Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC Meeting

Microsoft Teams

24 September 2020 10:30 - 24 September 2020 13:30

INDEX

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 24 September 2020
Venue: Virtual
Time: 11:00 – 13:30

Service User Story 10:30 – 11:00am				
A G E N D A				
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**
1.	**Welcome and Apologies for Absence:**	Chair		
2.	**Declarations of Interest**	Chair	**Note/Action**	Attached
3.	**Minutes of Meeting held on 30 July 2020**	Chair	**Approve**	Attached
4.	**Matters Arising Schedule**	Chair	**Review & Update**	Attached
5.	**CEO Brief**	Tom Cahill	**Receive**	Attached
6.	**Chair's Brief**	Chair	**Receive**	Verbal
QUALITY & PATIENT SAFETY				
7.	**Report of the Integrated Governance Committee – 19 August 2020**	Sarah Betteley	**Receive**	Attached
8.	**Integrated Safety Report: Quarter 1 2020/21**	Dr Jane Padmore	**Receive**	Attached
9	**Safer Staffing Report: Quarter 1 2020/21**	Dr Jane Padmore	**Receive**	Attached
10.	**Guardian of Safe Working: Quarter 1 2020/21**	Dr Asif Zia	**Receive**	Attached
11.	**Annual Quality Assurance for Responsible Officer and Revalidation 2019/2020**	Dr Asif Zia	**Receive**	Attached
OPERATIONAL & PERFORMANCE				
12.	**Report of the Finance & Investment Committee – 18 August 2020**	David Atkinson	**Receive**	Attached
13.	**Report of the Audit Committee – 15 September 2020**	Catherine Dugmore	**Receive**	Attached
14.	**Finance Report: Period to End August 2020**	Paul Ronald	**Receive**	Attached
15.	**NHS People's Plan**	Ann Corbyn	**Receive**	Attached

16.	**Equality and Diversity** **a) WRES and WDES Annual Report** **b) Public Sector Equality Duty (PSED) compliance and Equality Delivery System 2**	Ann Corbyn Dr Jane Padmore	**Approve** **Receive**	Attached Attached
17.	**Winter Planning/Covid Surge Planning and Phase III**	**Dr Jane Padmore & Sandra Brookes**	**Receive**	**Attached**
18.	**Business Case – Safety Suites**	Paul Ronald	**Approve**	Attached
GOVERNANCE & REGULATORY				
19.	**Board Assurance Framework**	Helen Edmondson	**Assurance**	Attached
20.	**Well Led Review**	Chair	**Assurance**	Attached
STRATEGY				
21.	**Mental Health and Learning Disability ICP Update**	Karen Taylor	**Receive**	Attached
22.	**Any Other Business**	Chair		
23.	**QUESTIONS FROM THE PUBLIC**	Chair		
Date and Time of Next Public Meeting: Thursday 22 October 2020, 11.00 – 13.30,				

ACTIONS REQUIRED

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

Chair: Chris Lawrence

Declarations of Interest Register

Board of Directors

24 September 2020

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

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

Minutes of the PUBLIC Board of Directors Meeting
Thursday 30 July 2020
VIRTUAL

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Sarah Betteley | SBe	Non-Executive Director & Deputy Chair
Tanya Barron | TBa	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
Janet Paraskeva | JPa	Non-Executive Director
Catherine Dugmore | CD	Non-Executive Director
Loyola Weeks | LW	Non-Executive Director
David Atkinson | DA	Non-Executive Director
DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Keith Loveman | KL	Director, Finance
Ann Corbyn | AC	Director of People & Organisational Development
Karen Taylor | KT	Director, Strategy and Integration
Dr Asif Zia | AZ	Director, Quality & Medical Leadership
Paul Ronald | PR	Director of Operational Finance
IN ATTENDANCE	
Kathryn Wickham	PA to Chair & Company Secretary (Minute Taker)
Jacky Vincent (JV)	Deputy Director of Nursing & Quality & DIPC
Sarita Dent | SD	Associate Non-Executive Director
Rakesh Magon | RM	Clinical Director East &North SBU
Jo Farrow | JF	Clinical Director, West SBU
Anne Hunt | AH	Nurse Consultant for Physical Health (Agenda Item 7c)
Dr James Sutcliffe | JS	GP Specialist Trainee (Agenda Item 7c)
APOLOGIES	
Dr Jane Padmore | JPad	Director, Quality and Safety
Chris Lawrence | CL	Chair
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
MEMBERS OF THE PUBLIC	
Richard Woolsey | RW	Mental Health Senior Oversight & Support Manager NHS England and NHS Improvement - East of England
Alison Castilow	Member of the Public – attended for Public Questions section only

Item	Subject	Action
051/20	**Welcome and Apologies for Absence** SBe welcomed all to the meeting. Apologies for absence were received from Dr Jane Padmore, Chris Lawrence and Helen Edmondson.	
052/20	**Declarations of Interest** The Declarations of Interest Register was noted. No conflicts of interest were noted for items on the agenda. **NOTED**	
053/20	**Minutes of Meetings held on:** **27 February 2020**	

