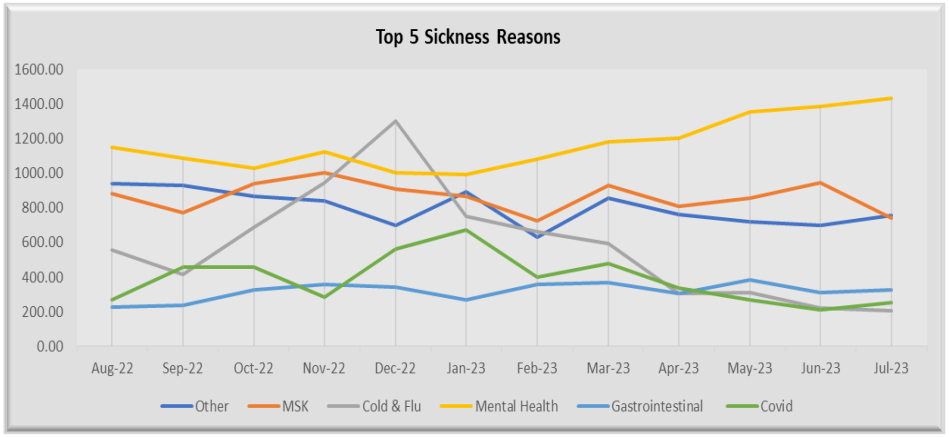




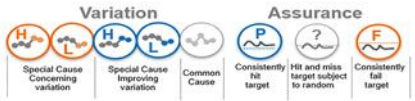
- Monthly Bank spend has reduced by £300k after increasing month on month in Q1. Fill rates have continued to improve each month since the end of Q3 of 22/23.
- Overall temporary staffing demand has continued to be lower than during 22/23, although demand increased slightly in July, which coincides with the school holiday period.
- Agency spend has increased by £35k in June. Whilst this remains lower than in 22/23, spend remains higher than our target.
- At the end of Q1 our agency spend as a percentage of paybilll was 4%, which was the 3rd best among the 12 trusts in the H&WE and BLMK ICSs, where the lowest was 1.2% and the average was 7%.
- 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 reduced from 4.4% in June to 4.2% in July. At the end of Q1 our sickness absence rates were 8th best among the 12 trusts in the H&WE and BLMK ICSs, where the lowest rate was 2.9% and the average was 4.23%.
- Whilst most absences reduced, mental ill health related absence increased to 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.
- A deep dive has revealed the vast majority of mental ill health related absence is not work-related. The Trust is currently reviewing the Here For You offer and continues to offer a comprehensive range of support for our staff.
- Whilst previous funding may not be available to implement a full psychologically informed approach to wellbeing this financial year, we recognise the need to identify additional funding sources especially as we expand our workforce to include greater numbers of people with lived experience of mental ill health.
- 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 self-care wellbeing festival taking place in September.
- The People and OD Group continues to monitor the impact of our wellbeing plans. To date, our work on self care has led to improvements in our annual staff survey results and pulse survey results.



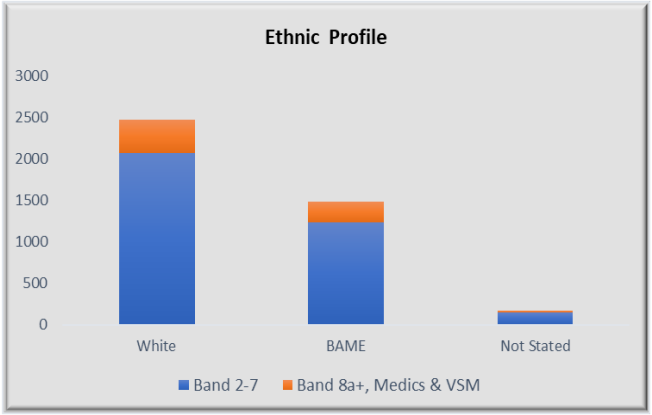
6. Employee Relations

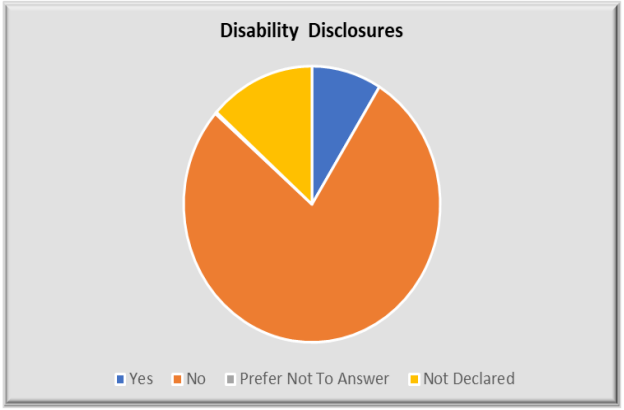
Disciplinary Cases		0 - 5 working days	6 – 10 working days	11+ working days	Notes
	Fact Find (10) (Date incident notified to date referred to decision making panel)	6		4	3 White 7 BAME
	Fact Find Outcome (15) Current investigations (Date decision making panel outcome to date investigation commences/letter of concern/other outcome notified to employee)	1	1	13	8 White 7 BAME
		0 - 12 weeks	13 – 18 weeks	19+ weeks	Notes
	Suspension	1	1	2	Already included in above (2 BAME 2 White)
	Alternative Duties	7	2	5	Already included in above 8 White 6 BAME
	Formal Investigation (Date investigating manager appointed to date investigation report sent to commissioning manager)				
		0 - 5 working days	6 – 10 working days	11+ working days	Notes
	Commissioning Manager Review (5) (Date investigation report sent to commissioning manager to date employee notified of outcome)	3		2	3 White 2 BAME
		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)				3 hearings rescheduled 1 hearing being finalised 11/08/23
	Appeal Stage (1) (Date of receipt of formal appeal to date employee notified of hearing outcome)			1	BAME Rescheduled 3 times
TOTAL DISCIPLINARY MATTERS		31			

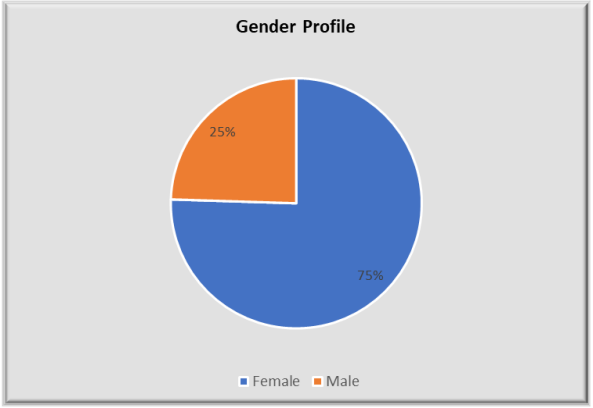
Medical Cases		0 - 12 weeks	13 – 18 weeks	19+ weeks	Notes
	Medical Conduct (1)			1	BAME
	Medical Capability	0			
TOTAL MEDICAL CASES		1			
Grievances		0 - 12 weeks	13 – 18 weeks	19+ weeks	Notes
	Informal Grievance (6)	1		5	2 BAME 4 White
	Formal Grievance (5)	3		2	1 BAME 4 white
TOTAL GRIEVANCE CASES		11			
Capability Cases		No. Cases			
	Informal Capability Management (1)	0	1		BAME
	Formal Capability Management (3)	3		3	3 BAME
TOTAL CAPABILITY CASES		4			
TOTAL OTHER CASES (B&H)		4			
TOTAL EMPLOYMENT TRIBUNAL CASES		4			
TOTAL EMPLOYEE RELATIONS CASES		55			

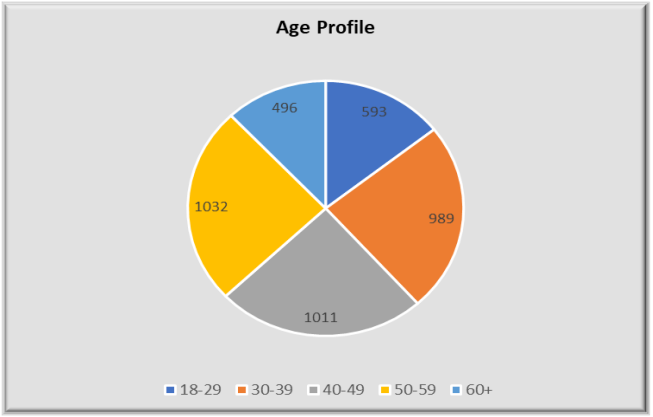
- There were 31 (increased from 29) conduct matters being supported by the ER team in June.
- The one medical conduct matter was due to be concluded in early July, however, the hearing has now been rescheduled to October due to ill health.
- Formal hearings are now being arranged in advance to avoid 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 to ensure cases are being progressed swiftly and agreed actions are embedded.
- Suspensions remain at 4.
- Grievance cases have increased from 9 in June to 11 in July
- There remain 4 employment tribunal cases, 2 of which 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







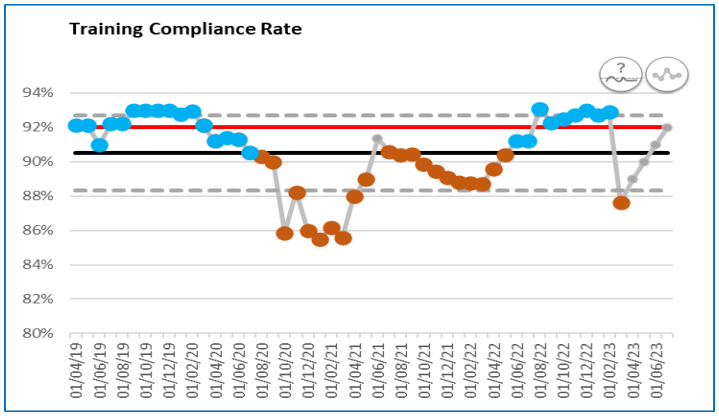


- The co-produced Belonging and Inclusion Strategy is currently being finalised and is due to launch in National Inclusion Week (25 September 2023).
- The strategy will be complemented by a comprehensive action plan which will:
    - Embed an inclusive culture
    - Ensure we have a diverse workforce
    - Eliminate discrimination
- The 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.

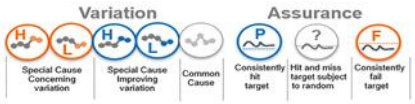
8. Staff Development – Mandatory Training

	Jun-23	Jul-23
Administration of Medicines M & C [3 Years]	82%	82%
Administration of Medicines RNs and Nas	95%	95%
Clinical Risk Assessment and Management [3 Years]	95%	95%
Complaints [None]	96%	95%
Data Security Awareness [1 Year]	91%	91%
Equality, Diversity & Human Rights [3 Years]	96%	96%
Fire Safety [1 Year]	94%	95%
Fire Safety [2 Years]	93%	94%
Food Hygiene [3 Years]	92%	93%
Health, Safety & Welfare [3 Years]	94%	97%
Infection, Prevention & Control Level 1 [2 Years]	94%	94%
Infection, Prevention & Control Level 2 [2 Years]	94%	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]	95%	96%
Physical Health	95%	95%
Preventing Radicalisation Basic	80%	83%
Preventing Radicalisation Level 3	74%	77%
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%

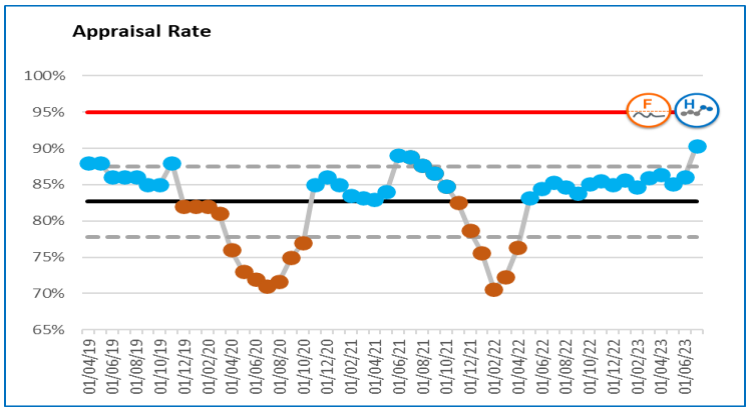
	Jun-23	Jul-23
BLS	82%	81%
ILS	82%	85%
PBLS	35%	47%
Advanced M&H	86%	84%
Basic M&H	86%	87%
Respect 3a	95%	96%
Respect Level 3b	71%	75%
Respect Level 4	82%	81%
Respect Level 4/5 (Norfolk)	89%	94%
Respect Level 5	78%	79%



- Mandatory training compliance has improved from 91% in June to 92% in July. At the end of Q1 our training compliance was 4th best among the 12 trusts in the H&WE and BLMK ICSs., where the highest was 95% and the average was 88%.
- Compliance dipped below our target of 92% in March as a result of two new mandatory training modules on Preventing Radicalisation being rolled out nationally with a relatively short implementation timeframe. Whilst compliance for both modules remains under target, our overall compliance is meeting our 92% target.
- A data cleanse for PBLS training has improved compliance to a degree. A full recovery plan will be put in place.
- 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, 801 people have accessed it and 494 have completed it which gives a compliance rate of 9%. 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 86% in June to 90.4% in July
- 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.
- At the end of Q1 our appraisal compliance was 3rd best among the 12 trusts in the H&WE and BLMK ICSs., where the highest compliance was 93% and the average was 65%.
- 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.

Simulation Hub

- 7 courses run through July
- CPD Study Day for higher trainer run
- Suicide Prevention course
- Tour of Simulation Hub at the Strategy Launch
- 1 training rescheduled due to Jr Dr Strikes.

Mandatory Training

- 743 staff attended face to face Mandatory Training in July
- Highest attended = BLS = 201

Induction

- 60 staff attended in July
- Session rated 4.8/5
- Onboarding experience rated 4.7/5

New Care Training

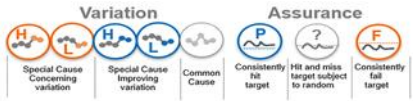
- Tier 2 Personalised Care Support Planning Training has been coproduced and will be delivered in September and October.
- Depression pathway training across the ICS has been coproduced and will launch in September
- Alcohol and Drug addiction training is launching in September
- Tier 1 Oliver McGowan e-learning has been rolled out across the Trust

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

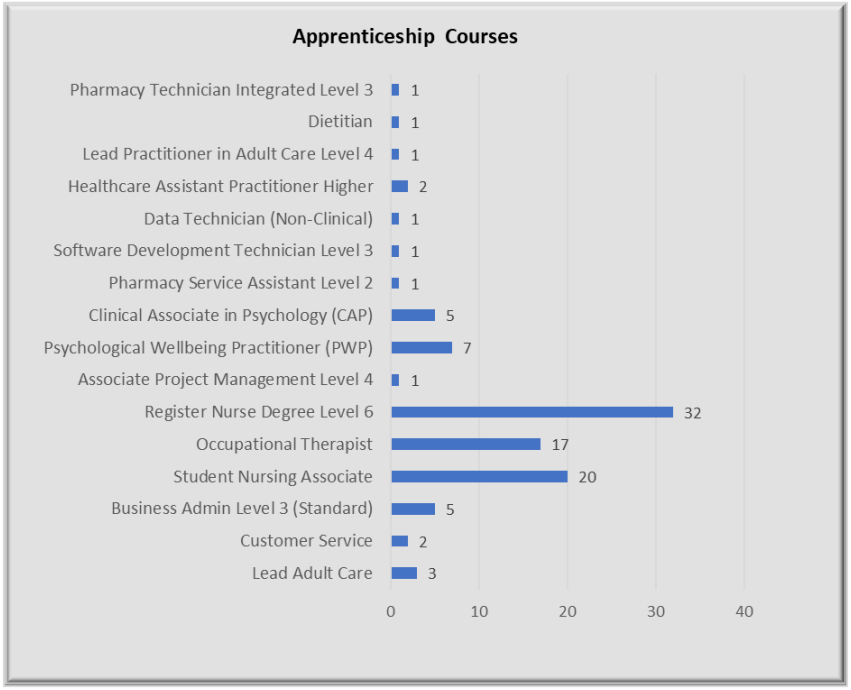
Medical Education

- Some activity rescheduled due to Industrial Action
- Simulation Hub used for first time for a presentation on Neurology with Practical Examinations
- 2 sessions of MRCPsych teaching in July with 41 attendees in total.
- Held CASC Zoom Practice in preparation for the mock CASC in August



9. New Role/Apprenticeships

Levy Pot	
Current Funds	£1,782,148
Funds spent since Aug 22	£636,897
Estimated spend for the next 12 months	£520,860
Funds Expiring in Jun 23	£1,898



- We currently have 100 apprentices (up from 90 in June).
- 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.
- We have 15 Mental Health and Wellbeing Practitioners (MHWPs) part way through their 12-month training.
- We continue to provide in-house functional skills training to support people to undertake apprenticeships. Cohort 3 will commence in September.
- 4 staff have been accepted onto a three-year Social Worker Apprenticeship programme starting in September, which is a first for the Trust.
- The community transformation programme is expected to create further opportunities to expand our apprenticeships.
- The Trust has part funded 8 members of staff to undertake an Open University Registered Learning Disability nurse degree programme as direct action to improve the pipeline in Norfolk and Essex.

9. Conclusion

The key headlines from Month 4 are as follows:

- Vacancy rates have remained at 12.2%. This is as a result of fewer staff traditionally commencing work over Summer months. However, turnover has improved to the lowest rate in two years and we continue to have a healthy pipeline of 712 FTE posts, 58% of which (416 FTE) are in the firm offer/starting phase. This means we are confident we will see a net positive impact 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 nurse recruitment pipeline and the potential increase of international nursing.
- Agency use mapped against recruitment activity is being scrutinised by the Agency Panel and Financial Recovery Board to generate clear trajectories to achieve the 2023/4 Trust targeted agency spend.
- The co-produced Belonging and Inclusion Strategy is being finalised and the supporting action plan will be implemented with ambitious targets for improvement across all workforce metrics which will be further developed to identify difference between our different staff groups through Q2.
- Formal employee relations cases remain low and we are seeing the impact of our action plan to re-set the approach to ER matters start to have an impact, albeit that some legacy cases will continue to be reported.
- Appraisal rates are at a record high level, albeit that they are 4.6% lower than our 95% target. Work will continue to achieve full compliance.
- Mandatory training rates have recovered to meet our 92% target, following the introduction of two new training modules nationally. 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.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 8h
Report Title	Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES) and Gender Pay Gap Action Plans	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Louise Thomas, Deputy Director of People and OD	
Approved by:	Jo Humphries, Chief People Officer	

The Board is asked to:
Approve

Executive Summary
This report outlines our co-produced WDES, WRES and Gender Pay Gap action plans for approval and publication. Following the publication of this year's data, task and finish groups comprising of staff network members were set up to devise action plans which have been discussed and finalised with the wider networks and were approved by the People and OD Group on 12 September 2023. The Trust is required to publish the WRES and WDES action plans by 31 October 2023, following Board approval. The Board is therefore asked to approve the attached action plans for publication on our website. Whilst there is no formal requirement to publish our Gender Pay Gap action plan, it is considered good practice and therefore Board approval is sought both for the plan and its publication to further promote our commitment to eradicating all forms of discrimination.

Recommendations
The Board is asked to approve the attached action plans.

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.	

WRES Action Plan – September 2023

Area & Objective	Action	Lead	Timescales	Outcome & Impact	Progress
Inclusive Culture	Ensure that belonging and inclusion is integrated into the appraisal of all staff, with specific objectives for the Board and Executive Team.	KAS	Mar 2024	A compassionate and caring workforce where all staff feel a sense of belonging and inclusion. Our communities can see themselves represented in the workforce of HPFT, which makes us feel more able to access, care and support. All staff are aware of their personal responsibility for embedding our belonging and inclusion culture.	
	Belonging and inclusion to be embedded within all Job Descriptions and Person Specifications.	CW/BH	Feb 2024		
Diverse Workforce	Expand the Inclusion Ambassador programme	BH	Dec 2023	Equality in relation to likelihood of appointment. Equality in likelihood of entry to formal disciplinary processes. Equality in relation to development. Increased representation at all levels of the Trust.	
	Ensure staff are fully supported to achieve informal resolution of grievances and throughout all formal HR processes for both the initiator and responder parties.	COR/BH	Dec 2023		
	Implement evidence-based actions in relation to achieving equity for BAME staff relating to entry into the formal disciplinary process.	COR/BH	Nov 2023		
	Review the development offer to staff ensuring equity of access and outcomes.	NK	Dec 2023		
	Establish a belonging and inclusion dashboard to monitor performance.	BH	Nov 2023		

Area & Objective	Action	Lead	Timescales	Outcome & Impact	Progress
	Expand the reverse mentoring programme for all senior leaders and all underrepresented groups.	BH	Nov 2023		
Eliminate Discrimination	Implement a comprehensive approach to address racism experienced by staff from service users or their carers.	BH/MN	Apr 2024	Eliminate discrimination, bullying and harassment at work. Our partners see HPFT always advocating for anti-racism and the elimination of discrimination in all that they do. People feel safe to call out discrimination whenever they see or hear it as part of our Freedom to Speak Up commitment.	
	Ensure that Trust policies and procedures are in line with the new Belonging and Inclusion strategy objectives.	MG/BH	Feb 2024		
	Embed our inclusive culture to create an environment where everyone feels heard, valued and respected in line with our values.	BH	Mar 2028		
	Educate leaders on being consciously inclusive to support the eradication of racism and microaggressions in the workplace, including insensitive and inappropriate 'banter'.	NK	Apr 2024		
Review the BAME Staff Network	Implement the NHS Staff Network best practices to review, refresh and reinvigorate the network, including accessibility to all different cultural heritages.	BH	Jan 2024	The BAME staff network provides effective support to staff. The BAME staff network effectively progresses a comprehensive programme of work. BAME staff have a strong voice within the Trust.	
	Increase network membership with effective and expanded allyship.	BH	Jan 2024		
	Develop a comprehensive plan of work for the network.	BH	Jan 2024		

WDES Action Plan – September 2023

Area & Objective	Action	Lead	Timescales	Outcome & Impact	Progress
Continue to Improve Disability Declaration Rates - ESR & Staff Survey	Continued encouragement to all employees to update their information on ESR – Ensure all staff are aware of why all types of disability declaration on ESR is important	BH/MW	Ongoing	Improved data quality, analysis and performance tracking. Improved ability to monitor and address underrepresentation throughout the Trust. Increasing the confidence of staff with disabilities to volunteer their data.	
	Investigate the disparity of declaration between non-clinical & clinical staff.	MW	Dec 2023		
	Guides to highlight how to update ESR information – highlighting the self-service feature – "how-to" video and animation to be developed and shared to all staff highlighting how their information will be used, who will have access to it and how will it benefit the Trust.	MG	Jan 2024		
Continue improving the reasonable adjustments framework for staff with disabilities to carry out their work.	Identify routes to further support our Staff with disabilities within the Trust.	MW/ BH	Mar 2024	Open access to a wider pool of talent. Every employee has the same opportunities to thrive and be successful at work.	
	Explore the collation of reasonable adjustments being made across the Trust to ensure equity across all business areas.	MW	Dec 2023		
	Improve the procurement of supportive technologies to reduce delays in delivery for new staff or staff with emergent disabilities.	MW	Dec 2023		
Improve accessibility throughout the Trust, both physical accessibility, communications and technical/software accessibility	Update and improve awareness of the Trust Access Guides ensuring they are embedded as standard operating practices across all sites.	MW	Mar 2024	No one is excluded from taking an active part in working life at HPFT. Recruiting and retaining staff with disabilities at all levels.	
	Research and design a Practical Guide to Accessibility for HPFT.	BH	Mar 2024		

Area & Objective	Action	Lead	Timescales	Outcome & Impact	Progress
				All staff have confidence in the Trust as a disability aware employer. Develop Disability Confident Leaders. Our workforce will feel physically and psychologically safe coming into work each day.	
	Ensure new sites, building works and facility Modifications are fully accessible.	MW	Mar 2024		
	Review application & recruitment processes to ensure reasonable adjustments are embedded as standard practice.	BH/ CW	Mar 2024		
	Assess and update as necessary our intranet and internal communications platforms to ensure they are accessible to all.	BH/ HB	Mar 2024		
	Improve the training & support related to accessibility features and programmes.	MW	Mar 2024		
We will implement and design management training, guidance, and support to enhance understanding of disabilities in the workplace and promote disability confident conversations.	Improve our existing non-mandatory training.	BH	Mar 2024	Enhancement of disability inclusion & awareness within the workplace. Increased confidence of staff with disabilities that sharing information on their disability status will not have any negative impact on their career experiences, but rather enhance their working experience. Managers will be equipped and confident to have regular discussions with their staff to find out where barriers remain.	
	Ensure all managers receive fundamentals training on disability awareness and making reasonable adjustments.	BH	Mar 2024		
	Embed our Belonging and Inclusion strategy to enhance our inclusive culture, improve the diversity of our workforce and eliminate discrimination.	BH	Mar 2028		