	19 June 2020 **APPROVE** **The Board APPROVED the minutes**	
054/20	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
055/20	**CEO Brief** TC presented the CEO Brief to the Board which was taken as read. Key headlines to note were: **National update** **Covid-19** Nationally we remain at incident level 4 and level 3 alert in the UK. We remain vigilant and preparing for any future outbreaks. **Pay rise for Public Sector Workers** TC reported that we would look at this and keep Board members briefed. **Review of NHS Structures** TC commented on the review of the NHS structure noting we are likely to see some legislation changes from the Autumn. **£3 Billion Funding** The Government announced an additional £3 billion for supporting the NHS through Covid and winter pressures. Detail of specific allocation was not yet clear however we would work to understand the impact on mental health and learning disability services. **National Announcement of Capital** There had been a recent announcement by the Government regarding capital investment into the NHS however there are concerns in relation to post Covid recovery and winter flu capacity, particularly concern for acute Trusts. **Flu** This would be a priority for the Trust with an expectation that all staff would receive a vaccination. **Regional and System update** **Herts & West Essex Integrated Care System** The ICS continued to develop with Dr Jane Halpin, Chief Executive beginning the process of appointing members to the joint Executive Team. **Mental Health and Learning Disability (MH&LD) ICP** The MH&LD ICP was back up and running following suspension during Covid-19. Beverley Flowers, Director of System Transformation and Integration of the ICS, had agreed to co-chair the ICP. **Provider Leadership** Clare Hawkins, Chief Executive of Hertfordshire Community NHS Trust had recently announced she would be leaving in the autumn. It was understood that	

	the Trust would seek to appoint an interim Chief Executive to take the Trust forward over the next 12-18 months. **East of England (EOE) Provider Collaborative – New Care Models** The Provider Collaborative was now up and running having been paused from mid-March due to the Covid outbreak. TC reported that this was a really important piece of work. **Trust-wide update** **Covid-19: Incident Management** We continued to manage the response to the incident and were still operating the command structure set out in our Business Continuity plan with key focus on Infection Prevention and Control, including outbreak management, restoring our services back up to pre-Covid 19 levels and risk assessments for BAME and other high risk staff. **Finance update** The position for month 3 continued to report as breakeven as required under the current arrangements. **Operational Services** Performance remained strong across the services with restoration of services continuing to be a key priority. It was, without doubt, a very busy time with increased demand and acuity and lots of new referrals into all services. **Our People** The wellbeing of our staff remains vital to the success of the Trust and we continued to offer psychological and emotional support. Our staff are fatigued with TC noting there was a possibility of us seeing a re-emergence of Covid cases. **Quality** The Trust had undertaken an engagement call with the Care Quality Commission to discuss our IPC arrangements which had gained a very positive outcome. The Health & Safety Executive had formally closed the HSE measures confirming satisfactory completion of the actions taken by the Trust. **Governance** In line with national guidance and the decision at last month's Board, the Covid-19 Board Assurance sub-committee held its last meeting on 9 July 2020. It was also agreed for the IGC and FIC committees to re-start their next meetings in mid-August 2020. TC concluded his update advising the recruitment process for the Chair and NEDs had restarted. Interviews for the Chair post would be held on the 7 September and the NEDs shortly after. TC invited questions. LW commented on the financial impact of the ICS, ICP and 3 CCGs querying whether our management costs would be higher than last year. TC commented that the new governance structure would cost more and noted that it was not clear on the journey for the 3 CCGs as yet.	

	TBa raised the BAME acronym referring to comments she had heard about people not liking it. TC thanked TBa for raising and reporting that the Trust had an active BAME network however this was not something we had heard but would certainly raise. TC further reported that all Exec Director objectives would now include an inclusion & diversity objective by September; this would then be rolled out to all staff by the end of the year. SBe questioned whether this would include reverse mentoring with TC confirming that it would. **RECEIVED** **The Board RECEIVED the CEO Update**	
	QUALITY & PATIENT SAFETY	
056/20	**Report from Board Assurance Sub-Committee Covid19 meeting held 9 July 20** SBe provided Board members with an overview from the work of the Committee at its last meeting held on the 9 July 2020. This was the last meeting of the Board Assurance Sub-Committee as we now returned to our regular governance structure. From an assurance point of view the committee had worked well with members receiving the appropriate assurance. **RECEIVED** **The Board RECEIVED the report**	
057/20	**Covid19** **Incident Management and running of service** JV presented the report. Of particular note to the Board were the below three points: ***Point 2.6 Currently we have no Covid-positive or Covid-suspected cases on our wards*** JV updated that as of yesterday (29 July) there had been a suspected case with precautionary measures put into place. ***Point 2.9 There is recognised legal complexity regarding the use of the Mental Health Act, the Mental Capacity Act and the Corona Virus Act for ensuring compliance with infection prevention & control measures. Guidance and support has been shared so that teams are supported in their decision making and the legal decision making is documented appropriately*** JV advised that CPAC continued with the above on-going challenges ***Point 2.18 Key themes are emerging from the risk assessment process including: worry about passing Covid-19 on to vulnerable people living in their household or to those they cared for, and the inability to continue caring responsibilities if they were to become unwell. Addressing staff concerns by allowing staff to work from home and to follow Trust and Government guidance is an important part of the Trust response to reduce the risk of transmission and infection*** JV highlighted these key themes to the Board which were taken from the Risk Assessments. **CQC Board Assurance IPC Inspection** JV presented the report which updated the Board on the outcome of the CQC	

	IPC board assurance discussion. Overall the result was positive with the CQC particularly noting the strong lines of 2nd and 3rd assurance within the BAF along with the work we had undertaken in developing the 'Elizabeth Court' response team and upskilling of staff the team had been able to deliver. The interview looked at 11 domains and the Trust had passed them all. LW recorded a direct thank you to JV for her hard work with SBe acknowledging the complimentary comments from the CQC. **Managing our services and restoration** KT provided the Board with an update on the Shaping our Future programme of work and an update on Phase III national planning. Points for the Boards attention were: **Restoring our Services** Although demand was beginning to increase it continued to vary by service with some at 100% but generally seeing 80% of pre-Covid levels. Acuity and complexity rates were high, however good progress had been made overall. Of note were IAPT where demand still remained low, however performance metrics were generally positive. EMDASS was the other key area of focus for the Trust with service users having to wait to be seen as a result of us pausing the service to new referrals for a short period during the Covid outbreak reflecting the vulnerability of the service users accessing this service. Plans were in place to address the backlog. CAMHS (Child and Adolescent Mental Health Services) had now returned to pre-covid capacity levels however demand remained low and we had been working with partners across the system to plan for the anticipated surge in referrals in the Autumn following the opening of schools. **Running our Services** KT reported that largely it was business as usual with plans in place for a possible future surge. **Reshaping our services** There were 4 major service evaluation pieces of work to be undertaken over the next 5 weeks. These were for: • A&E Diversion hubs • 24/7 helpline • Staff helpline • Use of technology – virtual delivery of care Our clinically/professionally led 'Reshaping our Service' Programme was also well underway. **National Planning & Regional Submission** We had now made several planning submissions with the latest on the 14 July 2020 to NHSE/I. This built on previous submissions we had made as an organisation and included planning assumptions asked to be modelled by NHSE. KT invited questions.	

	DA queried the additional resource being used to address the EMDASS backlog with KT confirming we had the resource to carry this out. TBa reflected on the low demand for CAMHS questioning whether schools were our main referrer. SBr responded stating that the decline was down to Covid however schools did play a big part along with GPs. KT added that lots of work was being undertaken nationally to look at this. **CPAC presentation** AZ introduced Anne Hunt (AH) Nurse Consultant for Physical Health and Dr James Sutcliffe (JS) GP Specialist Trainee, who had joined the Trust 6 months before the pandemic broke. AH and JS provided the Board with an informative and interesting presentation on CPAC and invited questions. LW recorded a formal thank you to AH and JS for their work noting they had been a pleasure to work with. JV echoed these words. KL commented that CPAC had provided significant assurance in supporting decision making, particularly for non-clinicians. **RECEIVED** **The Board RECEIVED the updates**	
058/20	**Patient Safety** JV advised the report provided the Board with a summary of the work which had been undertaken in the early stages of the pandemic. The report was taken as read. Key points highlighted to the Board were: Anne Hunt had led the review of Lambourn Grove. Additional staff with physical health experience who had been upskilled to work in Elizabeth Court were redeployed to support both units. Guidance had changed frequently over the period providing many challenges. In conclusion, the rapid review led to immediate changes and strengthening of practice as well as identifying good practice. As the pandemic had progressed and the services moved into new ways of working the lessons and good practice were being embedded across older adult services. AZ highlighted that it was important to note that more service users recovered on the unit than died. **RECEIVED** **The Board RECEIVED the report**	
059/20	**Trust Risk Register** JV briefed Board members on the current and emerging risks on the Trust Risk Register (TRR). JV highlighted the below points: There was one new risk to the TRR and 4 Risks to be considered for a reduction in score (full details within the paper).	

	A deep dive would be undertaken to assess the two workforce risks to review their current position. TC asked Board members if they felt assured and comfortable with the register and whether it reflected our activity and key issues. SBe acknowledged stating a thorough analysis of each risk was undertaken by the Integrated Governance Committee at each of its meetings with CD echoing this and commenting on the dynamic nature of our Risk Registers. It was agreed for the workforce risks to be addressed at the IGC in August. A request was made for more explicit clarity around the wording 'reduce likelihood'. CD raised the EU Exit commenting she felt it would be timely for us to start thinking about this again. KL acknowledged advising we would need to review what the risks now were and he intention is to bring back as a newly stated risk. **RECEIVED** **The Board RECEIVED the report**	
060/20	**Research Strategy** AZ introduced the item referencing page 137 of the overall pack which provided Board members with a slide deck which outlined the current context, overarching aims and objectives and the delivery plan by each workstream. AZ invited questions. SBe commented that it was helpful to see the depth of detail in the research skills. DA stated this was an important part of our work and we should think about measuring its performance. KT commented that she endorsed the Strategy and acknowledged the benefits it brought to the Trust. **RECEIVED** **The Board RECEIVED the report**	
061/20	**Quality Report 2020/21** JV presented the item advising Board members that this had been discussed in detail and approved at the Board Assurance Committee at its meeting held on the 9 July 2020. The report was taken as read. KL highlighted that as a Trust we had not been required to have a full report; however as an 'outstanding' organisation we had taken the decision to still do. All in attendance approved the 2020/21 Quality Report. **APPROVED** **The Board APPROVED the Quality Accounts 2020/21**	
062/20	**Annual Report Health, Safety and Security Compliance Report 2019/20** JV presented reporting that the paper provided the Board with detail of the health, safety and security incidents, the actions that had been taken, the assurance given and the priorities for the coming year. The report had been	