Area & Objective	Action	Lead	Timescales	Outcome & Impact	Progress
				All staff feel enabled and empowered within the workplace. Disability discrimination is eliminated.	
We will Improve career progression & opportunities.	Embed best practice standards for developmental feedback following interviews.	CW/ BH	Jan 2024	Increased career opportunities and progression for staff with disabilities. Assurance that staff with disabilities achieve equity in participation in career development opportunities. Our service users, carers and communities say HPFT is somewhere that they would want to work.	
	Developing carer pathways to support all staff	NK/ BH	Jan 2024		
	Ensure the voice of staff with disabilities are heard in the development of new learning and career opportunities to ensure they are accessible to all.	MW	Dec 2024		

Gender Pay Gap Action Plan – September 2023

Area & Objective	Action	Lead	Timescales	Outcome & Impact	Progress
Review gender pay gap intersectional issues and identify the key factors contributing to the gender pay gap, such as promotion rates, starting salaries and identify and implement actions to rectify pay gaps and ensure fair and equal pay for all staff.	Collate intersectional data	BH	Dec 2023	• Improved gender pay gap • Intersectionality pay gaps reduced. • Our workforce feels treated fairly and equitably	
	Analyse data for any differences	BH	Dec 2023		
	Consult with the networks, develop and implement a plan of action to eliminate root causes of pay inequity.	BH	Mar 2024		
To encourage the adoption and implementation of flexible and remote working practices wherever possible, including part-time work, job sharing (particularly at senior levels), and flexible hours, to support work-life balance for both men and women in the trust.	Evaluate impact of current policies and approaches to identify any improvements	MG	Jan 2024	• Increased flexibility at work for staff • Improved attraction and retention rates • Increased satisfaction with flexibility offer • Our workforce feels valued and respected.	
	Support implementation of the national flexible working measures in the Trust and implement the Happy to Talk Flexible standard	MG	Jan 2024		
	Raise awareness of what is available to all staff	MG	Jan 2024		
	Survey managers to identify any barriers to the uptake and effectiveness of flexible working arrangements.	MG	Dec 2023		
To review and enhance as requried career development programmes within the Trust, ensuring they are inclusive and provide equal opportunities for men and women.	Review and improve as required the career development information on the Hive and elsewhere	NK	Dec 2023	• Our workforce are able to say that they have received excellent training and development, and can see their future careers at HPFT	
	Identify and implement career development improvement programmes to address underrepresentation.	NK/BH	Feb 2024		

Area & Objective	Action	Lead	Timescales	Outcome & Impact	Progress
To ensure that return-to-work initiatives provide fair and equitable pathways for career progression and remuneration within the trust and provide support, training, and resources to employees returning from career breaks to facilitate their successful reintegration and advancement	Ensure that staff fully understand the support available to them during IVF, adoption, fostering, pregnancy, maternity and paternity.	COR	Dec 2023	• All our staff are equally supported to progress • No member of staff is disadvantaged as a result of IVF, adoption, fostering, pregnancy, maternity or paternity leave. • Our workforce feels included and supported by compassionate staff.	
	Survey women to better understand the issues and challenges facing women returning to work and their career advancement.	BH	Dec 2023		
	Review and improve as necessary the return-to-work initiatives offered by the Trust.	COR/BH	Dec 2023		
	Develop and implement a new talent mapping approach and career development programmes to support underrepresentation in the Trust.	NK	Jan 2024		
To fully integrate belonging and inclusion training into the professional development programmes within HPFT, ensuring that all staff are aware of and actively work to address underrepresentation.	All leadership programmes to support leaders to be consciously inclusive	NK	Jan 2024	• All development programmes equip staff with core belonging and inclusion knowledge and skills • All staff experience equity of outcomes in relation to recruitment and development, with discrimination and bias eradicated	
	Embed techniques to foster a positive learning environment, eliminate blame and create an environment where everyone feels heard, valued and respected in line with our values	BH	Mar 2024		
To incorporate belonging and inclusion improvement goals into	Introduce a metric for leaders to improve belonging and inclusion as a part of their annual performance appraisal.	KAS	Mar 2024		

Area & Objective	Action	Lead	Timescales	Outcome & Impact	Progress
the performance evaluation frameworks of Trust leaders	Review performance as a part of the annual appraisal.	KAS	Mar 2024	• Leaders champion belonging and inclusion • Leaders embed a culture of belonging and inclusion. • Our workforce feels able to say that their leaders are compassionate, and values based.	
To implement quarterly gender pay gap reviews to assess their effectiveness of measures introduced throughout the year.	Implement a quarterly review programme for the action plan. Make necessary adjustments and improvements based on the findings to ensure continuous progress towards gender equality	BH	Quarterly	• Momentum is maintained and tangible progress achieved. • Progress is communicated out to staff so that everyone feels heard and valued.	

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 9
Subject:	Patient Safety Incident Response Plan	**For Publication:** Yes
Author:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

This paper provides an 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 provides an overview of how Patient Safety Incident Investigations (PSII) will take place and other learning responses, the review of incidents together with the supporting governance structure. Furthermore, it outlines the oversight arrangements and key responsibilities.

Action required:

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

Summary and recommendations to the Board:

The Patient Safety Incident Response Framework is a key part of the National Patient Safety Strategy. Published in August 2022, it outlines how providers should respond to service user (patient) safety incidents for the purpose of learning and improvement.

The Patient Safety Incident Response 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 Serious Incident Framework and supports the development and maintenance of an effective patient safety incident response system,

The Patient Safety Incident Response Plan 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. This will, ensure the Trust continually improves the quality and safety of care provided.

Relationship with the Business Plan & Assurance Framework:

Strategic Objective 3 Quality - We will provide high quality care and support that is safe and achieves the best outcomes for service users and carers

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

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

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

PSIRF places an emphasis on service user/carer involvement and engagement.

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

Evidence of robust governance review process for the Safety standard.

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

Executive Committee (draft) 27/9/23

1. Introduction

1.1 This paper provides an overview of the Trust Patient Safety Incident Response Plan (PSIRP, its aims, the data analysed and the five priority areas from the analysis.

1.2 The paper also provides an overview of how Patient Safety Incident Investigations (PSII) will take place and other learning responses, the review of incidents, together with the supporting governance structure. Furthermore, it outlines the oversight arrangements and key responsibilities.

1.3 The Board is asked to note and approve the content of this paper.

2. Background

2.1 The Patient Safety Incident Response Framework (PSIRF) is a key part of the National Patient Safety Strategy. Published in August 2022, it outlines how providers should respond to service user (patient) safety incidents, for the purpose of learning and improvement.

2.2 PSIRF supports the development and maintenance of an effective patient safety incident response system, that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement.

2.3 PSIRF focuses on how patient safety incidents happen and, using a systems thinking approach, enables effective learning and improvement. It builds on how Hertfordshire Partnership NHS University Foundation Trust (the Trust) responds to patient safety incidents, replacing the current Serious Incident Framework.

3. The Patient Safety Incident Response Plan

3.1 According to the PSIRF, the Patient Safety Incident Response Plan (PSIRP) is a requirement of the Trust, as a provider organisation. In readiness, the Trust has reviewed its governance structure, analysed its data and identified five priorities for improvement over the next 12 months.

3.2 The PSIRP sets out how the Trust will seek to 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. Ultimately, to ensure the Trust continually improves in the quality and safety of care provided.

3.3 The overall aims of the PSIRP are:

- To improve the safety of care provided by the Trust and improve the experience of service users, families, and carers
- To further develop systems of care to continually improve their quality and efficiency
- To improve the service user, families, carers and staff experience, involvement and engagement when a patient safety incident or the need for a PSII and learning response are identified
- To improve the working environment for staff in relation to their experience of patient safety incidents and investigations.

3.4 The PSIRP will help the Trust measurably improve the efficacy of local Patient Safety Incident Investigations (PSII) and other learning responses, by refocusing PSIIs towards a systems approach, identifying any interconnected causal factors and system issues. It will also help by focusing on addressing the causal factors, to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

3.5 To ensure effective implementation of the PSIRP aims, the Trust will:

- act on feedback from service users, families, carers and staff about current challenges with patient safety incident response and PSIIs
- work in collaboration with Patient Safety Partners
- continue to build on the Trust's safety culture, supporting a just culture, and effective implementation of learning from patient safety incidents
- make effective use of the Trust's current resources, by transferring the emphasis from the quantity of investigations to a further improved and more proportionate response to patient safety incidents as a whole.

3.6 This will mean that the Trust will ensure PSIIs, and other learning responses, consider systems-based learning and improvement, achieved through meaningful engagement with service users, families, carers and staff.

4. Analysis of patient safety incidents

4.1 The Trust has analysed its data relating to patient safety incidents over the past two years to inform the development of its PSIRP. This analysis included both qualitative and quantitative data, from the following:

- incidents reported on Datix, considering:
  - incident type
  - patient safety subcategories
  - level of harm
- Serious Incidents
- patient safety incident reports
- complaints
- Freedom to Speak Up reports
- Mortality Governance reviews
- Electronic Patient Record (EPR) case note reviews
- Staff Focus group discussions
- Claims
- Coroners' findings from Inquests
- Safeguarding reviews
- Risk assessments
- Continuous Quality Improvement (CQI) projects
- Audits.

4.2 Trust wide workshops have also been held where other new and emergent risks relating to acuity, complexity and demand in services, could be discussed and reviewed.

4.3 As an outcome of this analysis, the Trust has identified five priority themes for improvement for the next 12 months. These are:

1. Violence and aggression
2. Self-harming behaviour
3. Inpatient falls
4. Medication incidents
5. Unexpected deaths.

4.4 These are in broad categories; each category may contain a number of subcategories as detailed in ***Appendix 1*****.** The subcategories are not exhaustive and may be added to, based on incident data.

5. Learning responses

5.1 Under the new framework, there will be a number of learning responses which the Trust may use, including the PSII, After Action Reviews and Swarms.

5.2 Based on the Trust's data analysis and identified priorities, it will now consider PSIIs and learning responses on priority incidents reported, and their potential for risk.

5.3 All reported incidents which fall into the priority area will be reviewed at the Trust's already established weekly Moderate Harm Review Panel. If an incident does occur, which has the potential for significant new learning, a PSII or other learning response will be considered via the Panel.

5.4 The PSIIs and other learning responses will be monitored via the Safety Committee.

5.5 Clinical effectiveness processes, such as clinical audits, national reviews, Safeguarding Adult Reviews, Learning from Lives and Deaths for people with a learning disability and Autistic people, Structured Judgment Reviews, and Domestic Homicide Reviews, will continue to be monitored, to ensure that any new patient safety risks are identified and acted upon in a timely manner.

5.6 An overview of all incidents will 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.

6. Patient Safety Incident Investigations

6.1 PSIIs are conducted for systems learning and safety improvement, achieved by identifying the circumstances surrounding incidents and the systems-focused interconnected causal factors. There will continue to be other investigations which may be conducted for or around individuals, for example complaints, claims, human resource (HR), professional regulation or criminal investigations, learning from which may inform safety improvement plans.

6.2 The selection of incidents PSIIs is based on:

- actual and potential impact (harm) of the incident's outcome
- likelihood of recurrence
- potential for new learning, considering enhanced knowledge and understanding of the underlying factors
- improved efficacy and effectiveness
- the opportunity to influence wider system improvement.

6.3 Where a PSII is indicated, the investigation will commence as soon as possible after the patient safety incident is identified. These will, ordinarily, be completed within one to three months of their start date. In exceptional circumstances, a longer timeframe may be required for completion of the PSII, which will be agreed with the service user/family/carer.

6.5 For each PSII, the Trust will:

- ensure it is conducted separately, in full and to a high standard, primarily investigated by the Safer Care Team, working with the trained investigators in the SBUs. This builds on what has been established and successfully implemented under the SI framework
- undertake PSIIs and other learning responses in line with national standards
- use the national standard template to report the findings of the PSIIs
- identify causal factors.

7. Review of incidents

7.1 Building on the already established processes in place, when reviewing incidents under the PSIRF, the Trust will discuss all incidents reported as moderate harm or above at the weekly Moderate Harm Review Panel, who will be responsible for reviewing the incidents against the framework and consider a learning response.

7.2 A three-day report will be brought to the Moderate Harm Review Panel, to inform discussions and decision making around learning response.

7.3 Should an incident require a multi-agency learning response to ensure system-wide learning, the Trust will engage with the ICS' Quality and Patient Safety Team to support the coordination of a cross-system review.

7.4 The Trust will continue to use Datix as its electronic system to report and record all incidents and learning. Each PSII or learning response will be recorded in Datix and assigned an identification number.

7.5 The Execuitve Director Quality & Safety (Chief Nurse) or Executive Director Quality & Medical Leadership will review and approve all final PSII reports. Once approved, the ongoing management of PSIIs and other learning responses, including actions completed, Trust wide learning and monitoring of ongoing compliance, with completed actions/changes, will be overseen by SBU's Quality and Risk Management meetings and the Safety Committee.

8. Patient Safety Incident Response Framework oversight and responsibilities

8.1 A Moderate Harm Review Panel report will be provided to the Executive Team on a weekly basis, detailing the planned approach for the incidents with an agreed learning response. A monthly team thematic report will be produced.

8.2 The Trust's Safety Committee, will oversee and monitor the PSIRP, reporting into the Trust's Quality and Risk Management Group (QRMG), Integrated Governance Committee (IGC) and to the Trust Board. It will be reviewed on a quarterly basis during its first year and then annually approved by the Trust and local commissioners thereafter.

8.3 The Trust has clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities, and upholding national standards relating to patient safety incidents. ***Appendix 2*** details the governance structure for patient safety incidents, as of 1 October 2023.

8.4 The Trust **Board** is responsible and accountable for effective patient safety incident management in the Trust. This includes supporting and participating in cross-system/multi-agency responses and/or PSIIs where required.

8.5 The Trust's **Executive Director Quality & Safety (Chief Nurse)** is the Executive Lead responsible for supporting and overseeing the implementation of the PSIRF, supported by the Executive Director Quality & Medical Leadership. They also have responsibility for:

- ensuring the Trust meets national patient safety incident response standards
- ensuring PSIRF is central to overarching safety governance arrangements
- quality assuring learning response outputs (PSIIs and other learning responses).

8.6 The Trust's **Quality and Risk Management Committee** reviews patient safety reports and monitors progress on safety initiatives, reporting to the **Integrated Governance Committee**.

8.7 The **Safety Committee** will oversee all work relating to PSIRF, including the PSIRP, PSIIs, and other learning responses, receiving reports from the PSIRF Implementation Group. The Safety Committee will report to the QRMC, into IGC and the Board on a quarterly basis.

8.8 The **Safety Committee** will:

- Design strong/effective improvements to sustainably address casual factors
- Inform a safety improvement plan for implementation of the planned improvements
- Monitor the implementation of the improvements
- Monitor the effectiveness of the improvements overtime

8.9 The Trust's **Patient Safety Team** will ensure that learning responses are undertaken for all incidents that require this level of response. They will be responsible for ensuring that the incident reporting systems and processes, to support the recording, sharing and monitoring of patient safety incidents are in place. They will also continue to support and advise staff involved in the patient safety incident response.

8.10 As members of the Patient Safety Team, **Learning Response Leads (**previously known as investigators) will work with identified individuals in the SBUs to undertake learning responses in line with PSIRF standards.

9. Policies and procedures

9.1 A number of the Trust's policies and procedures need to be reviewed and updated in consideration of PSIRF. A programme of work has been developed and will be overseen by the PSIRG Implementation Group. All policies and procedures will be reviewed and updated by the end of October 2023 ready for ratification at the QRMG in November 2023.

9.2 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.

10. Communications Plan

10.1 Weekly communications to all Trust staff will continue throughout October via *HPFT News,* providing updates on the progress made towards PSIRF implementation and key changes.

10.2 The plans also includes frequently asked questions (FAQ) and guidance for staff, determined by the feedback from the PSIRF Implementation Group. The messaging will focus on awareness on the four key aims of PSIRF, and what this means for staff.

10.3 A PSIRF email address has been circulated for staff to use and any feedback or questions will be developed into the FAQs for staff.

10.4 A PSIRF roadshow is being planned to provide ongoing support and respond to queries as PSIRF is implemented. The structure and organisation of this is being discussed with the PSIRF Implementation Group.

10.5 A timeline of key events, is provided in ***Appendix 3.***

11. Conclusion

11.1 The PSIRF is a key part of the National Patient Safety Strategy. Published in August 2022, it outlines how providers should respond to service user (patient) safety incidents for the purpose of learning and improvement.

11.2 The PSIRF focuses on how patient safety incidents happen and, using a systems thinking approach, enables effective learning and improvement. It builds on how the Trust responds to patient safety

incidents, replacing the current Serious Incident Framework and supports the development and maintenance of an effective patient safety incident response system,

11.3 The PSIRP sets out how the Trust will seek to 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. Ultimately, to ensure the Trust continually improves in the quality and safety of care provided.

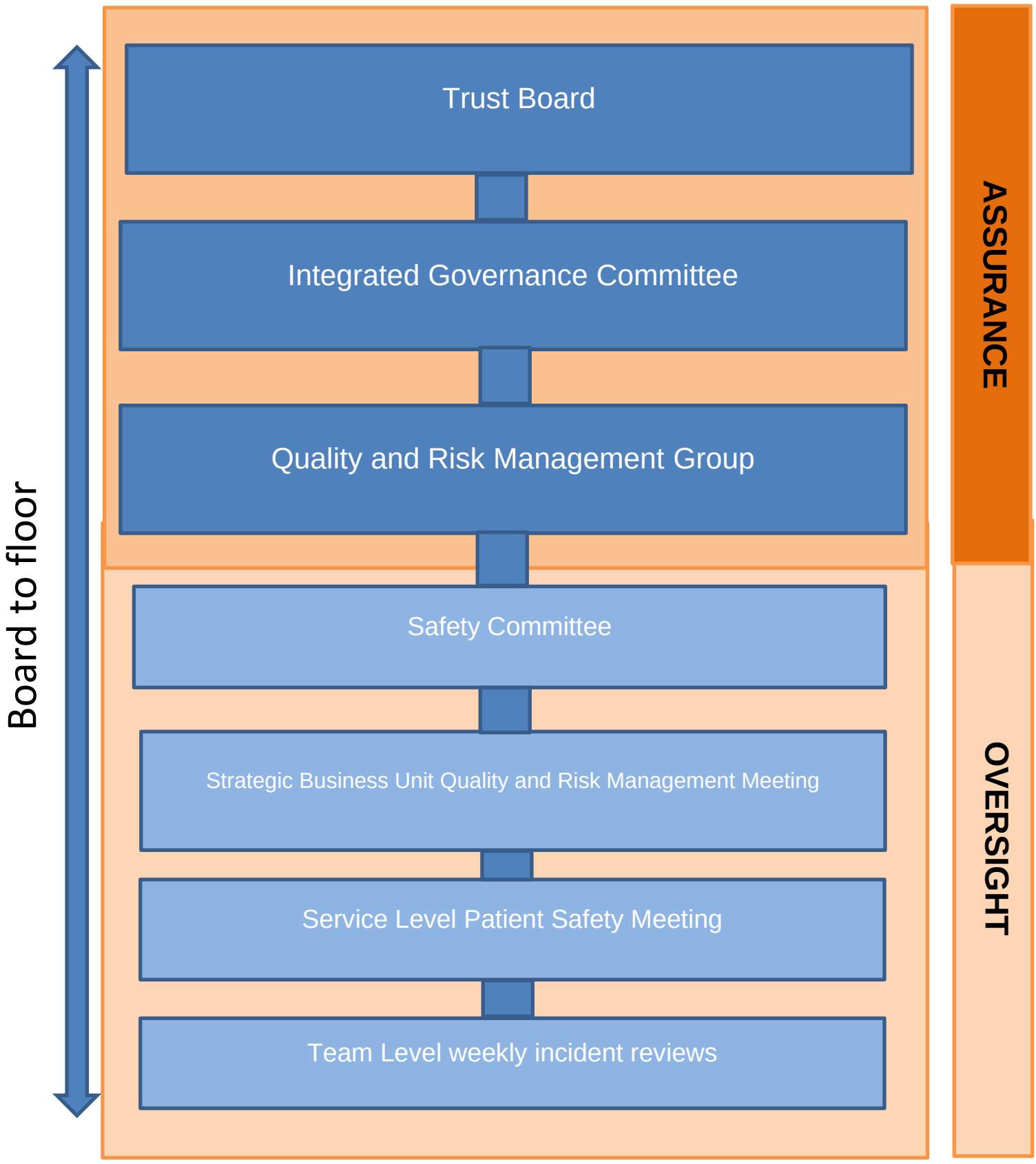
11.4 This paper has provided details regarding the PSIRP, its aims, the data analysed and the five priority areas from the analysis. It has also provided details of PSII and other learning responses, and the review of incidents, with the supporting governance structure. Furthermore, it has outlined the oversight and key responsibilities.

11.5 The Board is asked to note and approve the content of this paper.

Appendix 1 - Key Themes Identified

Category	Violence and Aggression	Self-Harm Behaviours	Medication	Inpatient falls	Unexpected Deaths
Sub-categories	Actual Assault	Ligatures	Medication error resulting in harm	Fall resulting in harm	Deaths related to drugs and alcohol
	Racial abuse	Headbanging	Near Miss Medication error	Series/increase in falls in one area	Suspected suicides
	Ongoing threatening behaviour	Drug and Alcohol abuse	Series/increase in medication errors in one area		Deterioration in physical health not recognised
	Use of Restrictive Practice not in line with policy	Use of Restrictive Practice not in line with policy			

Appendix 2 – Patient Safety Incident Governance Structure



Appendix 3 – PSIRF Plan Timeline

Quarter 3 23/24			Quarter 4 23/24			Quarter 1 24/25			Quarter 2 24/25		
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**
Five priority areas identified Board approve PSIRP Recruit Patient Safety Partners	PSIRF policy approved by JCNC Policy and procedure review and update	Launch of PSIRF PSIIs Receive feedback from service users, families carers and staff	Review of patient safety incidents and learning responses in Integrated Safety Report		Plan for 24/25 Review of PSIRP	Review of patient safety incidents and learning responses in Integrated Safety Report		Receive feedback from service users, families carers and staff	Review of patient safety incidents and learning responses in Integrated Safety Report		Review of PSIRP Review of PSIRF policy
Roadshows and communication plan			Monthly communications update via *HPFT News*								

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 10
Subject:	Report from the Finance & Investment Committee meeting held on 25 July 2023	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Philip Cave, Chief Finance Officer
Presented by:	Philip Cave, Chief Finance Officer	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Finance and Investment Committee at its most recent meetings held on 25 July 2023.

Action required:

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

Summary and recommendations to the Board:

Summary

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

- HPFT have a financial deficit of £2.9m year to date (M5) with a likely forecast deficit of £6.4m, £4.6m worse than plan.
- The HWE system has a deficit of £33.5m which is £19m worse than plan. The system is under scrutiny from the NHS regional team and are required to develop a recovery plan to deliver financial breakeven.
- The Trust is working closely with HWE ICS colleagues to develop a medium-term financial plan (3 years) which must be submitted by 30th September 2023. The work is very high level and will need to be refined for the 2024/25 financial and annual planning submissions.
- The FIC discussed the key assumptions which takes into consideration; the out turn position for 2023/24, national inflation rates, full year effect of 2023/24 investments, new cost pressures arising in 2024/25, additional MHIS funding expectations and delivering value targets.
- The current 2024/25 plan is showing a deficit of £27.6m, which is driven by non-recurrent income reductions (£12m, cost pressures £5m, FYE impact £5.6m on top of an underlying deficit of £6m. Further information would be provided at the Trust Board on 21st September 2023.

Recommendation

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

Relationship with the Business Plan & Assurance Framework:

List specific risks on BAF

Summary of Financial, IT, Staffing & Legal Implications:

There are no direct implications from the report.

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

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

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Finance and Investment Committee held on 25 July 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 25 July 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.

1.5 Committee members also had a briefing on 18 September 2023.

2. Finance

2.1 The Committee received a report that set out the Trust financial position at month three. It was noted 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. This was driven by use of out of area beds and use of temporary staff. Committee members were updated on the increased financial governance in place and actions being taken to reduce expenditure and increased income.

2.2 The Committee were updated on the financial position of the system and partners, noting that the Trust had been asked by the ICB to provide a forecast year end position.

2.3 It was reported that the finance team were planning for 2024/25 and that this included a number of different scenarios and analysis of run rate of expenditure.

2.4 The Committee were updated on the progress of the Delivering Value programme. It was noted that the programme included a number of recurrent and non-recurrent elements. It was reported that the programme was delivering but that it was being closely monitored.

3. Performance

3.1. The Committee considered the quarter one for 2023/24 report on performance. The report set out that things remained challenging, but that of the 63 key performance indicators almost 42% of them had been met. There remains challenges in inpatient services, older people, and access for Children and Young People.

3.2. Areas of strong performance were 48 hour follow up, 28 day access, Single Point of Access, along with steady progress across a number of metrics. The positive trend with regard to carers being involved was welcomed.

3.3. The Committee discussed the impact of Industrial Action on performance and it was confirmed that it was having a impact for example: initial assessments. It was noted that the Trust was collating the impact of Industrial action not only on performance but on quality and staff.

4. Annual Plan

4.1. The Annual Plan quarter one report detailed the progress that had been made, reporting that had achieved six out of seven of the quarter's milestones. It was noted that it was forecast that expected to meet the majority of milestones by year end.