	presented previously at the Board Assurance Committee and was taken as read. Of note in the report was that the year had seen an increase in the number of service user to staff violence and aggression incidents with plans in place for increased focus on this. JV concluded stating that our on-going journey of learning remained important and invited questions. TC commented on lone workers with a request for this to be reviewed through the Integrated Governance Committee. KL acknowledged sharing that the Executive Team had discussed this at their last meeting with a piece of work to be taken forward. **RECEIVED** **The Board RECEIVED the report**	
	OPERATIONAL & PERFORMANCE	
063/20	**Quarter 1 Performance Report** KL presented the report which informed the Board about the Trust's performance against both the NHS Oversight Framework (NHSOF) targets and the Trust Key Performance Indicators for Quarter 1 2020/21. It was of note that Quarter 1 would not be comparable to previous quarters due to the Covid outbreak; however the vast majority of metrics remained strong with no significant reduction in performance. KL continued that there had been a dip in demand during June however activity had remained high with staff busy across the quarter and access times not particularly impacted. Two areas which required focus were out of area placements and access rates. From July and going forward we would see real pressure coming through. KL invited questions. TBa queried what we had done in terms of re-setting levels of working for staff with KL advising that each key service area had a task and finish group to look at managing demand and activity. SBe queried the issue of out of area placements asking what plans there were to keep this under review. KL advised that alongside senior clinical input Dr Jo Farrow was leading some workshops on the lessons learnt. AZ added that strengthening our gate keeping had been key along with a handover each Monday. Our commissioners had been assured that we did not have gaps with our beds. **RECEIVED** **The Board RECEIVED the report**	
064/20	**Quarter 1 Workforce Report** AC presented the Quarter 1 Workforce report.	

	The below points were of note to the Board. Recruitment and Retention activity had continued throughout the Covid period with progress being made against our targets. The Trust vacancy rate at the end of Q1 was 11.55% (against a target of 10.5%). The pandemic had also had a positive impact on retention, with reduced numbers of people leaving the Trust. We ended the first quarter with an unplanned turnover rate of 9.1% compared to the rate of 10% at the end of Q4 and against a target of 9%. IPC focus had seen a significant decrease in staff being off with coughs, colds and gastrointestinal problems. Sickness absence was at 5% against a target of 4%. The Just & Learning Culture was showing a post impact on training. The BAME work had been given real focus with this year staff having a BAME objective, including reverse mentoring. We were able to maintain the Leadership Development activity this quarter and completed the latest cohorts of the Mary Seacole Programme and Cohort 10 of the Leadership Academy with a continued focus on development. An on-line programme had been developed for Team Leaders. Q1 had seen the launch of the new Employee Assistance Programme service and Occupational Health provider. Early reflection was both had been received well. Mandatory and Statutory training compliance had dropped slightly in the quarter with a full recovery plan in place to bring this back on track, including a review of essential face to face training, The trajectory will ensure that the Trust was back to compliance by the end of 2020. Key was that we had learnt lessons over this period and were able to further improve our employee experience. AC invited questions. JV highlighted the 56 nurses we had recruited who had joined us through the pandemic. DH queried if there were any other people related learning with AC noting that this was generally focused around co-productivity solutions which had really stood out. JPa referenced the appraisals and how we could really make the best use of these. AC advised that we had a real opportunity now to build on where teams felt a belonging to a collective team and having conversation led appraisals with their line manager. The new appraisals would be developed in conjunction with Team Leaders and the Senior Leadership Team. KT added that it was pleasing to hear about the initiatives in the report, new roles and ways of working along with the use of technology. We should now build on what we've done and push ourselves a stretch further.	

	RECEIVED **The Board RECEIVED the report**	
065/20	**Quarter 1 Finance Report** PR provided the Board with a broad overview of the Trusts financial picture advising the report set out the financial position to 30 June 2020 under the exceptional financial arrangements. The current financial arrangements which ensured the Trust achieved financial balance would now be extended beyond the first four month period to month five/six of the year. It was less clear on the detail of the changes which would be made from September or October onwards as NHSE/I looked to bring in more certainty and grip to the system. To date the Trust had performed strongly with no requirement for extra income beyond COVID-19 reimbursement. It was of note that our level of reimbursement had been below the regional average. Going forwards there were clear risks in terms of the level of demand and its complexity, with the requirement for specialist CAMHS inpatient beds and continued demand for Adult Acute and PICU beds. **The Board RECEIVED the report**	
066/20	**Annual Plan 2020/21** KT presented an updated Annual Plan 2020-21 which required approval by the Trust Board. The plan outlined the commitments we were making for the remainder of 2020-21, taking into consideration the impact and changes required as a consequence of COVID19. KT drew the Board members attention to page 2 of the summary (overall page 339 of the pack) which outlined the main changes and updates to the Trusts strategic objectives. KT reported that this was a strong plan reflecting the Trusts ambitions with KL acknowledging and advising the plan had no significant change to that which we had initially set out. The Trust Board were asked to note the changes made to the Annual Plan and provide approval. All in attendance approved. **APPROVED** **The Board APPROVED the Annual Plan 2020/21**	
	STRATEGY	
067/20	**Mental Health & Learning Disability ICP** KT provided the Board with a brief update on the developments for the vision, guiding principles and priorities. The guiding principles describe the role the ICP which would take across the system and the focus it would bring on the 4 key principals. In terms of priorities the MHLD ICP had identified a number of key priority areas with a programme plan now being developed to underpin the work on these areas: • CAMHS • Learning Disabilities • Alcohol and Substance Misuse • Autism	

	• Dementia • Crisis • Primary Mental Health KT concluded stating the remainder of 2020-21 would see the Partnership begin to establish itself more formally. HPFT continued to play a significant and leading role in the establishment and development of the ICP. KT invited questions. TBa referred to page 355 of the pack referencing the work of the volunteer sector and commenting that it was good to see inclusion of the Herts mental health and learning disability teams. KT acknowledged stating that each of the priority areas had a link to ensure all partners were linked in. These organisations would also be included in the Partnership Board and Assembly. LW raised co-production with 3rd sector partners with KT stating this was currently a topic under debate but would ensure representation of all priority groups. **RECEIVED** **The Board RECEIVED the report**	
	GOVERNANCE & REGULATORY	
069/20	**Governance review** KL presented the report which set out the interim governance arrangements that were in place from April to end of July 2020 during the Covid-19 pandemic. The report also provided the outcome of the review of the interim governance arrangements and the next steps with regard to corporate governance arrangements. KL drew the Boards attention to the two main recommendations. 1. To stand down the interim governance arrangements implemented during the Covid19 pandemic noting the Board Assurance Sub Committee COVID-19) which had been established to provide the Board of Directors with assurance during this phase had now held its last meeting. The workforce and organisational development group had be revamped with a new title of People & Organisational Development group (PODG), providing increased structure to the group. 2. Learning from Covid19. KL reflected that his phase had provided an opportunity to try a different approach. This included best practice and reflecting on what could be put in place for the longer term with regard to use of digital solutions and streamlining of governance. CD re-affirmed the usefulness of the Board Assurance Committee stating it had worked well and welcomed the governance review. The Board were asked to receive the report and note the interim corporate governance arrangements, agree the recommendation to cease interim corporate governance arrangements and support the governance review being undertaken. **RECEIVED/APPROVED** **The Board RECEIVED the report and APPROVED the recommendation to**	

	cease the interim governance arrangements, reinstating the full framework from August.	
070/20	**Mental Health Act Managers Annual Report** LW advised the Board this annual report was required by the Terms of Reference of the MHAM Committee meeting to inform the Board about MHAM activity and was for information only. There were currently 43 active MHAM covering our sites in Hertfordshire, Norfolk, North Essex and Buckinghamshire with LW commenting on their good work and noting they were not employees of the Trust There has been no significant change in the figures for 2019/20 since last year; however the number of discharges from section in 2019/20 rose to 5 from 3 in 2018/19. LW highlighted to the Board the recent changes which had been put in place due to the Covid pandemic advising these had only been used in emergency situations. LW concluded the update commenting this was an opportunity for the Board to record a thank you to Tina Kavanagh and her team for their work, along with Hattie Llewelyn Davies, manager of the MHAM. TBa recorded a thank you to LW for her work as Lead NED for the MHAM. KL commented on the MHAM Annual Conference which stood as a thank you to the managers for their work observing that we would need to look at how we took this forward during Covid. **RECEIVED** **The Board RECEIVED the report**	
071/20	**AOB** SBe noted that his was SD last public Board in her tenure as Associate Non-Executive Director and recorded a formal thank you for her contribution to the Trust. No further business was put forward.	
072/20	**Questions from the Public** A question was put forward by a member of the public in relation to services within the Trust. TC acknowledged this on behalf of the Board and agreed to pick up outside of the meeting. No further questions were put forward.	
071/20	**Date of Next Meeting** The next meeting is scheduled for 24 September 2020 (no meeting to be held in August)	

Close of Meeting

Agenda Item 4

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 24 September 2020

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
27/02/20	**031/20**	Quarter 3 Performance Report	Crisis pathway review update to a future Board	This has been added to the Board Planner for presentation at a future meeting as part of the wider transformation programme update.	SBr	November 2020	G
27/02/20	**024/20**	CEO Update	Paper for the Board on Accreditation for them to understand why we were accredited and what this meant for the Trust	Update on accreditations to be taken to IGC as part of a discussion regarding assurance regime	AZ	November 2020	G
27/02/20	**024/20**	CEO Update	Results of the Community Service workshops to be shared at a future Board	Feedback from community workshops to be included in report on 2020 community survey	SBr	November 2020	A

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 5
Subject:	CEO Briefing	
Presented by:	Tom Cahill, CEO	

National update

Clearly there is currently a lot of activity nationally which are summarised below under three main headings.

Covid update
Nationally we are seeing an increase in confirmed Covid cases, as well as certain areas being subject to specific lockdown arrangements. This is likely to lead to increased preparations for the anticipated second wave. The national picture of limited access to testing is mirrored locally with delays in staff and communities getting access to a test. Alongside planning for winter preparations are underway for a second wave of cases.

Prioritisation and Preparations for winter
Also Covid-19 the NHS is organising and preparing for increased pressure in winter. Organisations and systems are expected to develop their winter plans to help manage any expected surge. The staff flu vaccination programme throughout the NHs is expected to commence in October and this year it is anticipated that there will be much more uptake of the flu vaccine.