4.2. It was noted that the main risks to delivering the milestones lay with workforce and the transformation work and noted that Industrial action was causing a slowing down. The Committee discussed the continuing demand for ADHD services noting that was a national issue.

5. Bank and Agency

5.1. The Committee received a deep dive on the use of bank and agency staff and the associated costs. The Committee noted that in 2022/23 the Trust had spent over £15m on temporary staff across all disciplines. In 2023/24 the monthly level of expenditure on agency staff had reduced. The larges area of spend remained Health Care Support Workers which is linked with the need for safe and supportive observations both in mental health services but also acute trusts.

5.2. The Committee were informed on how a dashboard of information was available to services and was used weekly and monthly to monitor and track expenditure and progress with initiatives to reduce spend.

5.3. It was noted that the use of agency staff in corporate services had reduced significantly in 2023/24 due to increased financial governance.

5.4. The Committee discussed the continued work to increase recruitment which would have a positive impact on the need to use temporary staff. And work that had been completed to review and update staffing establishments.

6. Capital Programme

6.1 The Committee considered a report that set out the progress with the capital programme for 2023/24. It was reported that the programme had spent £2.7m to date against a plan of £4m but that it was expected to breakeven at year end.

6,2 It was noted that the planned disposal was scheduled for quarter three or four but there was a risk that this may be delayed with issues regarding planning permission.

7. System

7.1 The Committee received a report that provided an update on contracts and commercial activity. It was noted that good progress with finalising the six main contracts had been made. It was noted that main contract with Hertfordshire had been extended until 2026.

7.2 Discussions were continuing regarding the Trust becoming lead provider for perinatal, but it was reported that the start date may move from October 2023 to April 2024.

7.3 The Committee noted that the Trust had signed, alongside other partners the Herts and West Essex Integrated Care System Memorandum of Understanding (MoU). It was noted that the purpose of the MoU is to establish a collaborative agreement among the parties to work collectively towards achieving a balanced financial plan for the ICS in 2023/24.

8. Briefing for Committee members 18 September 2023

8.1 Committee members were provided with a briefing by Chief Finance Officer and Deputy CEO on 18 September. The briefing updated members on the financial position at month five, the actions being taken and likely forecast for year end. It was noted that the Board would be receiving a full finance report at its meeting in public on 5 October 2023.

8.2 The briefing also updated members on the developing medium term financial plan for the Trust. Noting that it was a system requirement. It was noted that the Board meeting being held on 21 September would receive a detailed report and provide an opportunity of discussion of the plan.

Appendix one – Agenda items 25 July 2023

Apologies for Absence
Declarations of Interest
Minutes of meeting held on 18 May 2023
Matters Arising Schedule
DEEP DIVE
Bank and Agency
PERFORMANCE
Quarter One Performance
Quarter One Annual Plan Report
OPERATIONAL
Month three Finance Report including Delivering Value
Contract Update
HWE ICS Finance MOU
STRATEGIC
Capital Programme
TO NOTE
FIC Business Programme 2023/24
Any Other Business
Date of next meeting: TBC

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 10a
Report Title	Quarter 1 Performance Report	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Sally Wilson, Head of Performance Improvement	
Approved by:	Hakan Akozek, Director of Innovation and Digital Transformation; Chief Information Officer	

The Board members are asked to:

Receive the report, discuss key areas of performance and to note actions being taken to improve performance.

Executive Summary

At the end of Quarter 1, 67% (42/63) of our Key Performance Indicators across the three operational performance domains were either fully met or almost met.

Please note that 63 indicators are reported in Quarter 1 instead of 65. This is due to the removal of two indicators following approval from Finance and Investment Committee on 25th July 2023; Use of Resources (Finance) which is no longer relevant and Staff Wellbeing at Work (Workforce) which will now be reported via the annual national staff survey.

In Quarter 1, the Trust performed well in:

- People starting treatment for psychosis within 14 days of referral
- Ensuring that people who are discharged from our inpatient services receive a follow-up within 48 hours.
- Children and Young People who need support from our Targeted Team being assessed within 28 days
- People with a learning disability having an assessment within 28 days of referral
- Maintaining flow through our Single Point of Access Service within a 14-day timeframe.
- Carers saying that they feel valued by our staff
- Our service users saying that they are treated in a way that reflects the Trust's values and that our staff are welcoming and friendly

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

- Demand and acuity in our inpatient and crisis pathways and delays in discharging service users who are ready to leave our inpatient services continues to result in an increased number of service users being admitted to out of area placements. We continue to focus on reducing length of stay in our inpatient units, exploring alternative pathways to support discharge and prevent admission to reduce our need for external beds. We expect to recover these areas to the agreed targets at the end of Quarter 4.
- Timely access and treatment for people entering our children and young people and adult community services, particularly in areas where recruitment is more challenging. We continue to focus on improving access times whilst balancing the ability to provide timely and effective treatment. We are reviewing our clinical processes and workflows in addition to our work on demand and capacity as part of the transformation of our services, including how we deliver ADHD services in consultation with our commissioners. We expect to recover performance in children and young people service in Quarter 4 and adult services in Quarter 3.

- 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 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.

This report was presented to Finance and Investment Committee on 25th July 2023 and there has been a delay in its presentation to the Trust Board due to timing of Trust Board meetings. Although a full Quarter 3 report will be provided to the Trust Board, the Trust Board is asked to note that at the end of August 2023:

- We have met or almost met 68% (41/60) of our Key Performance indicators.
- Key areas we have recovered such as 48 hour follow ups, urgent and routine eating disorder services for Children and Young People and people with serious mental illness receiving physical health checks in our adult community services continue to perform well
- Although we are performing well against the recovery trajectory for inappropriate Out of Area placements, we continue to see significant demand for our inpatient services and high number of service users who are clinically ready for discharged, but cannot be discharged due to lack of suitable places in the community, particularly in our Older Adult Services
- We continue to see significant demand for our Adult Community Services and are undertaking review of the current capacity in the service to meet this increased demand.
- Continue to have difficulty in recruiting and retaining the skilled workforce we need in key professional groups

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

Recommendations

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

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.	✓

Quarter 1 2023/24 Performance Report

1. Background

1.1. This report provides an overview of the Trust's performance at the end of Quarter 1 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.

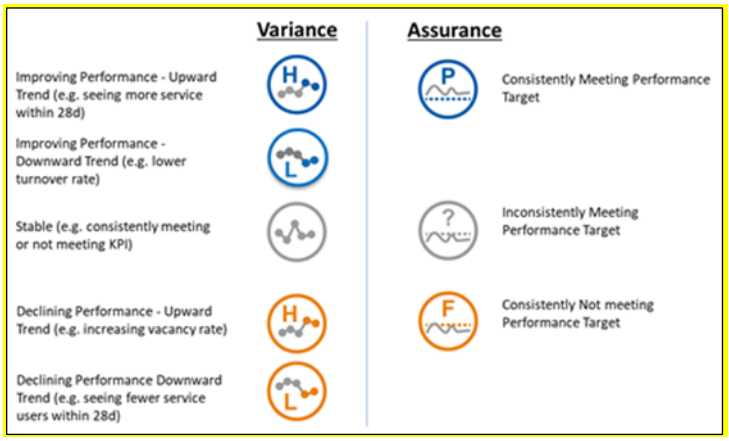


Figure 1 – SPC Icons

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 1 2023/24 Performance Summary

2.1. In Quarter 1 we continued to see pressure on our inpatient services, with high numbers 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 and a high number of people being placed in beds out of the local area in order to meet demand.

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 Quarter 1, 67% (42/63) of our Key Performance Indicators were either fully met or almost met. Please note that 63 indicators are reported in Quarter 1 instead of 65. This is due to the removal of Use of Resources (Finance) which is no longer relevant and Staff Wellbeing at Work (Workforce) which will now be reported via the national staff survey.

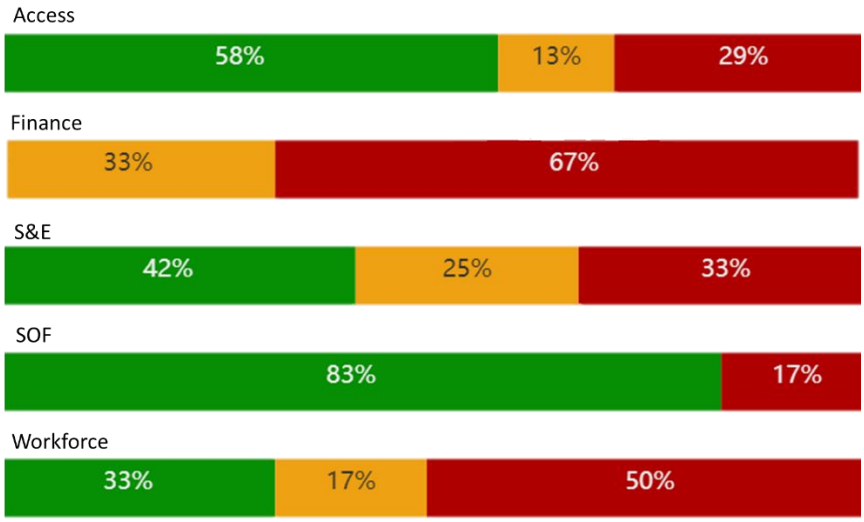


Figure 2 – Percentage of KPIs met in Quarter 1

2.4. Key areas of strong performance at the end of Quarter 1 include:

- Starting treatment for psychosis within 14 days of referral
- Ensuring that people who are discharged from our inpatient services receive a follow-up within 48 hours.
- Children and Young People who need support from our Targeted Team being assessed within 28 days
- People with a learning disability having an assessment within 28 days of referral
- Maintaining flow through our Single Point of Access Service within a 14-day timeframe.
- Carers saying that they feel valued by our staff
- Our service users saying that they are treated in a way that reflects the Trust's values and that our staff are welcoming and friendly

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

- Demand and acuity in our inpatient and crisis pathways and delays in discharging service users who are ready to leave our inpatient services continues to result in an increased number of service users being admitted to out of area placements. We continue to focus on reducing length of stay in our inpatient units, exploring alternative pathways to support discharge and prevent admission to reduce our need for external beds. We expect to recover these areas to the agreed targets at the end of Quarter 4.
- Timely access and treatment for people entering our children and young people and adult community services, particularly in areas where recruitment is more challenging. We continue to focus on improving access times whilst balancing the ability to provide timely and effective treatment. We are reviewing our clinical processes and workflows in addition to our work on demand and capacity as part of the transformation of our services, including how we deliver ADHD services in consultation with our commissioners We expect to recover performance in children and young people service in Quarter 4 and adult services in Quarter 3.

- 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 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 1 the Trust has met five out of six 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 86% of cases against the national target of 60%.

3.3. Our Talking Therapy (IAPT) services perform well for 6 and eighteen-week access targets as well as recovery target.

3.4. We remain challenged in reducing our inappropriate out of area placements which occur when people are admitted, often in crisis, and there is no suitable local bed available. At the end of Quarter 1, our inappropriate out of area bed utilisation remains higher than plan due to ongoing high demand for inpatient services. We continue to work with NHS England and system partners to ensure best practice in this area and working on reducing length of stay in our inpatient services to ensure our service users are supported in the most appropriate setting.

3.5. The table below summarises the end of Quarter 1 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)	Mar-2023	97%	95%			96.2%
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (National)	Jun-2023	87%	60%			79.2%
Improving Access to Psychological Therapies (IAPT)/talking therapies Proportion of people completing treatment who move to recovery (National)	Jun-2023	56%	50%			52.8%

KPI	Month	Performance	Target	Variation	Assurance	Mean
Improving Access to Psychological Therapies (IAPT)/talking therapies Waiting time to begin treatment (from IAPT minimum data set) – within 6 weeks (National)	Jun-2023	91%	75%			95.6%
Improving Access to Psychological Therapies (IAPT)/talking therapies – 18 weeks (National)	Jun-2023	100%	95%			100%
Inappropriate out-of-area placements for adult mental health services (National)	Jun-2023	938	850	N/A	N/A	

Table 1 – Single Oversight Framework KPIs

4. Access

4.1. At the end of Quarter 1, the Trust has met 14 out of the 24 access key performance indicators and almost met three 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 services are performing strongly against their access targets for children who are looked after and children with an eating disorder. We continue to give support to adults in crisis in an acute setting, meeting access standards for seeing people in A&E and on the ward. Anyone who needs admission to one of our wards is assessed to ensure that they are treated in the most appropriate and least restrictive environment.

4.3. We continue to work to improve access in our 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 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. Full recovery of waiting time standards is expected in Adult Community by the end of Quarter 3 and CAMHS by the end of Quarter 4.

4.4. 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 is predicted for Quarter 3.

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

4.6. The table below summarises the end of Quarter 1 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.

KPI	Month	Performance	Target	Variation	Assurance	Mean
CAMHS Eating Disorders - Routine 28 day Waited. (National)	Jun-2023	96%	95%			52%
Number of new cases of psychosis (National)	Jun-2023	69	37.5	N/A	N/A	
Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait (Contractual)	Jun-2023	98%	98%			98%
MHLT Response times: 1 hour wait for A&E referrals (National)	Jun-2023	95%	90%			94.4%
CAMHS Eating Disorders - Urgent referrals seen within 7 Days. (National)	Jun-2023	100%	95%			51.8%
Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team (Contractual)	Jun-2023	100%	95%			96.8%
SPA referrals with an outcome within 14 days (Internal) (Internal)	Jun-2023	100%	95%			93.4%
CAMHS referrals meeting social worker contact waiting time standards - TARGETED SERVICE 14 DAYS (Contractual)	Jun-2023	100%	85%			92.6%
CAMHS referrals meeting assessment waiting time standards - TARGETED SERVICE 28 DAYS (Contractual)	Jun-2023	100%	85%			75.4%
Urgent referrals to community mental health team meeting 24 hour wait (Contractual)	Jun-2023	100%	95%	N/A	N/A	
Urgent referrals to community eating disorder services meeting 96 hour wait (Contractual)	Jun-2023	100%	98%	N/A	N/A	
CRHTT referrals meeting 4 hour wait (Contractual)	Jun-2023	100%	98%			100%
MHLT Response times: 24 hour wait for ward referrals (National)	Jun-2023	98%	90%			97.3%
Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait (Contractual)	Jun-2023	No Referrals	98%	N/A	N/A	
Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental	Jun-2023	95%	98%			94.9%

KPI	Month	Performance	Target	Variation	Assurance	Mean
health and learning disability services (National)						
Routine referrals to community eating disorder services meeting 28 day wait (Contractual)	Jun-2023	95%	98%			83.6%
CAMHS referrals meeting assessment waiting time standards - CRISIS (4 hours) (Contractual)	Jun-2023	93%	95%			89.6%
Number of people entering IAPT treatment (ENCCG) (National)	Jun-2023	79%	100%			87%
Routine referrals to community mental health team meeting 28 day wait (Contractual)	Jun-2023	63%	95%			53.9%
Number of people entering IAPT treatment (HVCCG) (National)	Jun-2023	88%	100%			85.5%
Number of people entering IAPT treatment (Mid Essex) (National)	Jun-2023	73%	100%			77.3%
EMDASS Diagnosis within 12 weeks (Contractual)	Jun-2023	59%	80%			39.2%
CAMHS referrals meeting assessment waiting time standards - URGENT (P1 - 7 DAYS) (Contractual)	Jun-2023	0%	75%			78.1%
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS) (Contractual)	Jun-2023	84%	95%			76.2%

Table 2 - Access Key Performance Indicators

5. Safe and Effective

5.1. At the end of Quarter 1 2023/24, the Trust met ten out of twenty-four key performance indicators in the Safe and Effective domain and almost met a further six.

5.2. Service users continue to tell us that our staff reflect the Trust's values and are welcoming and friendly. They also tell us that they know how to get support when in crisis. Our carers tell us that they feel valued by staff.

5.3. 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.

5.4. 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.

5.5. The number of people who are delayed in our services when they are ready to leave has risen to 17% and we recognise that this needs to improve. Our focus is to work in

partnership with Hertfordshire County Council to find appropriate 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.

5.6. The Table below summarises the end of Quarter 1 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
The percentage of people under adult mental illness specialties who were followed up within 48 hrs of discharge from psychiatric in-patient care (Internal)	Jun-2023	86%	80%			82.6%
The percentage of people under adult mental illness specialties who were followed up within 7 days of discharge from psychiatric in-patient care (National)	Jun-2023	100%	95%			97.4%
IAPT % clients moving towards recovery (HVCCG) (National)	Jun-2023	59%	50%			54.9%
IAPT % clients moving towards recovery (Mid Essex) (National)	Jun-2023	52%	50%			50.5%
Rate of Service Users saying they know how to get support and advice at a time of crisis (Internal)	Jun-2023	85%	83%			79.6%
Rate of service users saying they are treated in a way that reflects the Trust's values (Internal)	Jun-2023	87%	80%			83.4%
Rate of Service Users Saying staff are welcoming and friendly (Internal)	Jun-2023	99%	95%			95.5%
Rate of carers that feel valued by staff (Internal)	Jun-2023	92%	75%			79.3%
IAPT % clients moving towards recovery (ENCCG) (National)	Jun-2023	56%	50%			51.8%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Identifiers) (National)	Jun-2023	99%	95%			99.8%
Percentage of eligible service users with a PbR cluster (Contractual)	Jun-2023	92%	95%			94%

KPI	Month	Performance	Target	Variation	Assurance	Mean
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (Contractual)	Jun-2023	91%	95%			81.8%
Rate of service users with a completed up to date risk assessment (inc LD and F and CAMHS from Apr 2015) Seen Only (Contractual)	Jun-2023	94%	95%			91.7%
Rate of service users that would recommend the Trust's services to friends and family if they needed them (National)	Jun-2023	79%	80%			81.1%
Rate of Service Users saying they have been involved in discussions about their care (Internal)	Jun-2023	82%	85%			85.5%
Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them (National)	2023 Q1	69%	70%	N/A	N/A	
Percentage of eligible service users with a completed PbR cluster review (Contractual)	Jun-2023	61%	95%			67.7%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services (Contractual)	Jun-2023	77%	90%			80.4%
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)	Jun-2023	75%	95%			72.7%
Delayed transfers of care to the maintained at a minimal level (National)	Jun-2023	17%	3.5%			16.5%
Data completeness against minimum dataset for Ethnicity (MHSDS) (National)	Jun-2023	84%	90%			84.4%
Rate of acute Inpatients reporting feeling safe (Internal)	Jun-2023	79%	85%			71.9%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set	Jun-2023	75%	85%			72.3%

KPI	Month	Performance	Target	Variation	Assurance	Mean
submissions to NHS Digital (Accommodation) (National)						
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment) (National)	Jun-2023	75%	85%			72.3%

Table 3 - Safe and Effective Key Performance Indicators

6. Workforce

6.1. The Trust met or almost met three out of the six Workforce indicators at the end of the quarter. Please note that staff wellbeing at work indicator for the Workforce section is now reported via the national staff survey and therefore not reported in Quarter 1.

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

6.3. Mandatory Training performance declined in March, due to the addition of two new nationally mandated courses in preventing radicalisation. However, compliance is now close to recovery.

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

6.5. Our staff in post figures and vacancy rates have significantly improved as a result of increased and successful recruitment activity. Our staff in post has increased by 26.2 FTE since the end of Q4 of 2023/3.

6.6. The table below summarises the end of Quarter 1 position for our workforce key performance indicators.

KPI	Month	Performance	Target	Variation	Assurance	Mean
Sickness rate (National)	Jun-2023	4%	4%			5%
Staff saying, they would recommend the trust as a place to work (Internal)	2023 Q1	70%	70%	N/A	N/A	
Mandatory Training (Contractual)	Jun-2023	91%	92%			90.7%
Turnover rate (Internal)	Jun-2023	12%	8%			13.1%

KPI	Month	Performance	Target	Variation	Assurance	Mean
Rate of staff with a current PDP and appraisal (Contractual)	Jun-2023	89%	95%			82.5%
Rate of staff experiencing physical violence from service users (Internal)	2023 Q1	13%	5%	N/A	N/A	

Table 4 - Workforce Key Performance Indicators

7. Finance

7.1. The Trust continues to have a financial challenge linked to the additional use of staffing to manage risk and acuity in inpatient services in particular, but also in supporting observations within Crisis services for CYP and Adults. Out of Area Placements also contribute significantly towards the Trust's current overspend and remains a high focus area to provide alternatives to inpatient admission for Adult acute beds in particular.

7.2. The table below summarises the end of Quarter 1 position for our Finance Key Performance Indicators. Please note that Use of Resources indicators has now been removed from the Finance KPIs as it is no longer relevant.

KPI	Period	Performance	Target
Year to Date Financial Position	June 2023	£2,143k deficit	£436k deficit
NHS Agency Price Caps	Jun 2023	445 Breaches	0 Breaches
Year to Date Delivering Value Achieved	June 2023	£3,194k	£3,761k

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 1 we met seven of the eight quarterly Quality Account indicators. The indicator for staff wellbeing is reportable on an annual basis.

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

8.4. The table below summarises the Quarter 1 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%			
2	Routine referrals to Specialist Community Learning Disability Services meeting 28-day wait.	>=95%	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%	86%			
	Clinical Effectiveness					
4	Achieving high quality 'formulations' for CAMHS inpatients	>=80%	100%			
5	Reducing the need for the use of restrictive practice in adult and older adult inpatient settings.	>=80%	97%			
6	Urgent CAMHS referrals seen within 7 days	>=75%	80%			
	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%			
8	Rate of service users that would recommend the Trust's services to friends and family if they needed them	>=75%	80%			
9	HPFT takes positive action to support my health and wellbeing. Staff wellbeing at work (Annual Staff Survey)	>=72%				

Table 6 – Quality Account Indicators

9. Conclusion and Recommendations

9.1. The Trust met or almost met 67% (42/63) of our key performance indicators at the end of Quarter 1 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

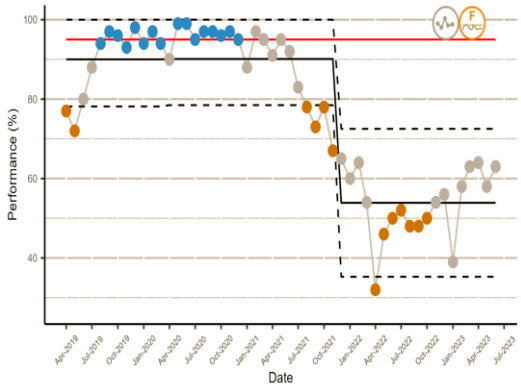
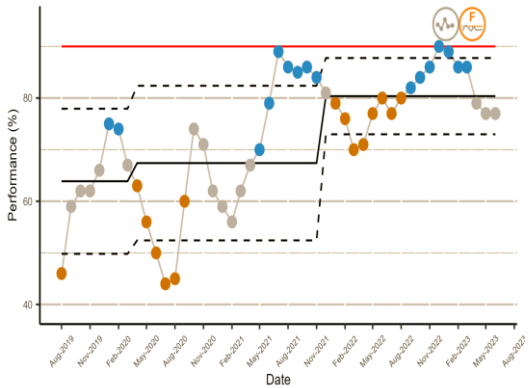
APPENDIX 1 – RECOVERY PROGRAMME UPDATE

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.