EU Exit
The government has recently confirmed that the transition period will cease as planned on 31 December 2020 and there will be no extension. Kevin Willetts has resumed the role as EU Exit SRO (along with Strategic Incident Director for COVID-19). EU Exit will be managed alongside the ongoing COVID-19 response and restoration of services, through established national and regional incident coordination centres. Hakan Akozek, Chief Information Officer will be the Trust's "UK end of transition SRO". As a Trust we have already reconstituting our processes and reformulated the associated risks. It is expected central reporting centrally will soon recommence.

Regional and System update

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

East of England (EOE) Provider Collaborative – New Care Models
All clinical design areas are progress towards a submission of clinical models to Boards in October 2020. Service user feedback and consultation is an important and large part of the clinical modelling and input into each clinical model. CAMHS Tier 4 is focusing on alternatives to inpatient beds, reduction of length of stay and bringing young people brought back from the independent sector where appropriate. Forensics is concentrating on developing enhanced community provision; a smoother transition throughout the pathway and greater collaboration between providers. With regard to Eating Disorders the clinical case is built on alternative to hospital admission, an independent panel to adjudicate out of area placements and a complex decisions panel.

The Collaborative are working towards an April 2021 Business Case submission and "go live" date for delegated commissioning arrangements. The new timetable has recently been released by

NHSEI, includes a first milestone in November 2020 of a draft Collaborative application on clinical models, case for change and draft partnership agreement.

An independent review of the financial offer made by NHSEI has been undertaken by Deloitte the outcome of which has been fed back to Trust CEO and SROs, who are considering next steps.

Herts & West Essex Integrated Care System (ICS)

The ICS continues to develop, led by Paul Burstow Independent Chair. The HWE ICS (Inaugural) Partnership Board meeting had its first meeting in September where it discussed priorities for the ICS, the recovery plan, a workforce update and development of ICPs.

Dr Jane Halpin, Joint Chief Executive, West Essex and Hertfordshire CCGs and the Hertfordshire and West Essex Integrated Care System is finalising the appointment of members to the ICS/CCG joint Executive Team, with the last two posts of HR and performance being externally advertised. Dean Westcott has been confirmed as the Director of Capital Planning and Estates for our ICS.

In the near future there is a strong likelihood of legislation that will see ICSs having a significant role in the system by being the route by which the local NHS system is performance manged and by providing a system rather than organisational based focus.

Phase III Planning

The Trust submitted an updated plan on 1 September as part of the Herts & West Essex ICS system return made to NHSE/I, this built on our previous submissions made and which has been reviewed by the Trust Board. A final return to NHSI/E will be made on the 21 September. The previous planning assumptions are likely to remain the same but will need to be subject to the financial allocation we receive. At the time of writing this report the financial allocation has been received by the Herts and West Essex Integrated Care System, the allocation for mental health and learning disabilities and for HPFT is part of this and is under review.

As previously reported to the Trust Board our current financial plan allows for reimbursement of COVID related costs. The financial plan also supports the running of the 24/7 helpline and the access hubs in place in Hertfordshire, together with provision to fund additional specialist beds reflecting demand levels anticipated for the remainder of the year.

National transformation funding is required to deliver our plans and this is assumed to be forthcoming within our plan for crisis, community and IPS services. Funding related to Mental Health Investment Standards (EIP, perinatal, IAPT and Eating Disorders) is also required to support delivery of the plans for the remainder of the year. As noted above, the financial allocation has now been received by the Integrated Care System, and the financial allocation for HPFT is contained within this. We are currently working to review and understand the allocation and what this may mean for the remainder of the year and impact on our plans.

Mental Health and Learning Disability (MH&LD) ICP

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

ICPs
Locally the ICPs for East and North Hertfordshire and West Hertfordshire are established and gathering significant momentum. East and North Herts ICP have appointed Sam Tappenden as the Development Director and he is leading the ICP's Development Plan

Local Leadership
Recently Herts Community Trust announced that Clare Hawkins, Chief Executive, would be leaving in the autumn and Elliot Howard-Jones has been appointed as interim Chief Executive. Elliot will be starting in post at the beginning of November 2020 and we look forward to working with him.

Trust-wide update

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

Winter Planning and Covid Update
We are finalising the winter plan which incorporates our response to any future Covid surges and winter pressures. Key actions being implemented to ensure that there we are providing adequate support to staff and service users and maintaining our ability to provide services.

We are working with system partners to ensure we can respond to any potential Covid surge and anticipated increase in mental health need. We have also made bids for winter funding to support discharge to assess, floating support and additional acute beds. We continue to offer 24/7 mental health helpline and ensure A&E divert centres are available to support the system. A report later on the agenda will provide a detailed update on Trust winter planning and planning for the anticipated Covid surge.

Winter Planning - Flu Planning
Our plans for providing all staff with their flu vaccinations are progressing well. We have over 100 clinics taking place across our geographies during October and November and we will also continue to provide informal vaccination opportunities for staff in their units and bases, including evenings and weekends. Our new innovation this year is an online booking system where staff can directly book an appointment in the flu clinic at a time and place that suits them, as of 16 September 872 staff had booked their vaccination. We have over 70 peer vaccinators supporting this year's campaign working alongside our new Occupational Health provider. We also have the ability for our staff to administer the vaccine to over 65's and pregnant women, something that was not in place last year. Our aim is to continue to increase the numbers of staff having their flu vaccination. With regard to service users we have upgraded our policy so that the flu vaccination is offered to them directly instead of being provided by primary care thereby ensuring more comprehensive coverage.

Operational Services

All our services are up and running and are fully restored. Performance remains strong across the services, particularly with regard to access and crisis services. Referrals into all services have increased and are now back to the same levels as this time last year and we are also seeing an increase in the acuity and complexity of referrals. Pressure on acute adult beds has continued to rise with a high number of s136 detentions, and admissions. EMDASS has been restored, the recovery plan is on target and all service users are being seen in 12 weeks.

All services are working to increase the number of face to face contacts and working with service users to agree on what is the most appropriate type of contact for them. Our Learning Disabilities services carried out a survey with service users to capture their experience of using virtual platforms or the telephone during the Covid period. The results were of a high preference for face to face

contacts. We are continuing to provide the 24/7 helpline and evaluating the impact of the A&E Divert Centres which were set up in the early stages of the pandemic.

IAPT have extended their digital options to expand the offer to meet demand to cover identified areas of concern such as returning to school and work. CAMHS are working with system partners to prepare for a potential increase in referrals as the schools return. This includes maintaining the school helpline, putting additional support into schools, providing support networks during the school holidays for students and ensuring effective triage at the "front door" of services to ensure a swift response to referrals.

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

The pressure on local health services is currently high. In particular ambulance, NHS 111 and accident and emergency department are experiencing high levels of demand. We are working as part of the system to support partners but also prepare for the expected increased demand for mental health services.

Our People

Nationally, the NHS People Plan was published on 30 July 2020; it outlines the actions that as an organisation we need to take, but also that staff themselves, and organisations such as NHSE/I and the wider NHS Systems will need to take in the coming months. A report later on the agenda details the Plan and the Trust's approach

Recruitment and Retention

The pandemic had had a positive impact on our retention, with reduced numbers of people leaving the Trust. We ended the first quarter with an unplanned turnover rate of 9.1% compared to the rate of 10% at the end of Q4 and against a target of 9%. We have continued to see these trends during July, with our vacancy rate at 11.12% and our unplanned turnover rate at 8.8%. We are particularly pleased to have secured almost all of our student nurses, who are opting to remain with HPFT – out of the cohort of 56, only 1 chose to leave at the end of their placement, and that was because they were moving home to Scotland.

Sickness Absence

The sickness absence figure for Q1 average was 5%, which was significantly elevated by the high levels of Covid19 related absence in April. The monthly figure for May was 4.79% and for June was lower again at 4.28%; in July we recorded only 3.7% sickness absence. A review of the numbers of episodes of the major sickness absence reasons has shown a significant drop of the number of episodes of colds and coughs and gastrointestinal illness as a reason for absence. This is almost certainly due to the enhanced IPC protocols at the work place and at home.

Just and Learning Culture

Our review of the WRES data for both the disciplinary process and recruitment process shows a significant reduction in the bias to non BAME staff in terms of both disciplinary processes and recruitment outcomes. This indicates a real change in the experience of staff but we are developing a more targeted short, medium and long term action plan to ensure that our employee experience is consistent, regardless of ethnicity or any other characteristic. The report later on the agenda details the WRES and WDES data.

Staff Awards Ceremony

Due to the current COVID restrictions, this year it will not be possible to hold a traditional awards ceremony as we have in previous years. We are committed to celebrating the hard work and achievements of our staff, albeit in a different way this year and it is also a great opportunity to recognise the efforts of all staff and the part everyone played in the Trust's response to the COVID-19 pandemic. The event will be a mixture of virtual and recordings and will take place on 2 December 2020.

Quality

There is an increased focus on getting momentum behind physical health clinics to ensure that the checks are taking place across all the services in a consistent way. A new model of delivery for physical checks is being proposed that is based on collaboration with primary care and looks to ensure checks are completed for all services users with severe mental health illness and those risk assessed Red or Amber as part of the pandemic.

The CPAC continues to meet and has recently agreed new guidance with regard to having face to face contact with service users, in a Covid safe way. This includes the screening and cohorting of service users as well as the continuation of video consultations.

The Trust marked the World Suicide Prevention Day on 10 September 2020 by holding a conference. The conference was held virtually and was attended by over 200 people, it included inspirational speakers giving heartfelt presentations, many based in very personal experience. Recordings of the speakers are also available on The Hive for those who were not able to attend.

A new process for Quality Assurance visits has been agreed. These visits are a vital source of information and will be triangulated with CCG visits and MHA visits to provide the Trust with an invaluable source of information on quality and safety at the Trust.

We have recently been informed by the Nursing and Midwifery Council (NMC) that the Trust's approach to ensuring the disciplinary process is fair and does not involve discrimination by having decision making panel will be used by them an example of good practice. This is very welcome news as we continue to work to reduce discrimination within the Trust.

Finance update

The Trust has achieved an overall break-even position for August and year to date. COVID-19 reimbursement has remained high at £1.3m, which is higher than expected due to several backdated amounts being claimed. The current financial arrangements which ensure that the Trust achieves financial balance have been extended for the first six months of the year. Changes are to be made from October onwards as NHSE/I seek to bring in more certainty and grip to the system, at the time of writing notification of expected values has just been received and is being worked through.