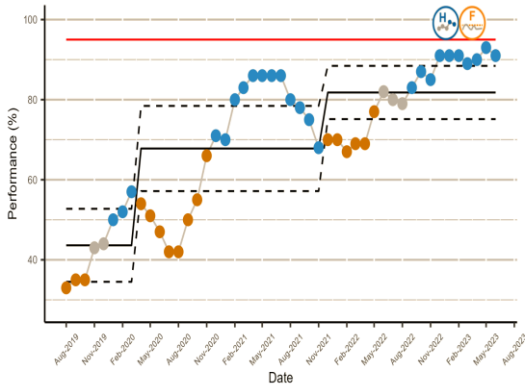
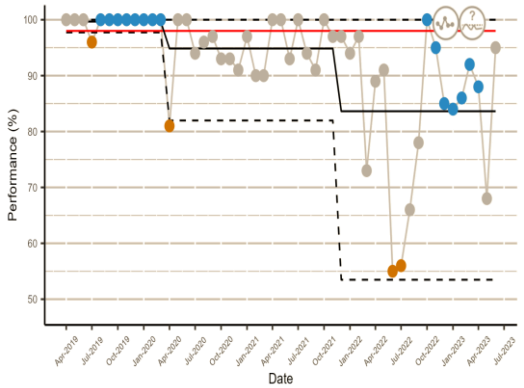
10.2. Each summary is broken into 5 sections (columns)

- 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

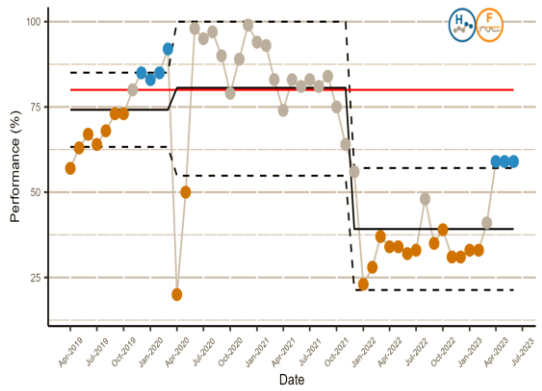
Adult Community MH Services

KPI	Chart	Narrative	Summary	Key Actions
Routine referrals to community mental health team meeting 28 day wait		**Jun-2023** 63% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assassurance** Consistently not meeting performance target	Recovery progressing well in all quadrants except southwest where increased demand and difficulties in recruiting to vacancies is impacting on performance. Increased number of adult ADHD diagnosis referrals is also impacting on capacity. Recovery in Southwest is expected in Quarter 3, with corresponding recovery of the Trust-wide target.	• 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 • Deep dive informed by CQI principles into key drivers and actions for Southwest ACMHS to recover and improve within 6 months • Continue with out of hours clinics and administrative support to clear backlog and manage demand • Provide proposals to commissioners for addressing the increase in ADHD referrals
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services		**Jun-2023** 77% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 90% **Assurance** Consistently not meeting performance target	We saw improvement in performance against this indicator in 2022/23, with target reached in December 2022. Performance has declined over the last two quarters due to vacancies being covered by Nurse Consultants who usually lead on the physical health agenda. Recovery expected in Q3.	• 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

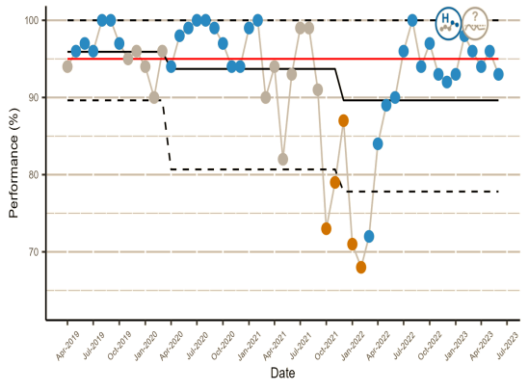
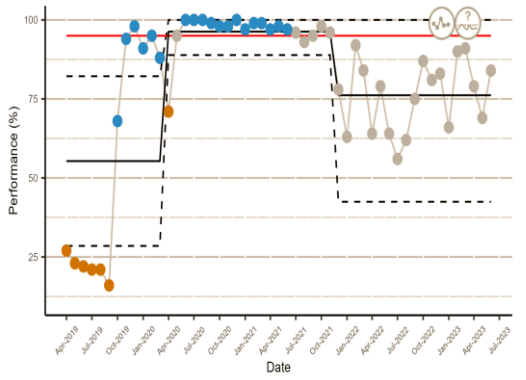
Adult Community MH Services

KPI	Chart	Narrative	Summary	Key Actions
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services		**Jun-2023** 91% **Variance Type** Special Cause Variation: Latest value above upper control limit Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance** Consistently not meeting performance target	We have seen improvement in performance against this indicator over the last ten months. There continue to be challenges due to a lack of resource in teams where there are vacancies combined with leave and sickness Recovery expected in Q2 but dependent on additional resource	• All teams have plans to recover their compliance, but the concern is that some clinics may need to be cancelled over the summer period due to staffing. • Physician Associate started in Southwest providing an additional resource. • Business case in progress to secure additional specialist resource to support physical health.
Routine referrals to community eating disorder services meeting 28 day wait		**Jun-2023** 95% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 98% **Assurance** Inconsistently meeting performance target	Referrals to service have stabilised at circa 30% higher than pre-pandemic, affecting the service's ability to see people within 28 days. Recovery expected in Quarter 2.	• A new Service Line Lead has been appointed to give increased support and oversight to the service and review processes for booking.

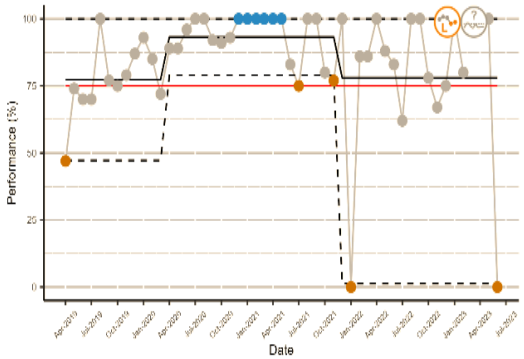
Older Adult Services

KPI	Chart	Narrative	Summary	Key Actions
EMDASS Diagnosis within 12 weeks		**Jun-2023** 59% **Variance Type** Special Cause Variation: Latest value above upper control limit (improvement) **Latest Target** 80% **Assurance** Consistently not meeting performance target	For a period over the winter 2021 COVID wave EMDASS staff were required to support inpatient units. This resulted in an increase in people waiting for diagnosis. Subsequently a sharp rise in referrals during June / July increased the waiting list. The waiting list continues to reduce, and the service is currently on track to meet its recovery trajectory in Quarter 3 2023/24.	• Recovery plan is in place that will reduce the waiting list to the optimum level in Quarter 3 2023/24 through additional weekend clinics and primary care diagnoses. • Weekly MD led meetings to monitor progress.

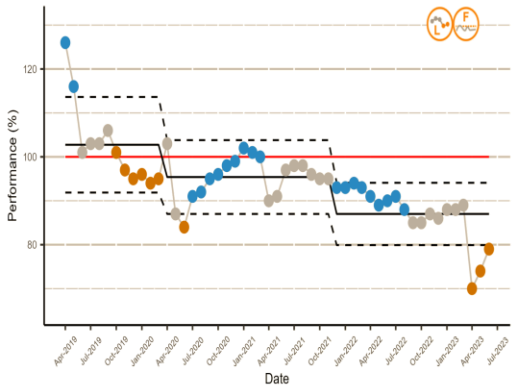
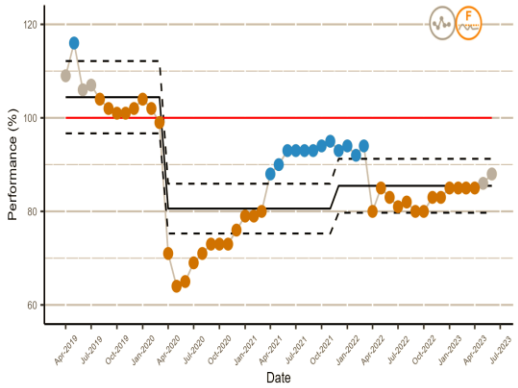
Children and Adolescent MH Services

KPI	Chart	Narrative	Summary	Key Actions
CAMHS referrals meeting assessment waiting time standards - CRISIS (4 hours)		**Jun-2023** 93% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance** Inconsistently meeting performance target	Performance against this indicator improved in the second half of 22/23 and has met target in four out of the last 6 months. Ability to meet the 4 hour wait has been dependent on the number and time of referrals made to the service. Recovery expected in Q2	• Additional twilight worker in place to cover busiest times and help meet demand within the 4-hour waiting standard
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS)		**Jun-2023** 84% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Inconsistently meeting performance target	An increase in demand, post-COVID, combined with capacity issues in our Single Point of Access (SPA) Service resulted in an increased number of children and young people waiting for an initial assessment. Referral numbers have now stabilised. We 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

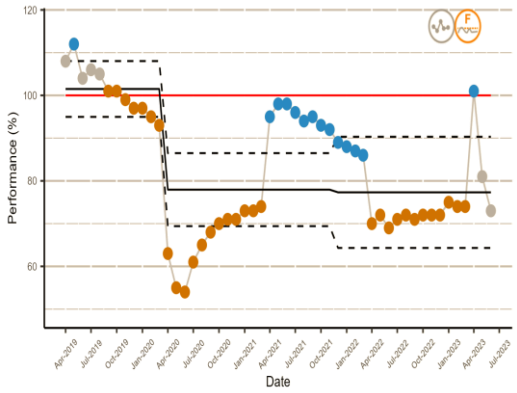
Children and Adolescent MH Services

KPI	Chart	Narrative	Summary	Key Actions
CAMHS referrals meeting assessment waiting time standards - URGENT (P1 - 7 DAYS)		**Jun-2023** 0% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) **Latest Target** 75% **Assurance** Inconsistently meeting performance target	One service user was seen on Day 8 due to lack of capacity in the East Team to see them within the 7-day target timeframe. Expected to recover in Q2.	• 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

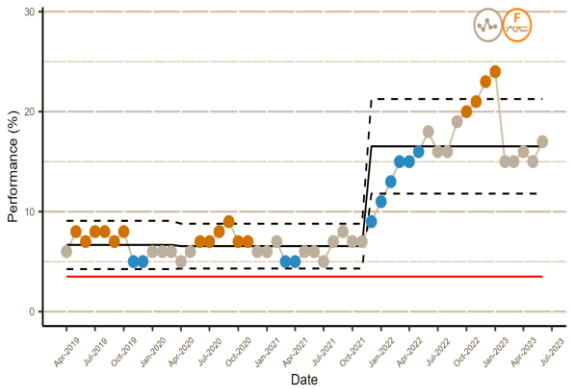
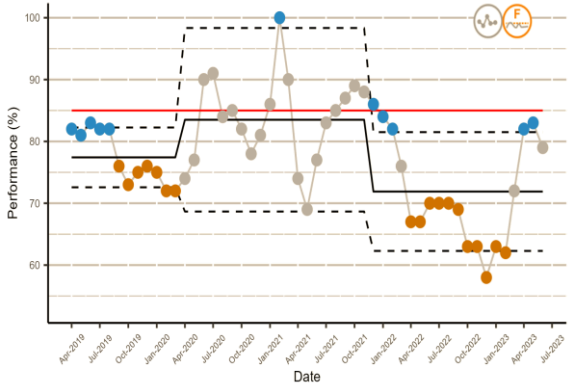
Talking Therapies (IAPT) Services

KPI	Chart	Narrative	Summary	Key Actions
Number of people entering IAPT treatment (ENCCG)		**Jun-2023** 79% **Variance Type** Special Cause Variation: Latest value below lower control limit (concern) **Latest Target** 100% **Assurance** Consistently not meeting performance target	Referrals into the Talking Therapies services remain below the volume needed to achieve access targets. We expect to be meeting our targets for all service by the end of Q3, 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.
Number of people entering IAPT treatment (HVCCG)		**Jun-2023** 88% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 100% **Assurance** Consistently not meeting performance target		

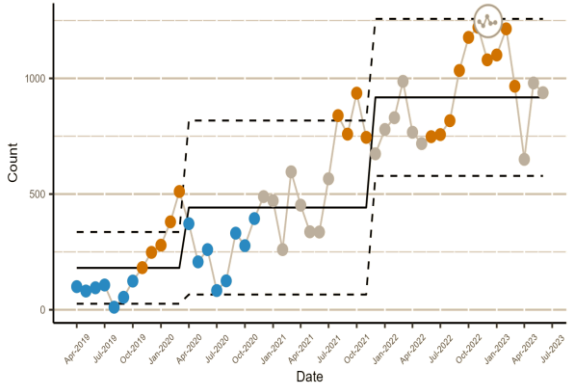
Talking Therapies (IAPT) Services

KPI	Chart	Narrative	Summary	Key Actions
Number of people entering IAPT treatment (Mid Essex)		**Jun-2023** 73% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 100% **Assurance** Consistently not meeting performance target		

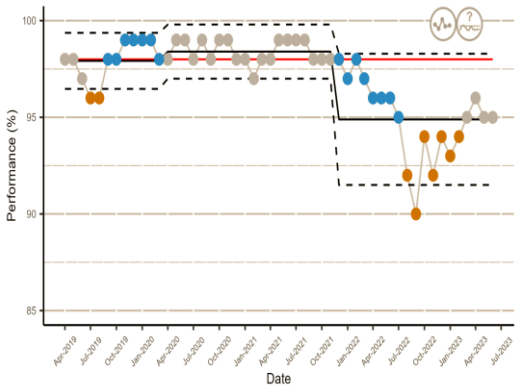
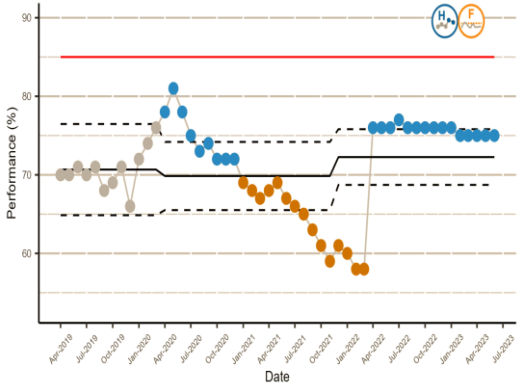
Inpatient Services

KPI	Chart	Narrative	Summary	Key Actions
Delayed transfers of care to the maintained at a minimal level		**Jun-2023** 17% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 3.5% **Assassurance** 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 being recruited, and ways of working developed • Wider system work, led at Executive level, to support placement of longer-term DToC • Analysis of reasons for different types of DToC and focussed action plan developed against key themes • Senior engagement / cover at DTC meetings
Rate of acute Inpatients reporting feeling safe		**Jun-2023** 79% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 85% **Assurance**	The number of people saying that they feel safe in our inpatient units had decreased due to high levels of acuity in our inpatient units. Following a detailed survey of reasons, we have developed ward level action plans to improve this. We have seen an improvement in Quarter 1, bringing us closer to target of 85%. The current method of securing feedback via the Having Your Say Forms will cease at the end of Q4 as	The actions from the feeling safe survey which was trialled in September 2022 have moved ahead with each SBU taking forward their own action plan. The survey is presently being repeated to understand how the experience has changed and whether actions taken are showing an improvement. Actions include: • Communication passports and calm-down boxes for staff to use with service users on Dove Ward • Peer listeners to work with our Medium Secure Units on post-incident support

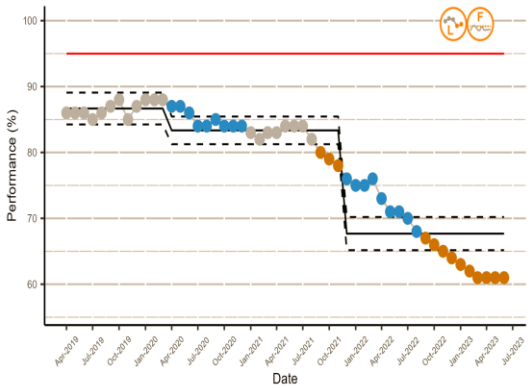
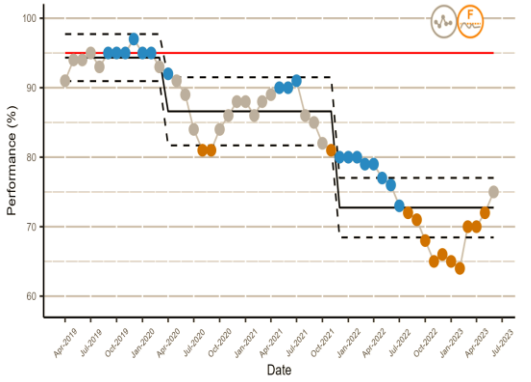
Inpatient Services

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target	we move to the new methods of feedback.	• 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.
Inappropriate out-of-area placements for adult mental health services		**Jun-2023** 938 **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 850 **Assurance** KPI is generally off target (at least four of the last six data points are off target)	Out of area placements (OAPs) have remained high, reflecting the national picture of increased demand and acuity within mental health services. The Trust also benchmarks at the lower end for number of inpatient beds per population (the equivalent of 50 beds below average) Expected to meet target by end of Q4	• COO sign-off for all out of area placements introduced from 19/6/23. • Increased visibility for all patients out of area. Out of area placements taking place twice weekly, including Community Team involvement. • Consultant-led bed management meetings 3 times per day, 5 days per week • Process controls in place to monitor, review, and balance demand and capacity. • Recruitment underway for dedicated staff to further improve access and flow and ensure sustainability across the year - Enhanced Discharge Team. • Implementing best practice from the national Getting It Right First-Time programme • Programme management plan and structures in place – recruitment for Programme Management support underway.

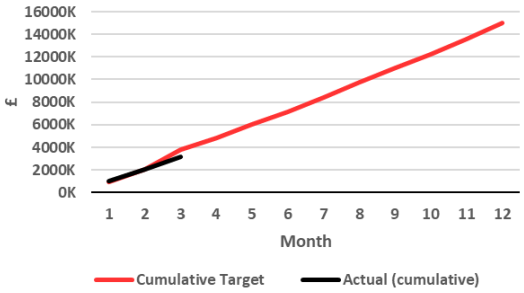
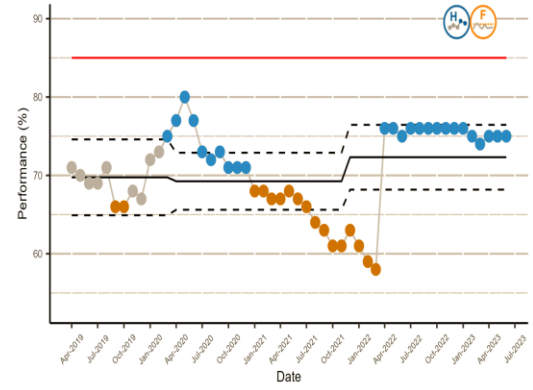
Trust-Wide Indicators

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		**Jun-2023** 95% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 98% **Assassurance** Inconsistently meeting performance target	Sustained high demand in our services is impacting on our 18-week wait to treatment times, particularly in hard to recruit areas. Recovery of waiting list in areas that are clearing long waiting lists have impacted on performance. Recovery expected by the end of Q4.	• Focused recovery work on access times that will result in overall improvement of our referral to treatment times. • 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)		**Jun-2023** 75% **Variance Type** Special Cause Variation: Latest 6 data points are above mean Two of three data points within upper zone A (improvement) **Latest Target** 85% **Assurance** Consistently not meeting performance target	Data quality campaign in previous quarters had limited success, increasing compliance temporarily. Recovery expected by the end of Q4.	• A long-term solution has been developed to provide an app for staff, that shows their caseload and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in July 2023. • Consulting with service users and carers on the possibility of one-off contact to ensure all demographic information is captured.

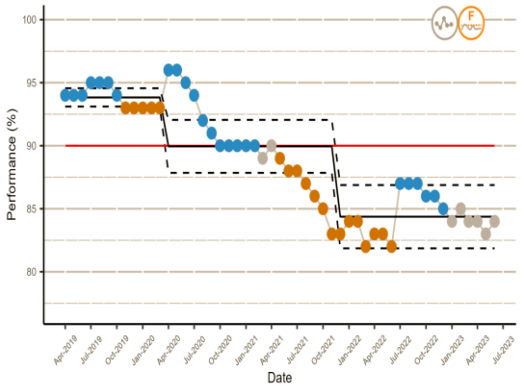
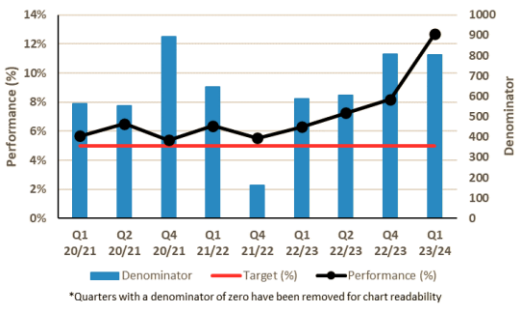
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Percentage of eligible service users with a completed PbR cluster review		**Jun-2023** 61% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean (concern) **Latest Target** 95% **Assurance** Consistently not meeting performance target	HONOS cluster reviews were introduced as part of the Payment by Results initiative. Performance declined over the Covid period and has not taken priority over access and safety indicators.	• Review of clinical outcome measures is underway as part of the Transformation Programme
The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months		**Jun-2023** 75% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance**	Service users with high complexity needs having an annual Care Plan Approach review declined from the start of the pandemic. As part of the trust business continuity planning (BCP) arrangements, this time we made changes to the risk assessment, contact approach and crisis planning. This allowed us to increase contact and provide more support to service users on CPA. This practice continued post-pandemic.	• We have improved our overall risk management and care planning to meet the challenge of rising complexity in cases on every clinical contact. • We are adapting our Care Plan Approach to take advantage of this and make the CPA process more streamlined. • Nationally, the system is moving away from CPA towards personalised care and support plans (PCSP).

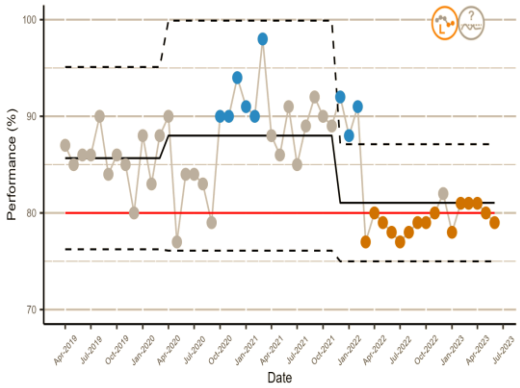
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target	Our Community Transformation programme is planning the transition from CPA to PCSP in Quarter 2 2023/24.	
Delivering Value achieved YTD		**Jun-2023** £3,194k YTD **Variance Type** SPC unapplicable to KPI **Latest Target** £3,761k **Assurance** N/A	£3,194k efficiencies delivered in June YTD against a plan of £3,761k. A majority of DV schemes are delivering as planned at the end of the first quarter. However, one significant scheme has not been delivered in month, as below: A rate rebate of £700k was planned for June but has not yet been confirmed.	• Seek to expedite rates rebate application. • Accelerate DV schemes as much as possible. • Identify and implement additional financial recovery actions to deliver additional value and reduce monthly expenditure run-rate deficit.
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment)		**Jun-2023** 75% **Variance Type** Special Cause Variation: Latest 6 data points are above mean (improvement) **Latest Target** 85% **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, that shows their caseload with non-compliant SU's records and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in July 2023. • Consulting with service users and carers on the possibility of one-off contact to ensure all demographic information is captured.

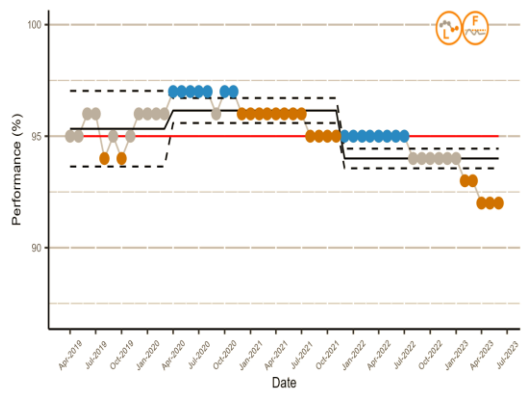
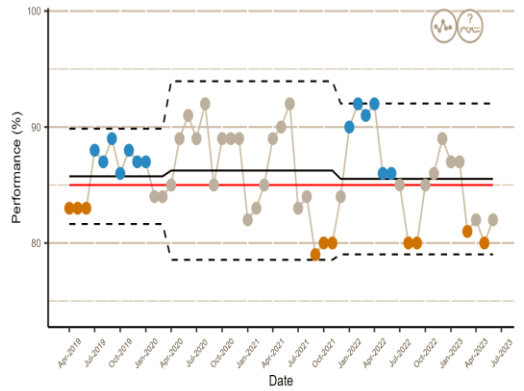
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target		
Data completeness against minimum dataset for Ethnicity (MHSDS)		**Jun-2023** 84% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 90% **Assassurance** 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 is being developed to provide an app for staff, that shows their caseload with non-compliant SU's records and enables them to update records without navigating in the EPR. The app is scheduled to go-Live in July 2023. • Consulting with service users and carers on the possibility of one-off contact to ensure all demographic information is captured.
Rate of staff experiencing physical violence from service users, carers, and members of the public		**2023 Q1** 13% **Variance Type** SPC unapplicable to KPI **Latest Target** 5% **Assurance**	From Q1 20/23 this measure includes 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. This may have caused some or all the increase that we have seen in Q1. Recovery expected by end of Q3 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

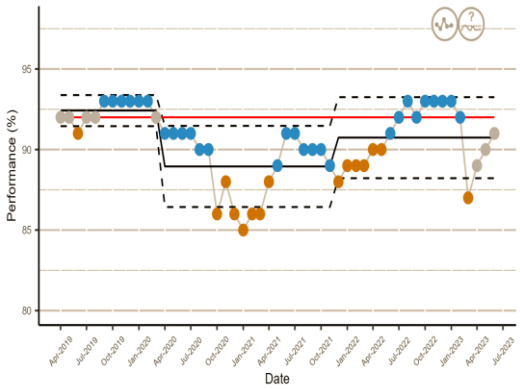
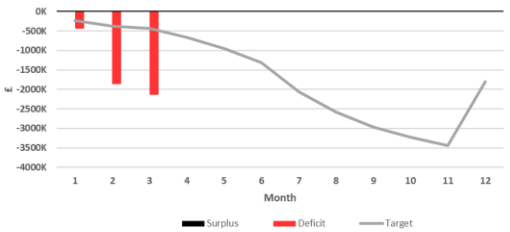
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		KPI is generally off target (at least four of the last six data points are off target)		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 • Body cameras working group is in place. CCTV is being rolled out to all wards.
Rate of service users that would recommend the Trust's services to friends and family if they needed them		**Jun-2023** 79% **Variance Type** Special Cause Variation: Latest 6 data points are below mean (concern) **Latest Target** 80% **Assurance** Inconsistently meeting performance target	Performance against this indicator has remained relatively stable in Q1 although the latest six points of data are marginally below the mean performance. Recovery expected in Q3.	• 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.

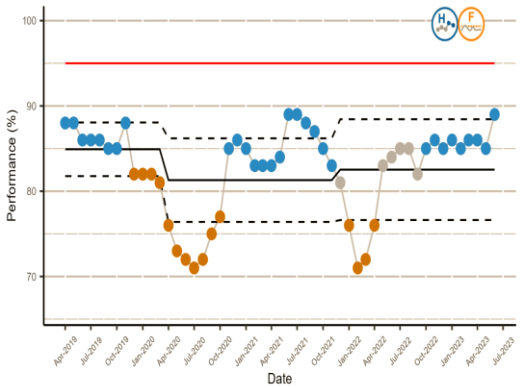
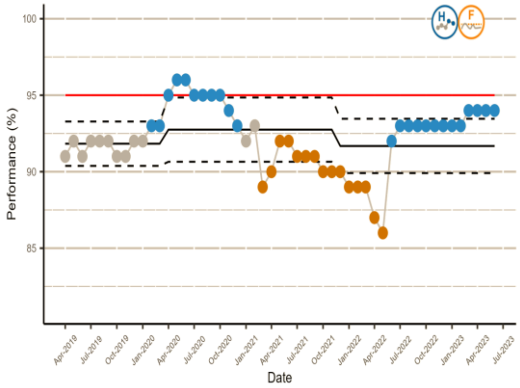
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Percentage of eligible service users with a PbR cluster		**Jun-2023** 92% **Variance Type** Special Cause Variation: Latest value below lower control limit (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		**Jun-2023** 82% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 85% **Assurance** Inconsistently meeting performance target	The completion rate for this indicator which is part of the Having Your Say Survey is comparatively low, with results fluctuating common cause variation. New methodology for gaining feedback will be introduced by end of Q4	• 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

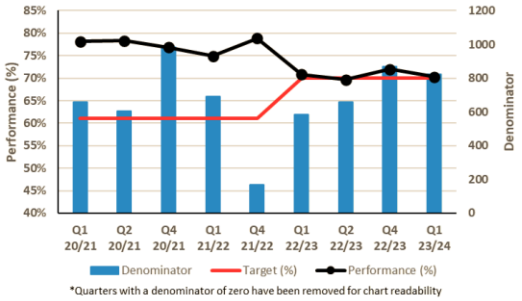
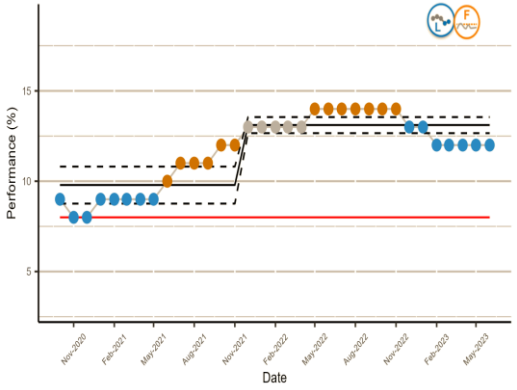
Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Mandatory Training		**Jun-2023** 91% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 92% **Assurance** Inconsistently meeting performance target	The previous Preventing Radicalisation training which clinical staff completed has expired. Nationally 2 new courses have come into place since the end of last year; • Preventing Radicalisation - Basic Awareness Training – all staff to complete • Preventing Radicalisation - WRAP Level 3 – clinical Staff to complete This has resulted in compliance falling to zero for Preventing Radicalisation training as all staff now need to complete this. Recovery expected in Q2.	• Key actions that have taken place so far is a communication going out Trust-wide by the Safeguarding Team who oversee preventing radicalisation training. This explained the courses which have been added to staff profiles and the time frame in which we need the training to be completed. • Monthly compliance reports are run and sent to all SB use including business partners, Modern matrons, service line leads, Team Managers etc showing a rag report of Rags records showing if they are either in or out of date with training. • Further communications are being sent out to ensure compliance in order to reach our target of 92% which may take until the end of Q2 to achieve.
Financial Position		**Jun-2023** £2,143k YTD deficit **Variance Type** SPC unapplicable to KPI **Latest Target** £436k **Assurance** N/A	The Trust continues to have a financial challenge linked to the additional use of staffing to manage risk and acuity in inpatient services in particular, but also in Crisis services for CYP and Adults. Out of Area Placements also contribute significantly towards the Trust's current overspend.	Please see actions for Out of Area Placements and Turnover

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
Rate of staff with a current PDP and appraisal		**Jun-2023** 89% **Variance Type** Special Cause Variation: Latest value above upper control limit Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance** Consistently not meeting performance target	Appraisal compliance improved slightly from 85% at the end of Q3 to 86% at the end of Q4. The SPC chart demonstrates that we have not met our target of 95% compliance historically, including pre-pandemic. However, the impact of launching the Appraisal App and potentially moving to an appraisal window will be monitored as it is expected to increase compliance significantly. Recovery expected by end of August 2023.	• New Appraisal App launched at the end of Q4 • Our new appraisal window launched at the end of Q4 and took effect from April 2023 • A further push on achieving compliance to coincide with the App and appraisal window launch and enhanced reporting • Monthly reporting to the Executive Team and People and OD Group
Rate of service users with a completed up to date risk assessment (inc LD&F and CAMHS from Apr 2015) Seen Only		**Jun-2023** 94% **Variance Type** Special Cause Variation: Latest value above upper control limit Latest 6 data points are above mean (improvement) **Latest Target** 95% **Assurance**	Pressures during COVID and increased caseloads, compounded by time consuming recording methods, resulted in people waiting longer for a review of their risk assessment. Performance improved with introduction of new recording method for risk and is now 1% below target level. 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 to ensure all new features are working as planned. Full rollout planned for July 2023 except for LD&F where discussion is underway. • Additional guidance for staff added to Paris to aid completion.

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target		
Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them		**2023 Q1** 69% **Variance Type** SPC unapplicable to KPI **Latest Target** 70% **Assurance** KPI is generally on target (at least four of the last six data points are on target)	Performance in Quarter 1 is marginally below target by 1% Recovery expected in Q2	• To monitor performance in next Pulse Survey, previous experience suggests that we are likely to be above target and we are seeing a common cause variation.
Turnover rate		**Jun-2023** 12% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean (improvement) **Latest Target** 8% **Assurance**	Our unplanned turnover has reduced to 11.7%. Our staff in post has increased by a further 36.2FTE this Quarter. Our unplanned turnover rate remains significantly above the target of 8% and the SPC chart indicates that historically we have not been able to meet this target since 2019. Our annual staff survey results show us to be the joint third best mental health trusts to work for in	• Launched new staff benefits and support. • Trained our newest cohort of Inclusion Ambassadors to help us realise our vision of ensuring that recruitment panels for all our management positions will have an Ambassador to help ensure fairness and equity • Finalising our Belonging and Inclusion Strategy based on staff feedback. • Launched our new Appraisal App and appraisal window to ensure all our staff receive an appraisal that helps to retain

Trust-Wide Indicators

KPI	Chart	Narrative	Summary	Key Actions
		Consistently not meeting performance target	the country. Our results also helped to reaffirm our top three areas of focus: improving self-care, reducing violence and aggression and making sure that everyone has a positive experience, regardless of who they are or where they work Recovery to 11% expected by November 2023.	them by ensuring they feel valued, supported and developed.

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 10b
Report Title	Annual Plan 2023/24 Quarter 1 Progress Report	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Simon Pattison, Deputy Director of Strategy and Development	
Approved by:	David Evans, Executive Director, Strategy and Partnerships	

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

Executive Summary

This report provides an overview of the progress during Quarter 1 of 2023/24 (Q1) against the Trust's Annual Plan. It also provides projected outcomes for the objectives at the end of the year.

This report was presented to Finance and Investment Committee (FIC) on 25th July and so there has been a considerable gap due to the timing of Board meetings. Although it is too early to give final results for Q2 there has been good progress in Q2 in many areas including:

- Experts by Experience have been involved in 5 innovation fund projects during this quarter.
- Electronic Prescribing and Medicines Administration (ePMA) has been rolled out to 13 of 27 inpatient units before the end of Q2 and so ePMA is now live in 48% of inpatient units.
- The Launch of our new Appraisal App has been completed. At the time of writing over 96% of staff had a completed appraisal recorded on the system
- The Virtual Mental Health Hospital Discharge service is up and running with the Home Group
- A business case has been developed for the Crisis Assessment Service
- Depression pathway: Q2 training target achieved and evaluation tool approved.

The Annual Plan report for Q2 of 2023/2024 will be presented to FIC on 26th October 2023 and to the Board on 2nd November.

Summary:

The Annual Plan is aligned to the Trust's seven 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.

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 1 2023/24

Quarter 1 2023-24 (Q1) was a challenging period for the Trust and the wider health and care system with continued demand and acuity pressures, together with extensive industrial action that has taken place. Despite these pressures the Trust delivered the majority of milestones for the quarter and is on track to meet the majority of outcomes for 2023-24.

At the end of Quarter 1:

- Six out of seven objectives achieved the quarterly milestones.
- Six out of seven objectives are forecast to meet the end of year outcomes.

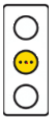
Six out of seven of all year-end outcomes are predicted to be on track to be delivered at the end of 2023-24 and recovery actions in place for the remaining outcomes that are not on track in Quarter 1.

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

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

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

Table 1 – Q1 and year end predicted achievement summary (Red: Below 59%, Amber 60-69%, Green 70+ %)

Ref	Objective	Q1 23/24		23/24 Year End Predicted Outcomes	
		Milestone Achievement	RAG Rating	Year End Prediction	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	9/10 (90%)		Green	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	8/13 (62%)		Green	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	12/13 (92%)		Green	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	11/12 (92%)		Amber	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	8/10 (80%)		Green	
SO6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	13/16 (81%)		Green	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	7/10 (70%)		Green	

The report summarises delivery against all Trust objectives.

Recommendations
Board are asked to receive the report and note progress against the Annual Plan during Quarter One

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.	✓

TRUST ANNUAL PLAN 2023-24

QUARTER 1 PROGRESS REPORT

1. Introduction

1.1. The Annual Plan is aligned to the Trust's seven 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 1 2023/24 (Q1) milestones for the Trust's annual plan and the overall predicted achievement of objectives in 2023/24.

2. Achievement against Quarter 1 Milestones

1.4. Quarter 1 2023-24 (Q1) 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.

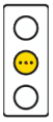
1.5. At the end of Q1:

- Six out of seven objectives achieved the quarterly milestones.
- Six out of seven objectives are forecast to meet the end of year outcomes.

1.6. During Quarter 1 the only objective that did not achieve most (70%+) of the key milestones as planned was Strategic Objective 2. This was amber rated with work taking longer than anticipated to address waits to treatment (follow up) in adult community mental health and LD services, challenging waiting lists in adult community mental health and work still required to finalise plans for the patient and carer race equality framework and carers transformation work.

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

Table 2 – Q1 Achievement against Milestones (Red: Below 59%, Amber 60-69%, Green 70+ %)

Ref	Objective	Q1 23/24	
		Milestone Achievement	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	9/10 (90%)	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	8/13 (62%)	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	12/13 (92%)	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	11/12 (92%)	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	8/10 (80%)	
SO6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	13/16 (81%)	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	7/10 (70%)	

3. 2023/24 Year End Achievement Against Objectives

2.1. Six out of seven 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 1.

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

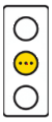
2.3. The impact of demand pressures and ongoing strikes, amongst other pressures, will again make 2023/24 a challenging year.

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

2.5. Strategic Objective 4 (Workforce) is projected to be Amber as we are below target on vacancy rates and turnover levels, which remain challenging on a national and local level.

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

Table 3 - 2023-24 Predicted End of year Achievement against Objectives (Red: Below 59%, Amber 60-69%, Green 70+ %)

Ref	Objective	23/24 Year End	
		Year End Prediction	RAG Rating
SO1	We will provide safe services, so that people feel safe and are protected from avoidable harm	Green	
SO2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	Green	
SO3	We will improve the health of our service users through the delivery of effective evidence-based practice	Green	
SO4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	Amber	
SO5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care	Green	
SO6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	Green	
SO7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	Green	

3. Conclusion

3.1. Overall good progress has been made during the quarter against the Quarter 1 milestones and towards year end outcomes. However, 2023-24 will be a challenging year and we will continue to review our plans to ensure we meet the challenges ahead.

4. Recommendations

4.1. The Board members are asked to receive the report and note performance against the Annual Plan in Q1.

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

<table>
<tr><th>Strategic Objective 1
Senior Responsible Officer JV</th><th>Q1 Key Actions / Milestones</th><th>Q1 Milestones Rating</th></tr>
<tr><td rowspan="3">We will provide safe services, so that people feel safe and are protected from avoidable harm

Key Priorities:
• Enhance & further embed our Safety culture
• Implement suicide prevention pathway
• Focus on ‘fundamentals of care’
• Adopt a Trauma Informed Approach
• Improve support for those with co-occurring addictions</td><td>• PSIRF (Patient Safety Incident Response Framework) readiness
• Violence and Aggression CQI group established and meeting monthly
• Suicide prevention pilot workshop & A&E (Accident and Emergency) mapping
• Fundamentals of Care (FoC) audits on inpatient units
• Clinical Response Guide review
• A new NEWS2 (National Early Warning Score) audit & commenced
• Trauma informed approach (TIA) roll out
• Trauma informated approach – site report and communications booklet
• Dual Diagnosis courses: Brief interventions training; Drug and alcohol awareness; Harm reduction training</td><td> 
(9/10)
Green</td></tr>
<tr><td>Commentary:</td><td></td></tr>
<tr><td>• PSIRF project Lead in post and project plan in place. 21 staff attended Level 1 training and 17 staff attended Level 2
• ePMA (electronic Prescribing and Medicines Administration) roll out to 8 of 27 inpatient areas.
• Monthly reports to Heads of Nursing on compliance and action plans for NEWS2
• Clinical Response Guide review completed – to be presented at Physical Health Committee Q2
• TIA started on 5 inpatient units (phase 2). Pilots in Enhanced Primary Mental Health & community services being developed; with TIA report & TIA Booklets in final stage development
• Dual diagnosis courses in place, designed with Change, Grow, Live; PARIS alert in place but not yet seen increase in numbers – focus area in Quarter 2</td><td></td></tr>
<tr><td>Summary:</td><td>Key Outcomes at Year End</td><td>Year End Outcomes Projection</td></tr>
<tr><td>There has been excellent progress during Q1 with the majority of milestones met. The majority of outcomes are already fully on track to be delivered by year end, with further work in Quarter 2 will focus on Violence and aggression noting that although we have seen a reduction in incidents resulting in severe harm, moderate harm remains relatively static.</td><td>• Achieve CQUIN target in relation to Restrictive Interventions (90% for both CYP and Adults)
• < service user to service user moderate-severe harm through violence & aggression (Target 1.1%)
• < service user to staff moderate-severe harm through violence & aggression (Target 0.51%)
• < anonymous Freedom to Speak Up referrals as a percentage of the total (Target <4.5%)
• Increased compliance with antimicrobial prescribing quality (Baseline 40%)
• >50% service users who present to A&E are screened for suicide risk
• Improvement in Fundamentals of Care audits across the year (Baseline Q1)
• 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
• Provide 40% of relevant staff with Dual Diagnosis training
• Increase in number of people with a Paris alert for dual diagnosis</td><td> 
Green</td></tr>
</table>

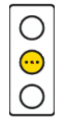
<table>
<tr><th>Strategic Objective 2
Senior Responsible Officer SB</th><th>Q1 Key Actions / Milestones</th><th>Q1 milestones Rating</th></tr>
<tr><td rowspan="2">We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience

Key Priorities:

• Address backlogs in care across services

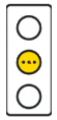
• Work with local communities to improve access & address inequalities

• Expand service user and carer involvement

• Strengthen our approach to improving Service User & Carer experience</td><td>• ADHD (Attention Deficit Hyperactivity Disorder) - new service launched and cases transitioning into Enhanced Primary Care service
• Recovery plan for EMDASS (Early Memory Diagnosis and Support Service)
• New MH service model for adults developed and roll out
• South Essex Learning Disability expansion business case finalised and submitted
• Waits for treatment (follow-up) across services – work continues into Quarter 2
• Underserved communities - Two community pilots mobilised in Watford and Stevenage
• High level scoping of co-production model for participation & engagement, with experts by experience (EBE) & carers.
• Peer support structure included in outline high level model of co-production
• Introduction of targeted surveys to replace Having your Say.
• PCREF (Patient Carer Race Equality Framework) - Self-assessment to be undertaken
• Equality Performance metrics for PCREF to be developed
• Questionnaires for EbEs has been developed and survey will commence within community transformation
• Carers Transformation and improvement work scoped and aligned with corporate and operational programme with central oversight</td><td> 
(8/13 = 62%)
Amber</td></tr>
<tr><td colspan="2">Commentary:
• ADHD - Volume of new referrals is more than double predicted level
• Waiting lists for EMDASS decreasing.
• Adult waiting lists remain challenging, with plans in place to address.
• Awaiting decision on ELDP business case from Essex County Council and Mid and South Essex Integrated Care Board
• Delivery of PCREF - Draft self-assessment to be presented to Exec Q2 setting out key actions
• Trust wide KPI dashboard in development to include equality analysis</td></tr>
<tr><th>Summary:</th><th>Key Outcomes at Year End</th><th>Year End Outcomes Projection</th></tr>
<tr><td>This Quarter has seen significant ‘set up’ activities to support improvements in experience and access to care. Increased demand for ADHD diagnosis has meant the backlog in CAMHS ADHD remains challenging, despite the new model now in place.</td><td>• 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%)
• PCREF (Patient Carer Race Equality Framework) in place and key actions delivered
• Dashboards in place to include equality analysis
• Service user/carer positive feedback on involvement within community transformation- questionnaires in development
• At least 98% of CQI projects have service users and carers involved
• Increase in the number of compliments received
• Reduction in the number of complaints received
• Service user Friends and Family Test Feedback (Target 85%)</td><td> 
Green</td></tr>
</table>

Strategic Objective 3 Senior Responsible Officer AZ	Q1 Key Actions / Milestones	Q1 Milestones Rating
We will improve the health of our service users through the delivery of effective evidence-based practice **Key Priorities:** • Provide a better **experience & environment for Autistic People** • Roll-out **evidence based pathways** to improve outcomes • Develop our approach to **7-day working** across services • Enhance **preventative physical health interventions** • Revitalise our **Recovery approach** across all services	• Consultation completed on Autism Strategy • Autism assessment pathway EPR changes complete. • Depression Pathway roll out and training • Personality Disorder summit with actions and leads identified. • Specialist Residential Services (SRS) Transition underway and on plan • Development of LD pathways • Evaluation of the Crisis House tenders and bidders being informed of the outcome • Enhanced Discharge Team (EDT) recruited ready for service commencement in Q2 • Standardise Physical health checks workshop • Collaborative physical and mental health education programme in partnership with HCT commenced • 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 in place	 (12/13 = 92%) Green
	Commentary:	
	• Autism Strategy approved at Executive Team in July – communications and plan being developed • Depression Pathway - Training has commenced. Data/infrastructure configuration in place. Comms rollout and plan completed. Evaluation framework being created. Digital library in development and evaluation on track for Q3 • Physical Health checks standardisation workshop to take place in Q2. • Bitesize face to face autism training delivered across Adult Acute Services excluding Thumbswood • Autism referrals before Jan 22 offered an appointment. Testing of new assessment pathway in Q2 • EDT / virtual MH hospital discharge – on track for pilot evaluated and longer term model developed by end Q4	
Summary:	**Key Outcomes at Year End**	**Year End Outcomes Projection**
Positive progress during Quarter 1 with new pathways and training developed. Acute pathway a key focus for Quarter 2; including 7 day working.	• Provide at least 40% of staff with basic autism training • Increase number of people on the new autism assessment pathway • Depression pathway – training programme in place and evaluation undertaken • 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 • 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 • Increase staff and service users trained in Shared Decision Making	 Green

<table>
<tr><th>Strategic Objective 4
Senior Responsible Officer JH</th><th>Q1 Key Actions / Milestones</th><th>Q1 Milestones Rating</th></tr>
<tr><td rowspan="2">We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment

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</td><td>• Belonging & Inclusion strategy engagement concluded, inlcuding approach to zero tolerance to discrimination
• Compassionate and caring teams & leadership development programme - initial design stage of programme
• Health and wellbeing support offer reviewed in Quarter 1
• New role of Leadership and Talent Academy Lead recruited to
• Appraisal App launched 1st April 2023
• ‘New roles’ group established with clear terms of reference
• Reasonable adjustments panel in place and policy ratified and launched.
• In-house ILM Level 5 coaching and mentoring programme for 14 staff underway
• Leadership and Talent Academy Lead recruited & leadership offers being developed
• Approach to Collective leadership developed
• CQI Onboarding Group established and management guidance developed
• WRES and WDES review undertaken and action plan in place</td><td> 
(11/12 = 92%)
Green</td></tr>
<tr><td colspan="2">Commentary:
• Inclusion and Belonging Strategy on track to be launched September 2023
• Health & wellbeing support offer - funding is being identified to take this forward. Core offer of menopause awareness, Schwartz rounds and mental health first aiders continue to be delivered and Employee Assistance Programme contract was renewed in Q1.
• Appraisal rates are currently just below target but with the new staff appraisal window closing on 31st July we anticipate an uplift for Q2.
• Appraisal App guidance, flowchart and pre-recorded Master Class promoted and available. Development of a collective leadership culture will be supported by Leadership and Talent Academy Lead who started in May 2023
• WRES and WDES review to be undertaken in Quarter 2</td></tr>
<tr><th>Summary:</th><th>Key Outcomes at Year End</th><th>Year End Outcomes Projection</th></tr>
<tr><td>Quarter 1 saw a good progress against the milestones identified; turnover and vacancy rates remain a key issue for the trust and at this stage of the year are slightly behind target – with actions to address during the remainder of the year</td><td>• Unplanned turnover will be 11% or less: Actual for Q1 11.7%
• Vacancy rates will be 11% or less: Actual for Q1 12.2%
• Appraisal compliance rates will be 90% or above
• 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</td><td> 
Amber</td></tr>
</table>

<table>
<tr><th>Strategic Objective 5
Senior Responsible Officer HA</th><th>Q1 Key Actions / Milestones</th><th>Q1 Milestones Rating</th></tr>
<tr><td rowspan="3">We will improve, innovate and transform our services to provide the most effective, productive and high-quality care

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</td><td>• Existing transformation portfolio reviewed by the Transformation Board
• Deployment of PARIS mobile to community services - Infrastructure development completed for pilot services.
• Developing new capabilities for Computer Systems Access
• Digital Library - Procurement completed
• Sustainability steering group in place.
• Monthly financial performance meetings with SBU’s introduced
• Initial planning model for 2024/25 established to support development of long term financial plan
• Capital plan delivery on track
• Education and training programme on research in place
• HPFT Research & Development external website updated</td><td> 
(8/10 = 80%)
Green</td></tr>
<tr><td colspan="2">Commentary:</td></tr>
<tr><td colspan="2">• Sustainability - Scope of works regarding sustainability projects for 23/24 include: Heat Decarbonisation Plan, Electric Vehicle Charging Points, LED Lighting, Solar PV Panels, Building Management Systems (BMS) Reduce use of gas and electricity
• Consent to be contacted in relation to research received from 1,600 service users (Target already achieved for year) 3 short videos have been developed for specific research studies
• Honorary contract issued to distinguished researcher and psychiatrist as a research fellow within HPFT.
• NIHR (National Institute for Health Research) RfPB grant application submitted "Is there a misuse/abuse potential of novel antidiabetics as image-enhancing drugs?” Second bid will be submitted in Q2.</td></tr>
<tr><td>Summary:</td><td>Key Outcomes at Year End</td><td>Year End Outcomes Projection</td></tr>
<tr><td>On track to deliver plan fully.

Significant progress made around Research and Development
Further digital developments implemented</td><td>• 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</td><td> 
Green</td></tr>
</table>

<table>
<tr><th>Strategic Objective 6
Senior Responsible Officer(s)
SB/ DE</th><th>Q1 Key Actions / Milestones</th><th>Q1 Milestones Rating</th></tr>
<tr><td rowspan="2">We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners

Key Priorities:

• Implement a new adult community model of care
• Expand adult crisis support and pathways
• Develop Community LD and crisis pathway
• Implement an enhanced service for older people, including dementia diagnosis
• Transform Children & Young People's Mental Health</td><td>• First draft of evaluation of Low Intensity Treatment Team and St Albans Community team completed
• Transition from adult to older adult services - Rockwood frailty scale used to inform decisions
• Connected Lives for carers project commenced
• Enhanced Discharge Team recruitment commenced
• Home Group Virtual MH Hospital Discharge service mobilisation ready for July start
• Mental Health Crisis Assessment Service preliminary business case developed
• Mental Health Liaison Team (MHLT) supporting Acute Assessment Unit (AAU) beds at Lister
• Expanded Offending Behaviour Intervention Service (OBIS) team in place
• Group established to evaluate & develop future LD Assessment and Treatment Pathways and model
• Evaluation of Essex LD partnership – Easy read version of survey shared with familes and service users
• Recovery plan for EMDASS is on track, with plans in place to review the current pre-diagnostic offer
• Review of community and crisis model of older people's services
• LD social care integration with Herts Adult Social Care and internal review of community LD
• Mobilisation plan agreed for CYP ARRS roles and Trauma Informed Approach embedded in Targeted Team
• Quality Network for Inpatient CAMHS inspection conducted at Forest House and building work completed
• Transition Navigator roles - Job Descriptions are being developed with commissioners.</td><td> 

(13/16 = 81%)
Green</td></tr>
<tr><td colspan="2">Commentary:

• Review of community and crisis model of older people's services deferred to Q2
• LD social care integration with Herts Adult Social Care and internal review of community LD deferred to Q2
• Forensic – development of business case to provide complete community forensic service offer underway
• South Essex LD Business case, working with Mid & South Essex ICB to agree engagement.
• New Model support for children and young people in primary care agreed with CYP ARRS roles
• Review underway of countywide dementia diagnosis model</td></tr>
<tr><th>Summary:</th><th>Key Outcomes at Year End</th><th>Year End Outcomes Projection</th></tr>
<tr><td>Progress made on schemes to reduce out of area beds such as Enhanced Discharge Team and Virtual Mental Health Hospital model.

End of year access and out of area targets remain challenging with improvement plans in place.</td><td>• Increase of 25% in service users on community rehab pathways
• Individual Placement Support Long Term Plan priorities met: 689 people seen by year end
• Early Intervention Psychosis Long Term Plan priorities met: 60% of people seen within 2 weeks
• Improve quality of Connected Lives assessments - (Baseline 43% audit)
• Reduce inappropriate out of area placements – 972 by year end
• 20% reduction in delayed transfer of care (baseline 57 – 45 by year end)
• 95% LD physical health checks completed
• Improve measurement of LD outcomes (HCR20 – 90% (baseline 83%) – Actual Q1 89%
• Improve measurement of LD outcomes as measured by LD Honos 95% (baseline 85%) Actual Q1 93%
• Achieve 12 week maximum wait for EMDASS
• Successful implementation and evaluation of county wide memory diagnosis model
• CAMHS 28 day wait time is ≥95% sustainably achieved
• Increase in number of CYP accessing support</td><td> 

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

<table>
<tr><th>Strategic Objective 7
(Senior Responsible Officer DE)</th><th>Q1 Key Actions / Milestones</th><th>Q1 Milestones Rating</th></tr>
<tr><td rowspan="2">We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

Key Priorities:

• 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

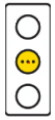
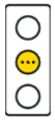
• Develop and deliver with the East of England Collaborative</td><td>• Dual diagnosis support offer to be developed in conjunction Herts County Council and HWE ICB
• Co-production of a system All-Age Autism Strategy group commenced.
• Herts-wide CYP Neurodiversity Steering Group established and operating
• System governance of MH and LD in Hertfordshire developed and in place
• Stakeholder Management approach and plan developed and agreed.
• Developed Mapping tool to ascertain “as is” position for relationships across ICB’s
• Relationship developed and maintained with ICB and partners in Norfolk
• Undertaken assessment of secure LD bed requirements across East of England and developed initial proposal for presentation to East of England Provider Collaborative Clinical Design and Delivery Group
• Meetings held between CAMHS Clinical Lead and East of England Provider Collaborative Head of Transformation to support transformation and delivery across the region
• Finalise the Trust Strategy ready for Launch in Q2, including stakeholder feedback and review</td><td> 

(7/10 = 70%)
Green</td></tr>
<tr><td colspan="2">Commentary:

• Agreed pilot between CGL & HPFT to place substance misuse workers into HPFT community teams – commencing September 2023
• MHLDA HCP continues to develop with a clear programme of work in place. The ICB is reviewing governance of all HCPs; and this is a key focus during Q2.
• National profile - HPFT’s Pharmacists presented at annual clinical pharmacy congress, HPFT Consultant Psychiatrist named Researcher of the Year in the University of Herts Vice-Chancellor's Awards 2023 and paper by Neurodevelopmental research stream lead for the Trust published by Cambridge University Press and the Royal College of Psychiatrists
• Plans under development to improve a structured relationship management approach across different Trust geographies
• Proposals around changes to LD secure provision to be considered by region in Q2</td></tr>
<tr><th>Summary:</th><th>Key Outcomes at Year End</th><th>Year End Outcomes Projection</th></tr>
<tr><td>Continued strong relationships in place with partners across ICB geographies and East of England Provider Collaborative. ICBs continue to develop and a key focus in Quarter 2 will be the development of MHLDA services and partnerships.</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 on development of the strategy
• HPFT positive impact showcased nationally
• Structured relationship management approach across the different geographies
• Positive feedback from stakeholders at year end
• 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</td><td> 

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

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

	Objective	Predicted			EOY	Year End Outcomes Commentary
		Q1	Q2	Q3	Q4	
1	We will provide safe services, so that people feel safe and are protected from avoidable harm					There has been excellent progress during Q1 with the majority of milestones met. The majority of outcomes are already fully on track to be delivered by year end, with further work in Quarter 2 will focus on Violence and aggression noting that although we have seen a reduction in incidents resulting in severe harm, moderate harm remains relatively static.
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience					This Quarter has seen significant 'set up' activities to support improvements in experience and access to care. Increased demand for ADHD diagnosis has meant the backlog in CAMHS ADHD remains challenging, despite the new model now in place.
3	We will improve the health of service users through the delivery of effective evidence-based practice					Positive progress during Quarter 1 with new pathways and training developed. Acute pathway a key focus for Quarter 2; including 7 day working.
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment					Quarter 1 saw a good progress against the milestones identified; turnover and vacancy rates remain a key issue for the trust and at this stage of the year are slightly behind target – with actions to address during the remainder of the year
5	We will improve, innovate and transform our services to provide the most effective, productive and high-quality care					On track to deliver plan fully. Significant progress made around Research and Development Further digital developments implemented
6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with partners					Progress made on schemes to reduce out of area beds such as Enhanced Discharge Team and Virtual Mental Health Hospital model. End of year access and out of area targets remain challenging with improvement plans in place.
7	We will shape and influence the future development & delivery of health and social care to achieve better outcomes for our population(s)					Continued strong relationships in place with partners across ICB geographies and East of England Provider Collaborative. ICBs continue to develop and a key focus in Quarter 2 will be the development of MHLDA services and partnerships.

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 11
Subject:	Month 5 Finance Report	**For Publication:** Yes
Author:	Philip Cave, Chief Finance Officer	**Approved by:** Philip Cave, Chief Finance Officer
Presented by:	Philip Cave, Chief Finance Officer	

Purpose of the report:

To formally receive and discuss the finance report for month 5.

Action required:

To note and discuss the report.

Summary and recommendations

The financial plan for the year outlines a projected deficit of £1.8 million, including a £15 million target for delivering value. However, due to various challenges, the Trust is facing a deficit of £2.9 million at the end of M5, which is £1.9 million worse than planned. The key drivers of this financial position are overspending on secondary commissioned beds and agency expenses above the plan.

To address the unsatisfactory financial position, the executive team has implemented enhanced financial controls, including agency/vacancy controls, reduced sign-off limits, and improved financial scrutiny and governance.

The Trust maintains a year-end deficit plan of £1.8 million but acknowledges the possibility this could increase to £6.4m. To mitigate the financial challenges, the Trust needs to focus on specific areas, such as reducing secondary commissioned beds and controlling temporary staffing.

Agency usage has significantly reduced since March 2023, but RN agency use is still high, primarily to cover vacancies, while HCSWs mainly use agency services for observations.

Secondary Commissioning remains a major source of overspending, particularly in Acute placements, however there has been a significant reduction during August and into September which will ease the financial pressures.

Regarding savings, the Trust's Delivering Value (DV) plan aims to achieve £15 million, comprising £10 million of cash-releasing efficiencies and £5 million of non-cash releasing productivity benefits. The Trust has a plan in the first five months to deliver £6m of benefits and is currently £0.4m behind this due to a timing issue on the rates rebate and under delivery of privately commissioned bed savings.

The Trust's gross capital spending is slightly behind plan due to project delays, and it has a planned allocation for a Crisis assessment centre with unallocated funds.

Recommendations

1. 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.

2. 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.

3. Income Maximisation: Pursue contract finalisations and billing of all due recharges to maximize income, particularly in CAMHS ADHD, Paediatric MH Liaison, and Education & training income areas.

4. Savings Execution: Strengthen efforts to achieve savings under the DV 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.

5. Focus on Capital Spending: Expedite the implementation of capital projects to ensure timely spending and alignment with the planned budget.

6. Contingency for Harper Lane Disposal: Monitor the situation regarding the planned disposal of Harper Lane closely and be prepared to adjust the rest of the capital spending program to accommodate potential changes.

7. Address OOA Bed Utilisation: Continuously work on reducing the usage of Out-of-Area (OOA) beds to planned levels to mitigate the financial burden.

8. Proactive Drug Spend Management: Monitor drug spend closely and explore opportunities to reduce expenses, particularly as the year progresses and patents on expensive drugs lapse.

9. 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.

By diligently implementing these recommendations and closely monitoring financial performance throughout the year, the Trust can work towards achieving its financial targets and mitigating any potential risks effectively.

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

Delivery of £1.8m deficit is key strategic goal

Summary of Financial, IT, Staffing & Legal Implications:

Delivery of £1.8m deficit is key strategic goal

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

Reviewed- no impact

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

Reviewed- no impact

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

Exec 21st September 2023

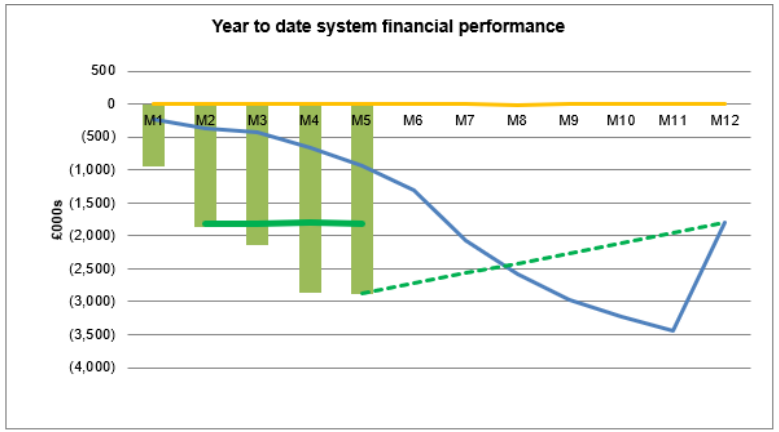
August (M5) Financial Report 2023/24

5 October 2023

Agenda

Executive Summary

	In Month				Year to Date			
Financial Position to 31st August £000	**Budget**	**Plan**	**Actuals**	**Variance to Budget**	**Budget**	**Plan**	**Actual**	**Variance to Budget**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Income	28,026	28,047	29,672	1,646	140,132	140,234	145,163	5,031
Income - Provider Collaborative	4,017	4,017	4,254	237	20,086	20,085	21,017	930
Pay	18,899	18,744	20,019	(1,120)	94,904	93,720	99,016	(4,112)
Secondary Commissioning	4,155	4,158	4,399	(244)	19,975	20,344	21,993	(2,018)
Provider Collaborative	4,017	4,017	4,254	(237)	20,086	20,085	21,017	(930)
Other Operating Expenditure	4,973	5,130	5,102	(128)	24,817	25,650	26,158	(1,341)
Non Operating Expenses	276	293	174	102	1,380	1,465	905	475
Surplus / (Deficit)	**(278)**	**(278)**	**(22)**	**256**	**(945)**	**(945)**	**(2,909)**	**(1,964)**



- 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 monthly position includes £0.6m of the £1.8m due in month 12.
- At the end of M5 the Trust has a **deficit of £2.9m,** which is £1.9m worse than plan. The key drivers for the financial position are: an overspend of **£1.8m** 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. **Key action** is for the Trust to reduce secondary commissioned beds and control temporary staffing. There has been positive impact on OOA beds on plan.
- 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 £6.4m 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	3.0	MH Crisis Assessment Centre Business Case/ OOA Action Plan
Provider Collaborative income	0.4	1.8	Negotiations with Commissioners
MH Patients in Acute Setting	0.6	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	0.1	0.2	Reviewed by NHS E
CHC Inflation	0	0.2	Negotiations with Commissioners
Interest receivable	(0.6)	(1.3)	Benefit of higher interest rates
Total	**3.0**	**6.6**	
Mitigating Actions			
Winter Pressures funding		TBC	Maximise share of £200m
Reduction in observations		(0.2)	Maximise 2023/24 phased impact
		6.4	

Income

Block Contract Income	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Contract #1 Hertfordshire IHCCT	20,944	21,557	613	104,720	107,781	3,062
Contract #2 East of England	629	637	8	3,144	3,192	48
Contract #3 Essex LD	1,535	1,600	66	7,673	7,769	96
Contract #4 Norfolk (Astley Court)	291	282	(9)	1,453	1,336	(117)
Contract #5 IAPT Essex	513	534	21	2,564	2,544	(19)
Contract #6 Bucks Chiltern CCG	374	415	41	1,868	1,820	(48)
Contract #7 - PC Specialised Commissioning	1,673	1,690	16	8,367	8,430	62
Total Block Income	**25,958**	**26,714**	**757**	**129,789**	**132,872**	**3,083**

Other Income	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Partnerships providing mandatory svcs (inc S3	182	274	92	908	1,654	746
Other - Cost & Volume Contract revenue	327	352	25	1,633	1,757	124
Education and training revenue	689	783	94	3,446	3,722	276
Misc. other Operating Revenue	448	1,183	736	2,241	3,182	942
Other clinical income from mandatory services	371	323	(49)	1,857	1,635	(222)
Research and development revenue	52	43	(9)	258	341	83
Grand Total	**2,068**	**2,958**	**890**	**10,343**	**12,292**	**1,948**

Commissioning Income	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Provider colloborative	4,017	4,254	237	20,086	21,017	930
Grand Total	**4,017**	**4,254**	**237**	**20,086**	**21,017**	**930**

Total income	**32,043**	**33,927**	**1,883**	**160,218**	**166,180**	**5,962**

- Block contracts are broadly in line with plan with increases above plan relating to the application of the pay award **(£2.4m).** 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 PC 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 £1,948k. The primary areas of additional income above plan are; CAMHS ADHD (£301k YTD matched with costs), Adult Primary Care (£99k YTD matched with costs), Patient Flow hub (£95k YTD matched to costs), Education & training income (£179k) related to trainee post salary support.
- An additional £600k was accounted for in month 5 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. The Trust is actively engaging in this process to seek additional funding against increased costs in both Adult Forensic and CAMHS Inpatient services and also in additional services within CAMHS for Children Looked after input.

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 He	1,073	781	292	(4,590)	(3,553)	1,037	(22,949)	(18,060)	4,889	(57,803)
Allied Health Professionals	210	165	46	(840)	(727)	113	(4,204)	(3,646)	559	(10,528)
Other Scientific, Therapeutic and Tech	836	690	146	(3,556)	(3,291)	265	(17,766)	(16,456)	1,310	(44,641)
Support to nursing Staff	943	794	149	(2,740)	(2,370)	370	(13,670)	(11,657)	2,013	(33,093)
Support to Allied Health Professionals	84	76	8	(205)	(213)	(7)	(1,027)	(1,037)	(10)	(3,759)
Support to other clinical staff	73	66	7	(185)	(174)	11	(927)	(908)	18	(2,325)
Medical and Dental	214	185	28	(1,894)	(2,256)	(361)	(9,463)	(10,808)	(1,345)	(23,740)
NHS Infrastructure Support	965	878	87	(3,709)	(3,554)	155	(18,566)	(17,962)	604	(46,514)
Other Pay	0	0	0	(466)	(191)	274	(2,619)	(776)	1,844	(252)
Permanent Staff Total	**4,397**	**3,635**	**762**	**(18,186)**	**(16,330)**	**1,856**	**(91,191)**	**(81,309)**	**9,882**	**(222,656)**
Bank										
Registered Nursing, Midwifery and Healt	36	120	(83)	(156)	(638)	(483)	(812)	(3,215)	(2,404)	(2,431)
Allied Health Professionals	0	7	(7)	(1)	(26)	(26)	(4)	(105)	(102)	(9)
Other Scientific, Therapeutic and Technic	0	19	(19)		(104)	(104)		(534)	(534)	
Support to nursing Staff	149	443	(293)	(445)	(1,520)	(1,075)	(2,335)	(6,797)	(4,462)	(5,702)
Medical and Dental	4	11	(7)	(39)	(200)	(161)	(197)	(978)	(782)	(493)
NHS Infrastructure Support	15	65	(51)	(36)	(221)	(185)	(180)	(1,088)	(907)	(452)
Other Pay	10	0	10	(37)	(1)	36	(185)	(1)	184	(20)
Bank Total	**214**	**664**	**(450)**	**(713)**	**(2,710)**	**(1,997)**	**(3,713)**	**(12,719)**	**(9,006)**	**(9,106)**
Agency										
Registered Nursing, Midwifery and Health visiting sta		83	(83)		(555)	(555)		(2,752)	(2,752)	
Other Scientific, Therapeutic and Technical Staff		6	(6)		(72)	(72)		(248)	(248)	
Support to nursing Staff		50	(50)		(165)	(165)		(1,179)	(1,179)	
Medical and Dental		8	(8)		(110)	(110)		(474)	(474)	
NHS Infrastructure Support		1	(1)		(71)	(71)		(291)	(291)	
Other Pay		0	0		(5)	(5)		(44)	(44)	
Agency Total	**0**	**147**	**(147)**	**0**	**(979)**	**(979)**	**0**	**(4,988)**	**(4,988)**	**0**
Total	**4,611**	**4,446**	**165**	**(18,899)**	**(20,019)**	**(1,120)**	**(94,904)**	**(99,016)**	**(4,112)**	**(231,763)**

- Employee expenses performance is adverse to plan in August by £1.12m and by £4.11m YTD. This includes the impact of the additional pay award above base plan backdated to April 23 in June and YTD. Of this £4.11m, circa £2.4m is matched with additional income to fund that pay award. There remains £0.1m unfunded pay award which has been flagged with the ICB.
- Expenditure on staffing in August increased by £395k compared to expenditure in July. The primary drivers of this increase are an increase in acuity in Adult inpatient wards resulting in increased bank shifts (£180k), positive recruitment across Perinatal and PATH teams (£80k) and the new rotation of Medical Trainees joining the workforce (£120k). Agency spend rose by £35k 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	987	998	11	375	535	(159)	1,877	2,197	(319)	4,506
Cambridge Tool - Health	1,240	1,389	149	23	104	(81)	115	320	(205)	276
Specialist Hospital	124	124	0	89	93	(4)	443	433	11	1,063
PICU	65	64	(1)	176	58	119	614	498	115	1,596
Acute	1,923	1,653	(270)	965	964	1	4,499	5,696	(1,197)	12,452
MHSOP - Organic	1,394	1,271	(123)	365	338	27	1,825	1,891	(66)	4,380
										0
Grand Total	**5,733**	**5,499**	**(234)**	**1,993**	**2,092**	**(99)**	**9,373**	**11,035**	**(1,661)**	**24,273**
Observations										
Health Placement Observations				90	116	(27)	448	391	58	1,076
PICU Observations				81	(91)	172	283	287	(4)	735
Acute Observations				223	330	(108)	1,039	1,028	12	2,877
Grand Total				**394**	**356**	**38**	**1,770**	**1,705**	**66**	**4,688**
Social Care										
Personal Budgets	0	0	0	296	328	(31)	1,474	1,627	(153)	3,532
Residential Placements	4,340	4,340	0	609	784	(175)	3,045	3,425	(380)	7,307
Nursing Placements	1,023	1,023	0	200	185	15	1,001	917	83	2,402
Social Care other	0	0	0		5	(5)		23	(23)	
Social Care Supported Living placements	7,471	7,531	60	671	652	19	3,354	3,272	82	8,050
FNC Income	0	0	0	(8)	(2)	(6)	(42)	(10)	(31)	(100)
Grand Total	**12,834**	**12,894**	**60**	**1,768**	**1,951**	**(183)**	**8,832**	**9,254**	**(422)**	**21,191**
Grand Total				**4,155**	**4,399**	**(244)**	**19,975**	**21,993**	**(2,018)**	**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 (£1,197k).
- There has been a large decrease in the number of Acute bed days in August, however there have been increases in the number of observations related to the remaining Acute placements. Increases in the cost of rehab beds relates to a backdated agreement for inflationary uplift above the level previously estimated (£130k in month). This will create an ongoing cost pressure that will need to be offset by a reduction in bed usage.
- The £244k overspend in month against plan and £2,051k 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	53	(21)	162	258	(96)	389
Drugs	304	314	(10)	1,518	1,672	(154)	3,643
Other Contracted Services	725	676	49	3,534	3,356	178	8,607
Consultancy expense	1	39	(38)	5	118	(113)	12
Education and training expense	91	134	(43)	455	738	(282)	1,093
Hard & Soft FM Contract	777	812	(35)	3,883	4,341	(458)	9,319
Additional Hard FM	117	179	(63)	584	1,098	(515)	1,401
Information & Communication Technology - Contracts	434	382	51	2,168	1,878	290	5,203
Information & Communication Technology	180	238	(58)	902	989	(87)	2,184
Misc. other Operating expenses	352	240	112	1,761	1,282	480	4,266
Non-clinical supplies	68	100	(32)	340	456	(116)	817
Other Contracts	252	273	(21)	1,261	1,612	(351)	3,027
Site Costs	412	442	(30)	2,061	2,383	(321)	4,950
Travel, Subsistence & other Transport Services	324	356	(32)	1,660	1,689	(29)	3,937
CNST/LTPS/PES	102	102	0	511	511	0	1,226
Depreciation and Amortisation - owned assets	561	543	18	2,805	2,684	121	6,733
Depreciation and Amortisation - assets held under finance leases	241	219	22	1,205	1,094	111	2,893
Total Other Operating Expenditure	**4,973**	**5,102**	**(128)**	**24,817**	**26,158**	**(1,341)**	**59,700**
Interest Expense on Non-commercial borrowings	19	18	0	93	91	1	222
Interest Income	(115)	(221)	106	(576)	(1,068)	491	(1,383)
Interest Expense on Finance leases (non-PFI)	16	12	4	78	60	18	186
PDC dividend expense	352	352	(1)	1,758	1,761	(4)	4,218
Other Finance Costs	6	6	(0)	28	28	(0)	67
Depreciation Peppercorn	-	6	(6)	-	32	(32)	-
Total Non Operating Expenditure	**276**	**174**	**102**	**1,379**	**905**	**474**	**3,310**
Total Non Pay Expenditure	**5,249**	**5,275**	**(26)**	**26,196**	**27,063**	**(867)**	**63,010**

Drug spend is adverse to plan in August by £10k and by £154k 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 £43k in month and £282k YTD. The largest expense area here is the support to provide mandatory training within the Learning & Development team.

Hard & Soft FM Contract - adverse to plan by £35k in month and £458k 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 £30k in month and £321k 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.

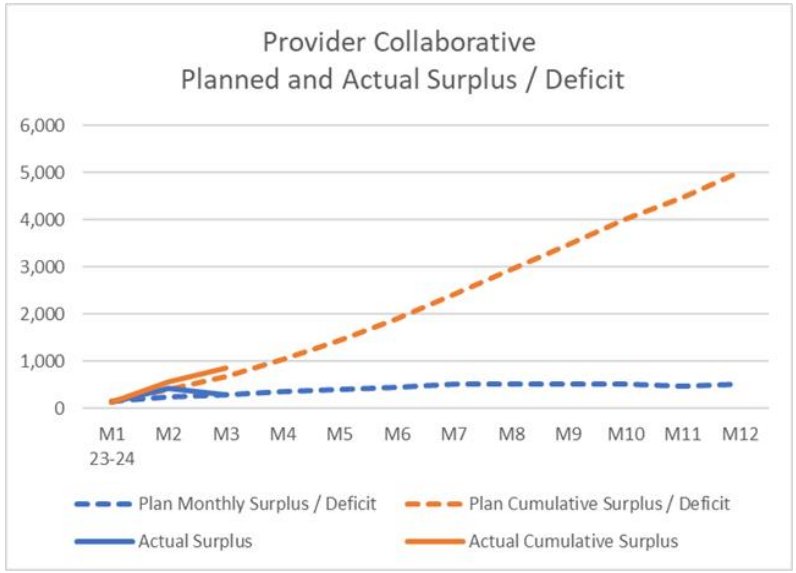
Other Contracts - Adverse to plan by £21k in month and £351k YTD. This primarily relates to CAMHS ADHD expenditure which is matched to income.

Interest income is favourable to plan by £106k in month and £491k YTD.

Provider Collaborative

- **NB. M4 position only supplied by provider collaborative**

Service	Lead Provider	YTD Plan	YTD Actual	Variance
CAMHS	HPFT	766	692	(74)
Adult Secure	EPUT	(377)	(549)	(172)
Adult Eating Disorders	CPFT	639	891	252
Total		**1,028**	**1,034**	**6**



- 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 July of £1,034k 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	1,550	1,550	0
OOA beds	238		(238)	1,190	684	(506)
Rates rebate	-	58	58	700	290	(410)
Observations/agency reductions	58		(58)	150	155	5
Provider Collaborative income	-	-	0	-	-	0
Social Care & Rehab placements	56	-	(56)	150	-	(150)
Corporate schemes	41	105	64	147	350	203
Other SBU Schemes	33	93	60	89	93	4
Bank interest	-	126	126	-	456	456
Sub-total	**736**	**692**	**(44)**	**3,976**	**3,578**	**(398)**
Productivity schemes (Non-CRES)	415	415	0	2,075	2,075	0
Grand Total	**1,151**	**1,107**	**(44)**	**6,051**	**5,653**	**(398)**

- 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 £1.11m in August, which is £44k below Plan in month and £398k behind plan YTD.
- YTD underperformance reflects the non receipt of the rates rebate in line with plan, but the expectation that this will be received later in the year 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 early indications in September are that further savings will be achieved with reduced volumes. Recurrent savings YTD amount to £5.47m with £354k 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	1,850	1,350	1,481	(131)
A Completion of Existing Schemes: Other	309	31	309	209	100
B Patient Safety Schemes: CCTV	706	838	590	640	(50)
B Patient Safety Schemes: Elizabeth Court	750	750	625	69	556
B Patient Safety Schemes: Other	1,383	1,263	437	665	(228)
C Recurrent: Backlog Maintenance	1,200	1,200	331	129	202
C Recurrent: Reactive Operational Capital	887	800	235	(111)	346
C Recurrent: Sustainability	500	500	210	231	(21)
C Recurrent: Digitisation	1,942	1,942	810	158	652
C Recurrent: Laptops/Tablets	880	880	365	92	273
D Discretionary: MH Crisis Assessment Centre	1,350	1,350			
D Discretionary: Other	2,009	2,017	293	316	(23)
E Other	206	201			
E Right of Use	497	497	288	158	130
Total Gross Programme	14,119	14,119	5,843	4,037	1,806
Disposals	(1,350)	(1,350)		1	(1)
Total Net Programme	**12,769**	**12,769**	**5,843**	**4,036**	**1,805**
Funded By:					
System CDEL	8,980	8,980			
National CDEL - Frontline Digitisation	1,942	1,942			
Right of Use Asset Liabilities	497	497			
Disposals	1,350	1,350			
Total	**12,769**	**12,769**			

- Capital year-to-date spend to the end of Month 5 is £4.0m, against a year to date Plan of £5.8m. This is behind Plan by £1.8m due to several key projects spending more slowly than anticipated, and significant levels of VAT reclaims received. There are a number of large purchase orders out including c. £0.5m on laptops for Month 6.
- Oak Ward is nearing the end of its final phase with £1.5m spent year to date and a further £0.35m now expected to complete the project. This is an increase on the original Plan of £0.35m due to slightly expanded clinical scope and unforeseen works, and will necessitate a revised Purchase Order.
- Spend against recurrent items is c. £500k year to date, largely on Sustainability (Solar Panels/LED lighting) and Digitisation (where the gross spend is higher but a VAT refund was received for the Bed Management System giving a net spend of £250k at Month 5, including laptop purchases). There is a large purchase order due in September for additional laptops.
- In addition, there is Plan allocated to a Crisis Assessment Centre, as well as some unallocated funds; the Modernising Our Estate meeting continues to prioritise funds with several items agreed at the most recent meeting, as well as more detailed business cases to be prepared for others, such as the Warren Court Generator project.
- The main risk currently relates to the planned disposal of Harper Lane, which is expected to net £1.35m but which is subject to planning permission which has yet to be received. It is likely this issue will remain open until Quarter 4 and may slip to 2024/25 necessitating some flexibility in the rest of the programme to accommodate this; a revised Plan is being worked up to accommodate 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 4	Movement in month 5	Current month 4	Movement YTD
	£000	£000	£000	£000	£000
Assets	258,189	254,612	2,741	257,352	(837)
Non Current Assets	**183,345**	**186,471**	**(36)**	**186,435**	**3,090**
Intangible Assets	2,975	2,842	(33)	2,809	(166)
Property Plant & Equipment	163,899	165,055	223	165,278	1,379
Tr & Oth Rec: Non-Nhs Rec	358	358	0	358	0
Other Assets	931	931	0	931	0
Right Of Use Assets	15,182	17,284	(225)	17,059	1,877
Current Assets	**74,844**	**68,141**	**2,776**	**70,917**	**(3,927)**
Inventories	60	60	0	60	0
Trade and Other Receivables NHS	17,352	7,407	1,053	8,460	(8,892)
Trade and Other Receivables Non NHS	4,479	17,844	(2,715)	15,129	10,650
Credit Loss Allowance	(591)	(591)	0	(591)	0
Assets Held for Sale	1,274	1,274	0	1,274	0
Cash & Cash Equivalents GBS/NLF	52,181	42,063	4,434	46,497	(5,684)
Cash & Cash Equivalents Other	90	85	5	89	(1)
Liabilities	(89,940)	(89,251)	(2,762)	(92,013)	(2,073)
Current Liabilities	**(64,637)**	**(61,420)**	**(2,951)**	**(64,371)**	**266**
Trade & Other Payables Capital	(1,922)	(2,136)	220	(1,915)	6
Trade & Oth Payables Non-Capital	(54,720)	(50,462)	(3,175)	(53,637)	1,083
Borrowings	(3,023)	(2,978)	(19)	(2,997)	26
Provisions	(3,625)	(3,240)	117	(3,123)	502
Deferred Income	(1,347)	(2,605)	(94)	(2,699)	(1,351)
Non Current Liabilities	**(25,303)**	**(27,830)**	**188**	**(27,642)**	**(2,339)**
Borrowings	(19,580)	(22,051)	175	(21,876)	(2,296)
Provisions	(5,723)	(5,779)	13	(5,767)	(43)
Other Liabilities	0	0	0	0	0
Equity	(168,249)	(165,361)	22	(165,339)	2,910
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)**	**(24,563)**	**22**	**(24,541)**	**2,910**

- Non-Current asset values reflect in-year additions (£6.9m YTD) less depreciation charges (£3.8m YTD). A full revaluation was undertaken in 22/23 and it will be determined later in 23/24 whether a desktop or impairment review is required in 23/24.

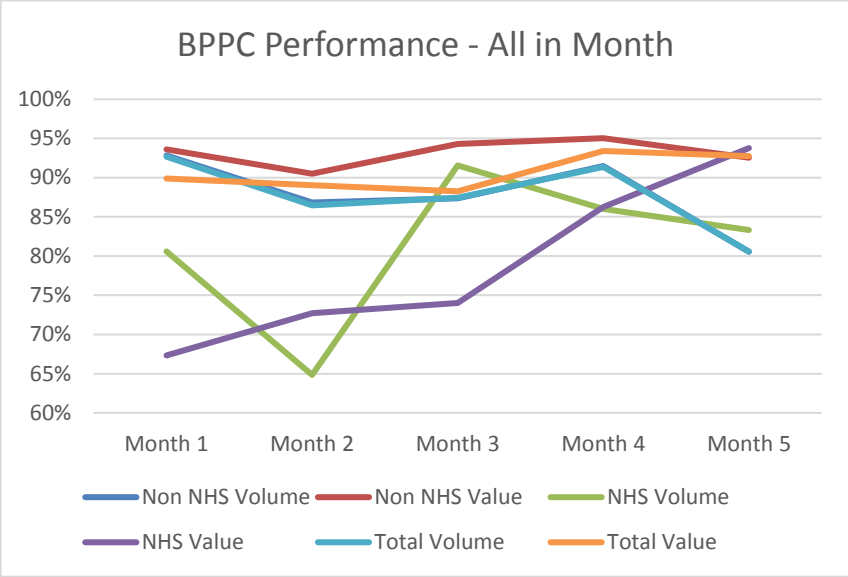
- The Trust cash position at the end of Month 5 is £46.5m. This is a £4.4m increase in month which is due to the increase in receivables and reduction in payables explained below. £10.9m SDF (full year) which was expected to be paid in month 5 will now be paid at 50% only in Month 6 due to HWE ICB not having yet received the full year funding; the remainder will then be invoiced later in the year.

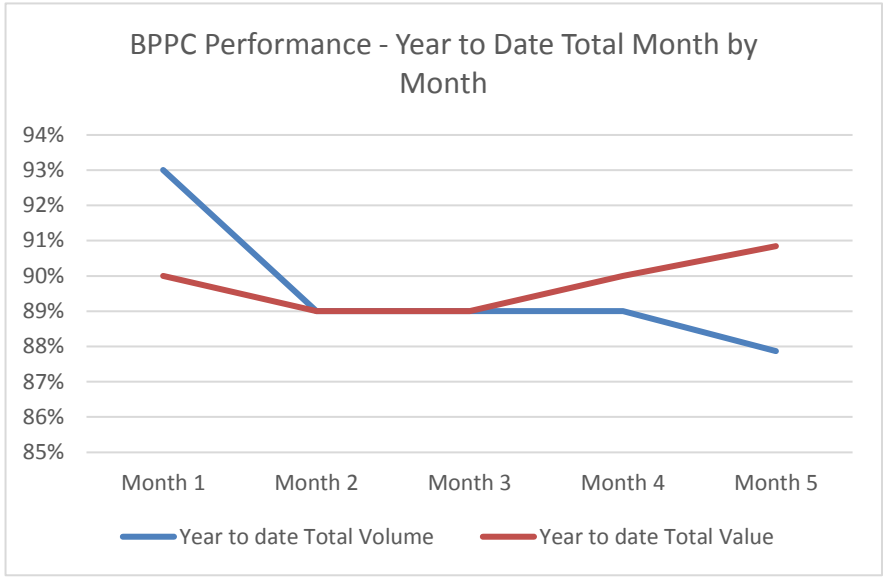
- Trade and other receivables has decreased by £1.7m in month, £1.7m relates to ongoing discussions on HCC block pay award and investment values, £1m relates to VAT received relating to delaying the June VAT claims to maximise the final 22/23 VAT claims. Offset by £1m increase in other accrued income.

- Trade and other payables has increased by £3m in the month. £1m relating to the timing of payment runs, £1.5m relating to the increase in accruals for services not billed for (mainly EPUT and PDC charges), £0.3m relating to increased liabilities for tax and NI relating to increased staff costs in 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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NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 12
Report Title	Belonging and Inclusion Strategy	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Jo Humphries, Chief People Officer	
Approved by:	Jo Humphries, Chief People Officer	

The Board is asked to:
APPROVE

Executive Summary
Having happy, healthy, diverse and thriving teams is a key priority for the Trust. This means we can be confident of achieving our Vision of Delivering Great Care, Achieving Great outcomes – Together. This strategy has been created following extensive co-production with staff, our staff networks, service users, carers and our partners and offers the opportunity for the Trust to continue to build on the strong foundations already in place to create an equitable employee experience and remain an outstanding place to work for all our staff. It has also been created with the insights we have from our annual staff surveys, the Workforce Race and Disability Standards data and our Gender Pay Gap Data and it is fully reflective of the National and Regional workforce improvement plans, which recognise the inequity in day to day experiences of staff within the NHS. Within our Great Together Strategy, we make three key commitments as part of our People Priority: • embedding our inclusive culture • building a diverse workforce • eliminating any form of discrimination. These are the three main priorities of the Belonging and Inclusion Strategy and the accompanying paper summarises the journey we have been on to develop them and to articulate what will be different as a result of achieving them. It is proposed this strategy is launched in October, coinciding with Black History Month and National Inclusion Week.

Recommendations
The Board is asked to approve this strategy for an October launch and publication on our external website.

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.	✓

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Belonging and Inclusion Strategy

2023 - 2028

as One

Our Values
Welcoming Kind Positive Respectful Professional

Contents

Foreword

An organisation is only as great as its people, and it is true that in HPFT we have some of the most talented, caring, and skilled people in the NHS. We have a strong sense of who we are as an organisation and what we stand for. Our ***'Great Together'*** Strategy, launched in 2023 and coproduced with those that use our services, local communities our partners and staff, places services users and carers at the heart of all that we do. Our Values 'Welcoming, Kind, Positive, Respectful, Professional' are the glue that hold us together and form the basis on which we recruit, develop and support individuals and teams.

'Great Together' describes our determination to address inequalities and achieve equity for the people and communities we serve, and this also extends to our workforce. We know that for people to thrive at work, they need to feel safe, feel they belong and feel included. We must therefore understand, encourage, and celebrate diversity in all its forms across our organisation. More than this, we must also actively seek out and eradicate discriminative practices and behaviours – and this means unashamedly setting our bar high – there is no room for discrimination in HPFT.

Positively, we believe diversity brings possibility and opportunity. A diverse workforce means a greater breadth of thinking, greater understanding, greater and expanded approaches, greater innovation, and new ways of working. Diversity brings better connection with and understanding of the communities and people we serve, which leads to better care and outcomes. A culture where people feel they are safe, that they are treated with respect and dignity also mean we can continue to successfully attract and retain an increasingly vibrant and diverse workforce.

We are hugely proud of HPFT and every member of it, we want everyone to feel and have a positive experience of working in our organisation, to feel part of our exciting future as we deliver 'Great Together'. Although we have made progress, there remains more to do to ensure everyone feels they belong and are included across HPFT. We are delighted to be able to present our 'Belonging and Inclusion' Strategy which we believe provides a clear commitment and 'plan' for the future against which we can measure our success. We hope you will feel as excited as we are about bringing this strategy to life, so that every person, every day has a positive experience of working in HPFT, one where they feel they belong and can be themselves, safe in the knowledge they will be treated fairly and supported to thrive.

Karen Taylor
Chief Executive

Sarah Betteley
Chair

Introduction

Since joining the Trust in April 2023, I have been impressed with the progress HPFT has already made to develop our compassionate and inclusive culture creating a great foundation on which to build. I have seen a real commitment to living our values with teams being welcoming, kind, positive, respectful and professional and I believe this creates the opportunity for every member of HPFT to feel they belong and can bring their whole selves to work. I have also been impressed by our wide range of staff networks which provide safe and supportive spaces in which the daily lived experience of our teams can be shared and whose vibrant calendar of events and awareness days celebrate, educate, inform and support everyone's understanding of the power of our diversity.

I have also seen how our Inclusion Ambassadors are passionate about eliminating discrimination and actively participate in de-biasing our recruitment and other key people policies and processes. They are an established part of how we work now and the network continues to grow, influencing and championing equity for all across HPFT.

Yet, there is still more to do if we are to ensure every member of our team has the same positive, rewarding experience of working for HPFT. This strategy therefore has **three main priorities:**

- **to celebrate and develop our inclusive culture**
- **to grow our diverse workforce**
- **and to eliminate discrimination in all its forms.**

It is a bold strategy and one which will require us all to learn to think differently about what inclusion and belonging really means and how everything each of us say and do will contribute to our being Great Together.

Everyone working in HPFT has the right to feel safe, to be supported, to be included and to feel that they truly belong here. I look forward to working with you all and to ensure we remain one of the best places to work.

Jo Humphries
Chief People Officer

Our Trust Strategy, Vision, Mission and Values

Our Great Together Strategy, Vision and Mission collectively set out an exciting journey for HPFT for the next 5 years and, alongside a strong commitment to our Values, we are confident HPFT will continue to be a great place to work and in which our people are able to thrive, develop and be treated with compassion and care.

Our strategy – Great Together

Our Vision – what we aim to achieve

"Delivering Great Care, Achieving Great Outcomes – Together"

Our Mission – why we do what we do

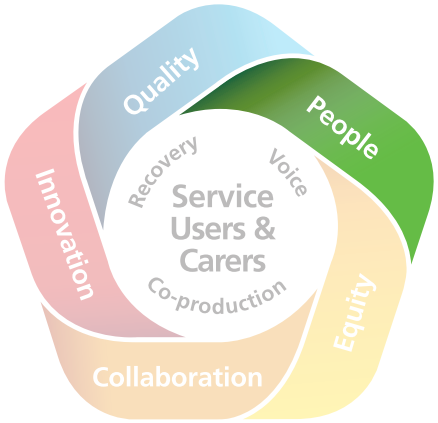
"We support people to live their lives to their full potential by enabling them to keep mentally and physically well"

Our Values

We are **welcoming** so you feel *valued as an individual*	We are **kind** so you feel *cared for*	We are **positive** so you feel *supported and included*	We are **respectful** so you feel *listened to and heard*	We are **professional** so you feel *safe and confident*

Our Trust People Priorities

Having happy healthy, diverse and thriving teams is a key priority for the Trust. This means we can be confident of achieving our Vision of Delivering Great Care, Achieving Great Outcomes – Together. People are one of our Key Priority areas within our Great Together Strategy with the following commitments being made to every individual and team working for HPFT.



Our People

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

We will do this by...

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

Our workforce

We are hugely proud of our diverse workforce and the work our teams do in providing mental health, learning disability and autism services across Hertfordshire, Essex, Norfolk and Buckinghamshire.

35%
of our staff are from culturally and ethnically diverse groups

We have **9%** **disabled staff**

We have **4,121** **people** working across HPFT

Outstanding

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

We are ranked **8th** across all NHS Trusts for the positive experience reported by 9% of our staff with disabilities

We are in the **top 3** **Mental Health Trusts** to work for in the country in 2022

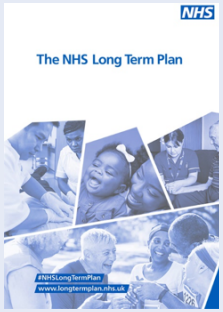
76+ **Nationalities**

4%
of staff told us they identify with diverse gender orientations

Developing our Belonging and Inclusion strategy – What is happening around us

NHS Long Term Plan

Sets out the priorities and goals for NHS England through to 2029.

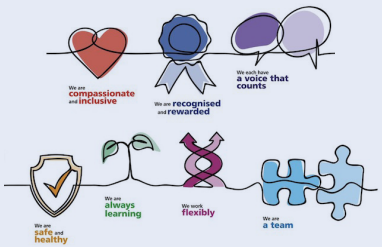


NHS Workforce Plan

Sets out how to address existing and future workforce challenges.

People Plan

Sets out how we will achieve a positive, compassionate and inclusive culture.



NHS Equality, Diversity and Inclusion Improvement Plan

Sets out 6 high impact areas of action to improve equality, diversity and inclusion

NHS Workforce Race and Disability Standards

Sets out the standards and measurements for an improvement in equality, diversity and inclusion.

EoE Anti Racism Strategy

Sets out the Regional plan to achieve a culture of civility, respect and safety

A number of recent NHS improvement plans, both National and in the East of England Region, have been published in response to the ongoing workforce challenges of recruitment and retention and which specifically acknowledge the inequity of day to day experiences across NHS staff groups. These have been used to inform our Belonging and Inclusion Strategy alongside feedback from our NHS annual staff survey, the National Workforce Race and Disability Equality Standards and Gender Pay Gap reporting.

Developing Our Belonging and Inclusion Strategy – Our approach

Over the past few months, we have carefully considered the wider NHS context and engaged with, actively involved, and co-produced this workforce strategy with service users, carers, local communities, staff, and partner organisations. It is linked to, yet distinct from, our approach to equity and diversity for our service users, carers and communities, another key strategic priority for the Trust.

Through our Big Conversations and Local Conversations staff engagement events across the Trust, our annual and quarterly pulse surveys and service user and carer focus groups, we have been able to capture what it is our people want to see us improve. During the development of our Trust's Great Together strategy, we have been able to understand what our culturally and ethnically diverse communities want both for, and from, our staff to help improve their sense of belonging and inclusion.

We heard…

Our service users, carers and communities say they…

- want us to communicate in ways that are tailored to them, reflecting their needs and preferences
- want to feel safe to be our whole selves when they approach us for support
- want us to focus on addressing inequalities & improving access for all

Our staff and Experts by Experience say they…

- want everyone to feel comfortable calling out discriminatory behaviours and see them be acted on
- want to feel safe to be their whole self at work
- feel we need more career development options for all staff

Our partners say they want us to…

- continue to work collaboratively with them
- develop our workforce together
- reduce the instances of staff abuse from Service Users, Carers and members of the public
- see more people with lived experience in our direct employment

We want to feel a strong sense of belonging and inclusion and bring their whole selves to work

We need line managers who role model exemplary inclusive, compassionate leadership and demand this from their teams

We want every person to feel seen, heard and valued for the contribution they make to service user care

5 Service User and Carer Groups attended by over 50 people

1,834 staff surveys received

Over 3,000 comments received

200+ listening sessions attended by over 1,000 staff

Our Belonging and Inclusion Strategy

Our belonging and inclusion strategy has three key ambitions.

Inclusive Culture

We will embed our just and inclusive culture in compassionate and caring teams where everyone feels valued, respected and able to thrive

Diverse Workforce

We will build a diverse workforce representative of our service users and local communities, encouraging and recruiting candidates with different backgrounds

Eliminate Discrimination

We will eliminate discrimination, bullying and harassment at work through education, training, and targeted actions.

Inclusive culture

We will embed our just and inclusive culture in compassionate and caring teams where everyone feels valued, respected and able to thrive.

We will do this by:

- **Making equity everyone's business,** through building it into everyday practices, training and governance
- **Developing values-based, compassionate leaders** at every level of the Trust by embedding the values and expected behaviours in all employee, and potential employee, interactions
- **Celebrating cultural differences** through providing opportunities for people to connect and to expand their knowledge and understanding of different cultures, communities, backgrounds and beliefs
- **Fostering a sense of community and support for our people** by strengthening our staff networks and links into local community groups
- **Ensuring people feel safe to learn about all our differences** to enhance understanding in a safe and supportive environment

Diverse workforce

We will build a diverse workforce representative of our service users and local communities, encouraging and recruiting candidates with different backgrounds.

We will do this by:

- **Embedding fair and inclusive recruitment processes** that target under and over representation and lack of diversity
- **Developing clear talent management strategies** that enable our workforce to thrive and develop and support the development and career progression of under represented groups
- **Implementing a comprehensive, culturally insightful induction** to recognise and celebrate difference
- **Developing an onboarding, pastoral care and development programme for internationally recruited staff** to improve their sense belonging and retention
- **Addressing health inequalities** within our workforce by ensuring our wellbeing programme addresses the diverse needs of all our staff
- **Ensuring reasonable adjustments are easily accessible** to enable our employees with disabilities to thrive at work

Eliminate discrimination

We will eliminate discrimination, bullying and harassment at work through education, training and targeted actions to support our teams.

We will do this by:

- **Delivering the high impact actions** set out in the NHS Equality, Diversity and Inclusion Improvement Plan and East of England Anti-Racism strategy
- **Educating leaders to eradicate racism and micro-aggressions** in the workplace, including insensitive and inappropriate "banter" such that all staff feel safe and able to be themselves at work
- **Including belonging and inclusion objectives** into Board and senior manager annual performance reviews to which they will be held individually and collectively accountable
- **Targeting actions** to eliminate bullying, harassment, violence, aggression and racist behaviour towards our staff from service users, their carers or members of the public
- **Ensuring people feel safe to call out discrimination** whenever they see or hear it as part of our Freedom to Speak Up commitment

Implementing our strategy – what will be different

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

- I am confident that HPFT staff understand, value and respect me for who I am, and I can be my whole self in their care
- I feel fully included and supported in my care by the welcoming, kind, respectful, positive and professional staff
- I experience teams who are effective and compassionate and work together to deliver great care
- I understand the consequences of my behaviour if I bully, harass, or am violent or racist towards HPFT staff

We want our workforce to be able to say

- I have received excellent training and development, and I can see my future career at HPFT
- I am confident in the fairness and equity of our recruitment and development activity
- I am treated fairly, equitably, and I feel I belong here
- I can bring my whole self to work
- I feel safe and confident to speak up to raise concerns and challenge where behaviours do not meet our standards and values
- I feel valued and respected
- My leader is compassionate, values-based and supports my individual and our team development
- I feel physically and psychologically safe coming into work each day

We want our communities to be able to say

- HPFT is somewhere we would want to work and receive care – we have confidence and trust in them
- We can see ourselves represented in the workforce of HPFT, which makes us feel more able to access care and support

We want our partners to be able to say

- We see HPFT always advocating for anti-racism and the elimination of discrimination in all that they do
- We see the HPFT values in action in everything they do
- We want to work with HPFT as we know they are fair and inclusive in their business partnerships

Conclusion

This strategy outlines an exciting and ambitious plan for improvement which we are fully committed to delivering.

It is said that diversity is a fact, equity is a choice, inclusion is an action and belonging is an outcome. It is through the actions and words of every single employee of HPFT that will bring this belonging and inclusion strategy alive and deliver the outcomes that our staff, service users, carers and our partners want and deserve.

Our leaders will continue to role model inclusive behaviours and create workplaces within which the happiness, wellbeing and success of all our staff is inevitable. Together we can create a strong culture of belonging and inclusion in which we can all thrive.

The delivery of this strategy will be purposeful, rewarding and challenging at an individual, team and organisation level, but we believe it will ultimately result in HPFT being recognised by all staff as being a great place to work. A place where you belong. A place where we can be *Great Together.*

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

as one

Our Values

Welcoming Kind Positive Respectful Professional

The Colonnades
Beaconsfield Road
Hatfield
Hertfordshire
AL10 8YE

www.hpft.nhs.uk

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Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 13
Report Title	Unison Anti-Racism Charter	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Jo Humphries, Chief People Officer	
Approved by:	Jo Humphries, Chief People Officer	

The Board is asked to:
APPROVE

Executive Summary

In addition to the ongoing commitments we have as a Trust to both NHSE and the East of England Anti-Racism strategies this paper proposes entering into a new partnership agreement with Unison, fully supported by the Trust Joint Consultative Negotiating Committee, to pledge our support to their Anti-Racism Charter and to provide the overt recognition that the Trust and Trade Union are working as one in our commitments to eradicating racism in the workplace.

This 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.

The Charter is as follows:

By signing this charter we are committing to introduce the following ongoing commitments within 12 months of signing if they are not already in place:

Our leaders will

□ Recognise the need and benefit in championing a racially diverse workforce.
□ Challenge racism internally and externally wherever it arises in relation to the organisation.
□ Recognise the impact of racism upon staff members' wellbeing.
□ Set and regularly review strategy to improve racial equality, diversity and inclusion so that the organisation reflects the communities it serves.

Our organisation will

□ Have a clear and visible race equality policy championed by leadership.
□ Have a clear and visible anti-racism programme of initiatives and actions.
□ Undertake equality impact assessments for all strategic-level decisions.
□ Undertake ethnicity pay gap recording and publicly publish results.
□ Undertake workforce ethnicity recording and publicly publish results.
□ Provide unconscious bias and anti-racism training for all staff members.
□ Provide a racism reporting process for notifying, investigating and recording outcomes.
□ Provide robust equality training for managers involved in recruiting, promotions and investigating allegations.
□ Provide a wellbeing support facility for staff experiencing racism in the workplace.
□ Will be anti-racist, not just non-racist in all we do.

Our equality auditing process will review

□ Recruitment processes to identify and address race disparities in equality of opportunity.
□ Exit interview results to identify and address race disparities in retention of staff members.
□ Promotional processes to identify and address race disparities in equality of opportunity.
□ Discipline and grievance to identify and address race disparity in outcomes of comparable cases.
□ Policies and research under a duty or commitment to promote solidarity and tackle racism.
□ Our mission, values, and support to removing racial discrimination in all its forms

It is proposed to invite our full time Unison representative and a senior member of the regional Unison office to co-sign the Charter during Black History Month and coinciding with the launch of our new Belonging and inclusion Strategy.

Recommendations
The Board is asked to approve the commitment of the Trust to this charter and the development of the necessary action plans to deliver the commitments we are making within 12 months of signing.

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.	✓

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PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 14
Report Title	Sexual Safety in healthcare – organisational charter	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Jo Humphries, Chief People Officer	
Approved by:	Jo Humphries, Chief People Officer	

The Board is asked to:
APPROVE

Executive Summary

On the 4th September 2023, NHSE published its first ever charter on sexual safety at work with 10 pledges for organisations to follow to safeguard staff. The new charter asks employers to commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce.

By signing this charter we will be committing the Trust to:

1. Actively work to eradicate sexual harassment and abuse in the workplace.
2. Promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. Take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. Provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. Clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted, and/or harmful sexual behaviour.
6. Ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. Ensure appropriate, specific, and clear training is in place.
8. Ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. Take all reports seriously and appropriate and timely action will be taken in all cases.
10. Capture and share data on prevalence and staff experience transparently.

These commitments will apply to everyone in our Trust equally and where they are not in place already, we are asked to commit to having them in place by July 2024.

There is a publicly available list of organisations who have signed up to the charter on the NHS England website NHS England » Sexual safety in healthcare – organisational charter. At the time of writing this report, 74 organisations have registered their commitment.

To provide further information regarding sexual safety in healthcare, the following question will be included in the 2023 (current) National Staff Survey.

- In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault.

Recommendations
The Board is asked to approve the commitment of the Trust to this charter and the development of the necessary action plans to deliver the commitments we are making by July 2024 where they are not in place already.

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

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 15
Subject:	Report of the Audit Committee held on 18 July 2023 and 5 September 2023	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Phil Cave, Chief Finance Officer
Presented by:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Audit Committee at its most recent meetings held on 18 July 2023 and 5 September 2023

Action required:

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

Summary and recommendations to the Board:

Summary

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

Matters for Escalation to the Board

There were no items for formal escalation to the Board.

Relationship with the Business Plan & Assurance Framework:

List specific risks on BAF – 5

Summary of Implications:

None

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

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

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Audit Committees held on 18 July 2023 and 5 September 2023

1. Introduction

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

1.2 Since the last Audit Committee report to the Trust Board in Public, the Committee has met twice on 18 July 2023 and 5 September 2023 in accordance with its terms of reference and was quorate.

1.3 The Committees were chaired by David Atkinson, Non-Executive Director.

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

1.5 The meeting held on 18 July 2023 focused on three deep dives as detailed below.

1.6 The meeting on 5 September 2023 welcomed the Trust's new external auditors, Deloitte, noting the eternal audit plan would be discussed at the meeting held in December 2023.

2. Committee meeting - 18 July 2023

2.1 Deep Dive -Data Security and Protection Toolkit

The Committee received an in-depth presentation regarding the Data Security and Protection Toolkit (DSPT). It was reported that the Trust takes part in an online self-assessment and HPFT is considered Category one with 13 mandatory points to be completed. The Committee were informed that an internal audit against the DSPT is also undertaken as part of the submission. The audit seeks assurance over and above the detail required in the DSPT.

The Committee were updated on the audit findings noting a number of actions related to wording in policies, training and technical controls. The work underway to make the required improvements was reported along with the process in place to track the work by HBLICT to action them.

The Committee discussed the transfer of learning from the incident related to tracking on the public website, and opportunities and risks associated with the rapidly developing AI capability.

2.2 Deep Dive – People: Internal Audit Recommendations

The Committee received a presentation providing an update on the internal audit recommendations relating to People audits. It was noted that there had been some concerns with the recommendations from the HR audits completed between 2017 and 2020. It was reported that recent audits had demonstrated an improved position, all reporting positive opinions.

The Committee were informed that there were clear actions identified from each of the audits and the Committee were advised that a number of these had been resolved resulting in improved levels of assurance.

The Committee welcomed the improved quality of the internal audits. It was reported to ensure controls and assurances were robust there would be a rotating cycle of audits built into future internal audit programmes.

2.3 Deep Dive – Financial Governance

An in-depth presentation was provided to the Committee that included a comprehensive overview of the Trust's updated financial governance framework and practices. The actions that had been taken to enhance financial governance across the organisation were described.

It was confirmed that the finance team are working with Senior Leaders to set out expectations regarding financial controls. That a robust finance risk register being developed, and the Trust is working towards no purchase order, no payment process.

It was reported that Financial Planning is moving to a 3-year cycle which will ensure early thinking about coming years. It was noted that the Scheme of Delegation (SoD) and Standard Financial Instructions (SFI) will also be reviewed and have bite-sized versions published for all staff.

The Committee welcomed the focus on the budget process noting that in future years the budget process will be bottom up and will see that by quarter one being able to hold people to account against agreed budgets.

3. ommittee Meeting - 5 September 2023

3.1 Deep Dive – Procurement

At the meeting the Committee received a presentation from the system wide procurement service in place for the Herts and West Essex system. The presentation provided background to the new procurement Bill that is due to return to the Lords for them to consider Commons amendments. It was reported that the new Bill aims to simplify aspects but it remains a complex piece of legislaiton.

The update also provided details of the local position with regard to the the Trust. It was reported that the procurement service was supporting the Trust with implemeting new delegated limites and move to 'no purchase order no pay'.

The latest data on number and vaue of purchasse ordres was discussed, noting the increased number of purchase orders relating to hard and soft facilities management. The tender activity for 2022/23 and 2023/24 year to date was presented, noting the majority of tenders related to estates and facilities.

The Committee were updated on the challenges facing the service such asan increase in demand for advice, managing disruption to the supply chain and net zero and sustainability.

Committee members discussed the opportunity for buying strategically to maximise value across the system. The Committee discussed the target for savings and progress with the trajectory. The Committee also discussed Social Value and how we ensure is meaningful and how mitigation any risk associated with it being part of the tender requirement.

3.2 Quarter One Reports

The meeting received a number of quarter one reports for assurance and approval. The Committee considered a report that set out the waivers approved in the quarter, noting that there was a similar number to the previous quarter but that overall, the total value was higher. The Committee discussed the reasons for the waivers and need to continue to be vigilant and how the 'no purchase order no pay' approach will help increase the robustness of controls.

The Committee considered and approved the recommendation to write off losses for quarter one. The Committee discussed the efforts made to retrieve the costs but that the advice was that they were uneconomical to pursue and that all efforts of recovery had been exhausted. The Committee were updated on the total irrecoverable debt provision and continue focus on reducing overpayments.

It was reported that in quarter one the Trust had used the corporate seal once for an estates matter.

3.3 Compliance

The Committee received a report on the implementation of the annual declaration process for key decision-makers within the Trust, as detailed in the Trust's Standards of Business Conduct Policy. It was reported that the at the time of the meeting the Trust had 97.3% compliance of 'decision makers' who have completed a Declaration of Interest and that the Corporate Affairs team are working to ensure the reaming ten outstanding staff members completed their declarations.

The Committee considered the updated Declarations and Gifts and Hospitality register noting it is updated regularly and that they are publicly available on the Trust website. It was noted that the number of declarations was slowly increasing, and the Trust was continuing to work to increase awareness of all aspects of the Standards of Business Conduct Policy.

The Committee considered a report on the national clinical audits the Trust had participated in within the last 12 months. It was reported that once an audit is completed, a local action plan is created by the operational staff and to ensure the action plans are completed, evidence is requested by the PACE team. The PACE also liaise with the SBUs on a quarterly basis to review progress and review mitigation of any risk associated with outstanding action for the action plan.

Committee members welcomed the report and the level of participation by the Trust, noting the areas of improvement identified by the audits and the process in place to track actions required.

The Committee considered and approved the updated Board Assurance Framework (BAF), agreeing the proposed changes to scores and update to the controls and

assurance. It was noted that the revised BAF would be presented to the Board for approval.

The Committee received an update on the completion of the recommendations included in the external auditors ISA260 Yearend Report. It was noted that there are systems in place to avoid the recurrence of issues that caused some of the recommendations and that others recommendations are being implemented and on course to be completed. It was reported that the two outstanding recommendations from 2021/22 were closed.

It was noted that the Trust will work with Deloitte to ensure that learning from 2022/23 is taken into 2023/24.

3.4 External Assurance Reports

The Committee received update reports from internal audit and counter fraud, which detailed the good progress with the relevant work programmes. It was noted that two audits had been finalised, both with a positive opinion.

The Committee also considered a report that set out the progress with the actions identified from audit reports noting the progress with their completion, noting the significant progress that had been made with closing the actions on tracker.

4. Matters for Escalation to the Board

4.1 The Board are asked to note that the Board Assurance Framework is being presented to the Board for approval following recommendation from the Audit Committee.

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

Appendix One: Audit Committee 5 September 2023

Welcome and apologies for Absence:
Declarations of Interest
Minutes of the meeting held on 18 July 2023
Matters Arising Schedule
Deep Dive Procurement
Other Matters a. Use of Waivers: quarter one b. Provision for Irrecoverable Debt: quarter one c. Use of Corporate Seal: quarter one d. Standards of Business Conduct Compliance Report e. Clinical Effectiveness Report - National Clinical Audits f. Board Assurance Framework g. Progress with external audit actions from 2022/23
External Reports a. Internal Audit Progress Report b. Internal Audit Action Tracker Exception Report c. External Audit Plan 23/24 d. Counter Fraud Progress Report
Items to Note
a) Minutes of Finance and Investment Committee held on 23 March 2023 b) Minutes of Finance and Investment Committee held on 18 May 2023. c) Minutes of Integrated Governance Committee held on 16 March 2023 d) Minutes of Integrated Governance Committee 16 May 2023 e) Committee Planner
Any Other Business
Date of next meeting: 5 December 2023

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 16
Report Title	Board Assurance Framework	**For publication:** **Yes ☒** **No ☐**
Report Author (s)	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Approved by:	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

Background

The Trust's Board Assurance Framework (BAF) underwent a fundamental review to ensure it is line with best practice and acts as a clear guide for the Board on the strategic issues and risks it should be focussing on. The review also responded to a recommendation from the externally commissioned Well-Led Review that was undertaken in 2020/2021.

The BAF is a dynamic document and tool to ensure that the Trust Board is focused on the key strategic issues and risks.

Board Assurance Framework (BAF).

The BAF has been reviewed by the Executive Team and recently by the Audit Committee at its meeting on 5 September 2023.

There have been no changes to the Strategic risk descriptors, but the BAF has been updated to:

- include the new strategic objectives for the Trust that are included in the new Trust strategy 'Great Together'.
- Include new controls and assurance identified by the Exec team and Audi Committee.

There are currently eight strategic risks (note the table includes the revised scores for Strategic Risk one and four):

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 quality of care for our service users and our staff satisfaction levels.	**20**
Strategic Risk Two: Our People	Failure to maintain positive health and wellbeing support for all our staff which could mean staff and do not provide an inclusive work experience with equity of opportunity which could mean staff do not feel valued or enabled to reach their potential	**12**
Strategic Risk Three: Quality – Safety	There is a risk that we do not provide safe standards of care due to failure to maintain agreed safe staffing levels meaning service users do not feel safe and are not protected from avoidable harm or deaths through suicide.	**20**
Strategic Risk Four: Quality – Experience	There is a risk that the unavailability 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**

Strategic Risk Five: Finance	Failure to maintain a sustainable financial position over the longer term, will impact on the Trust's ability to deliver high quality services consistently, making progressive and sustained improvements.	**20**
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.	**12**
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 MHLDA the services users and communities served by HPFT.	**12**
Strategic Risk Eight: Social Care	Failure to engage with partners and organisations to deliver the right care and improved outcomes of service users. Including failure to implement social care reform and meet Section 75 requirements which may result in social care outcomes not being met.	**16**

The Executive Team and Audit Committee have reviewed the BAF and are proposing two changes to the risk scores (as detailed above).

a) They are recommending that the score for strategic risk one should be reduced from 25 to 20 (4x5) in the light of the improved position regarding people metrics such as vacancies, retention and training.

b) They are recommending that the score for strategic risk four be increased to 20 (5x4) from 16, in the light of the continued increase in demand for services, rise in complaints about waiting times and access to services.

Recommendations

The Board is asked to:

a) Review the updated BAF.
b) Consider the proposal to amend scores for strategic risks one and four.
c) Approve the updated BAF.

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.	✓

Board Assurance Framework October 2023

Strategic Risk One: Our People	**Current Risk Rating (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 quality of care for our service users and our staff satisfaction levels.	**4 x 5** ⬇	**3 x 3**	**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	**Current 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 do not provide an inclusive work experience with equity of opportunity which could mean staff do not feel valued or enabled to reach their potential.	**3 x 4**	**2 x 3**	**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	**Current Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Integrated Governance Committee
Risk Descriptor: There is a risk that we do not provide safe standards of care due to failure to maintain agreed safe staffing levels meaning service users do not feel safe and are not protected from avoidable harm or deaths through suicide.	**4 x 5**	**3 x 4**	**Executive Lead**	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.	High	Monthly

		Quarterly reports to IGC. Use of Force and Restrictive Practice Committee CQC MHA Inspections		
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	**Current Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Finance and Investment Committee
Risk Descriptor: There is a risk that the unavailability 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.	**5 x 4** ↑	**3 x 3**	**Executive Lead**	Deputy Chief Executive and 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	**Current Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Finance and Investment Committee
Risk Descriptor: Failure to maintain a sustainable financial position over the longer term, will impact on the Trust's ability to deliver high quality services consistently, making progressive and sustained improvements.	**4 x 5**	**2 x 4**	**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	**Current 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 3**	**2 x 3**	**Executive Lead**	Deputy Chief Executive and 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 QRMC	Medium	Aug 2022
Digital Strategy implementation	2nd Level	Internal audit reports Board workshop Reports to Digital and Innovation 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

Strategic Risk 7. System	**Current 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 MHLDA the services users and communities served by HPFT.	**3 x 4**	**2 x 3**	**Executive Lead**	Executive Director of 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 ICAG	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	**Current Risk Rating (LxC)**	**Target Risk Rating (LxC)**	**Committee**	Finance and Investment Committee
Risk Descriptor: Failure to engage with partners and organisations to deliver the right care and improved outcomes of service users. Including failure to implement social care reform and meet Section 75 requirements which may result in social care outcomes not being met.	**4 x 4**	**2 x 3**	**Executive Lead**	Executive Director of 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

NHS
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PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 17
Report Title	Fit and Proper Persons Test (FPPT)	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Jo Humphries, Chief People Officer	
Approved by:	Jo Humphries, Chief People Officer	

The Board is asked to:
RECEIVE

Executive Summary

NHS England published a new Fit and Proper Persons Test Framework on 2 August 2023 alongside guidance for chairs and for staff on its implementation. Key points are as follows:

The majority of the requirements echo those that already existed in the previous Fit and Proper Person Test guidance. Core elements that continue to be assessed are; good character; possessing the qualifications, competence, skills and experience required; and financial soundness. These are in addition to standard employment checks such as CV checks, proof of identity and right to work.

The framework introduces a new standard board member reference. These should be created whenever a board member leaves an NHS organisation, regardless of whether they are moving immediately to another NHS role and should be sought by employing NHS organisations when making a job offer. The reference is based on the NHS standard reference template but includes additional questions relevant to the Fit and Proper Persons Test.

The Electronic Staff Record (ESR) will be used to store information related to FPPT checks and references. This will provide a standard way to record and report compliance internally. The collation of retrospective data is not proposed.

A full FPPT against core elements of the framework should be undertaken whenever new appointments are made, if a board member moves to a new board role in their current organisation, and annually thereafter.

Annual self-attestations by board members to confirm adherence to the regulations will continue.

Implementation

- Board members to be individually notified their details will be included in ESR for the purposes of FPPT
- From 30th September 2023, the new board member reference template should be used for all new board appointments
- From 30th September 2023, complete and retain locally the new board member reference for any board member who leaves the board for whatever reason and record whether or not a reference has been requested.

From 30th September 2023, use the Leadership Competency Framework (LCF) as part of the assessment process when recruiting to all board roles. Note: This has not at the time of reporting been published by NHSE.

- By 31st March 2024 have implemented the full FPPT framework incorporating the LCF, including updating the ESR database.
- In Q1 2024, incorporate the LCF into annual appraisals of all board directors for 2023/24, using the board appraisal framework.

These changes have been reviewed by the Executive Committee and individually communicated to all members of the board.

Recommendations
The Board is asked to receive this report noting the changes proposed.

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.	

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PUBLIC Board of Directors

Meeting Date:	5 October 2023	**Agenda Item:** 18
Report Title	Nominations & Remuneration Committee Terms of Reference	**For publication:** **Yes** ☒ **No** ☐
Report Author (s)	Jo Humphries, Chief People Officer	
Approved by:	Jo Humphries, Chief People Officer	

The Board is asked to:
APPROVE

Executive Summary
On the 19th September 2023, two changes were proposed to, and accepted by, the Nominations and Remuneration Committee to the Terms of Reference as follows: Section 4.2 to include the Chief People Officer in all meetings in support of the change in: Section 8.1 to reflect the Chief People Officer replacing the Company Secretary in support of the Committee The review dates at the end of the report and a recommendation for Board approval on the 5th October 2023. The Board is asked to approve these changes to the Terms of Reference.

Recommendations
The Board is asked to APPROVE this report.

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.	

NOMINATIONS AND REMUNERATION COMMITTEE
TERMS OF REFERENCE

1. Establishment

1.1 The Nominations and Remuneration Committee is a Committee of the Trust Board of Directors.

2. Purpose

2.1 The Committee is responsible for:

2.1.1 Reviewing and making recommendations to the Board of Directors on the composition, balance, skill mix and succession planning of the Board. It recommends to the Board of Directors the appointment of Executive Directors.

2.1.2 Setting the remuneration policy for the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2.1.3 Approving contracts of employment for the Chief Executive, Executive Directors, and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2.1.4 Agreeing arrangements for termination of contracts, including severance payments paid to the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2.2 The Committee will also be mindful of the gender pay gap and take account of equal value and equal pay principles and legislation for the group of staff it has responsibility for.

2.3 The Committee will take into account relevant national guidance and advice where necessary.

3. Membership and Quoracy

3.1 The Committee shall consist of all Non-Executive Directors of the Board of Directors.

3.2 The quorum for any meeting of the Committee shall be attendance of a minimum of three members.

3.3. The chair of the Committee shall be the Chair of the Board of Directors.

4. Attendance at Meetings

4.1 The Chief Executive will attend all meetings, except when their own performance and remuneration are under consideration.

4.2 The Chief People Officer shall be in attendance when invited by the Committee and shall provide the Committee with such information and advice as they require.

4.3 It is expected that all members will attend at least three quarters of all meetings per financial year. An attendance record will be held for each meeting and an annual register of attendance will be published.

4.4 Every effort shall be made to ensure that the decisions of the Committee are made within its properly constituted meetings. In exceptional circumstances, where very urgent and unanticipated decisions are required to be taken, these may be requested by email circulation to all Committee members. In order for a Committee decision made in this way to be effective, it shall require the prior approval of the Committee Chair that the urgent decision be made in this manner and a positive response from at least 70% of Committee members (which shall include the Committee Chair and Deputy Chair) signifying their assent to the decision.

4.5. The Chair may request attendance by relevant staff at any meeting.

5. Frequency of Meetings

5.1 Meetings of the Committee will be held at least quarterly.

5.2 Meetings will be convened by the Chair and can also be requested by the Chief Executive or their nominated deputy.

6. Authority

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference.

6.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent advice, and to secure the attendance of external individuals with relevant experience and expertise if it considers this necessary.

7. Duties

7.1 To regularly review the composition, skills and experience of the Board of Directors and to make recommendations to the Board.

7.2 To ensure appraisals are undertaken for all Executive members of the Board of Directors.

7.3 To ensure a succession plan is in place and appropriate actions are taken to ensure the continued leadership of the Trust.

7.4 To ensure an appropriate process is in place for the appointment of the Chief Executive and Executive Directors and to recommend the appointment of Executive Directors to the Board of Directors and the Chief Executive to the Board of Governors.

7.5 In conjunction with the Council of Governors Appointments and Remuneration Committee and the Council of Governors, ensure that the process for appointing the Trust Chair and Non-Executive Directors, and the process for appointing the Chief Executive and Executive Directors are aligned.

7.6 To maintain an overview of the relationship between total remuneration and that of the market equivalents for the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive. The Committee will, where appropriate, commission others to collect market information on salaries and other forms of reward to ensure it is sufficient to attract, retain and motivate the relevant individuals, whilst ensuring it is not more than is necessary for this purpose.

7.7 To advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Executive, Executive and non-voting Directors, and other senior managers reporting directly to the Chief Executive, taking account of such national guidelines as is appropriate. This will include:

- All aspects of salary (including any performance related element / bonuses).
- Provisions for other benefits, including pensions and allowances.
- Agreement of contracts of employment and if applicable terms of office.
- Arrangements for termination of employment and other contractual terms, including the proper calculation and scrutiny of termination payments taking account of such national guidelines as is appropriate.

7.8 To consider a report annually from the Chair on the performance of the Chief Executive and from the Chief Executive on the performance of Executive Directors and determine any adjustment to salary.

7.9 Ensure that the right performance and talent management arrangements are in place for the individuals and groups in 2.1.2.

7.10 To agree the annual inflationary uplift on pay and reward for the Chief Executive, Executive and non-voting Directors, and other senior managers reporting directly to the Chief Executive.

7.11 Scrutinise and agree severance terms for the termination of a contract of employment for an individual covered by this Committee giving due regard to HM Treasury requirements and ensuring compliance with the NHS Improvement guidance for NHS Trusts and Foundation Trusts on processes for making severance payments.

7.12 Undertake any other duties as directed by the Board.

8. Administrative Support

8.1 The Committee will be supported by the Company Secretary, in attendance for all meetings except when issues regarding their own salary are discussed.

8.2 The administrative support in this respect will include:

8.2.1 Agreement of the agenda with the Committee Chair.

8.2.2 Collation and distribution of papers at least five working days before each meeting.

8.2.3 Taking the minutes and keeping a record of matters arising and issues to be carried forward.

8.2.4 Providing support to the Chair and members as required.

9. Accountability and Reporting arrangements

9.1 The Committee shall be directly accountable to the Board of Directors.

9.2 The minutes of all meetings shall be formally recorded and a six monthly report provided to the Board of Directors on its work in discharging its responsibilities, delivering its objectives and complying with its Terms of Reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Monitoring Effectiveness and Compliance with Terms of Reference

10.1. The Committee will carry out an annual review of its effectiveness and compliance with its Terms of Reference.

11. Review of Terms of Reference

11.1. The Terms of Reference of the Committee shall be reviewed at least annually by the Committee and approved by the Trust Board.

Date approved: **Nominations and Remuneration Committee 19th September 2023**
Approved by: **Board of Directors 5th October 2023 (to be confirmed)**
Next review date: **October 2024**