To date the Trust has performed strongly; there has been no requirement for extra income beyond COVID-19 reimbursement, with the level of this reimbursement below the regional average. There is a detailed paper later on the agenda will provide an opportunity for detailed discussion including the identified risks and plans in place to mitigate them.

Governance

We have restarted the Independent Well Led Review process with Deloitte, a paper later on the agenda outlines the proposed process and associated timelines.

Following cessation of interim corporate governance arrangements the Integrated Governance Committee and Finance and Investment Committee held meetings in August 2020 and the Audit Committee met earlier this month. Detailed papers on the business discussed at the Committee's will be considered later on the agenda.

At the Council of Governors meeting held on 10 September changes to the Constitution were agreed in line with previous discussion at the Board.

Tom Cahill
Chief Executive

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item: 7**
Subject:	Integrated Governance Committee Report 19 August 2020	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Sarah Betteley, Non-Executive Director, Committee Chair
Presented by:	Sarah Betteley, Non-Executive Director, Committee Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting held on the 18 August 2020.

Action required:

The Board is asked to receive and note the report.

Summary and recommendations to the Board:

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

The Board is asked to note that this is the first meeting of the IGC since April 2020, following the cessation of interim corporate governance arrangements.

Recommendation:

To receive and note the report and to note that there is one item in relation to HSE regulatory notice to be formally escalated.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Financial, IT, Staffing and Legal Implications:

None.

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

The Committee regularly receives updates from the Equality, Diversity and Inclusion Group.

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

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

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

None.

Introduction

1.1 The latest Integrated Governance Committee (IGC) was held on the 19 August 2020 in accordance with its terms of reference and was quorate.

1. **Reports were received from the IGC Sub Committees**

1.1 The Committee noted the minutes of the WODG meetings held on 20 January 2020 and 15 May 2020.

1.2 The IGC noted that there had been changes made to the WODG's Terms of Reference and it had been renamed to Peoples' and Organisational Development Group (PODG) The significant review means the group will be focusing on NHS People's Plan and Trust's own People's Plan and will provide assurance to the IGC regarding the whole People's agenda. The Committee noted the notes of the PODG meeting held on 4 August 2020. It was agreed that the PODG Terms of Reference would be received at the next IGC meeting.

In response to a question from Tanya Barron, Ann Corbyn confirmed that the work of the Trust was aligned with the work streams that were spanning the ICS and ICPs.

1.3 IM&T and Information Governance Programme Board meet on 23 March and 9 July 2020: The Committee received the report which detailed the main areas covered namely: Information Governance; Policy Changes and Compliance; management of the shared service relationship with HBLICT; and the major projects associated with delivery of the digital strategy.

2.4 QRMC had held two meetings in 2020 which were reported to the Committee. The January meeting had received a presentation from the LD&F SBU, including discussion regarding the increasing frail service users in SRS and what the SBU was doing to reduce violence and aggression.

At the March 202o meeting the East and North SBU presented the work they had done on the Transformation for Older Adults and the Transformation for CAMHS. It was reported Adult community teams have achieved accreditation and that a visit from CQC had picked up on a couple of points about Section 136. The IGC were updated with the plans for the PACE Clinical annual audit programme to be approved and ratified at QRMC; and the reporting on the quality element of CQUIN goals also to be brought to QRMC each quarter.

In response to Loyola Week's question Asif Zia confirmed that QRMC had significant involvement from service user and carer representatives. Tanya Barron sought an update on the position with The Mount contract. It was confirmed a new provider had been secured and HPFT would be likely to cover the service until March 2021.

2. **Governance and Regulation**

2.1 **Trust Risk Register**
IGC considered and approved the Trust Risk Register for August 2020, it was noted that it had been approved by the Trust Board following it being updated. It was noted that a new risk relating to finance had been added. The

Committee discussed the risks that had been downgraded. The Committee discussed the proposal to amend risks following a deep dive relating to the recruitment of staff and Trust's ability to retain staff.

Loyola Weeks raised a query regarding the removal of the EU exit risk, Keith Loveman clarified that the risk relating to EU Exit was being updated and would be added to the risk register following the next update.

With regard to MHA and the safeguarding, Jane Padmore advised the Committee that she had recently received a report that provided detail on the number of cases in quarter one. Review had identified some areas to be improved but was difficult to get comparative data.

2.2 **Head of Information Rights and Compliance Update.**

The Committee were provided with a quarter one report for assurance. The key areas discussed were the areas that had been stepped down during the peak of the pandemic, which allowed the Information Governance Team to be redeployed. Responding to Freedom of Information requests had been restored. Subject Access Requests had continued in the pandemic but there had been some delays. The Committee noted that there were no outstanding issues with the Information Commissioners Office, with regard to two breaches which had been reported and the ICO had indicated no further action was required.

The Trust had submitted the Data Security & Protection Toolkit, a regulatory requirement. It is anticipated that the Trust will receive an initial finding of "Standards Not Met, Action Plan Agreed" due to a dip in mandatory training compliance. The targets and process for 2020/21 have not been published. It was noted there were no significant risks to be escalated up to IGC.

2.3 **Health and Safety Contravention Notice Update.**

The Committee received an update on the Notice of Contravention (NOC) and 4 improvement notices received in May 2019. In response to the notices the Trust had provided evidence to the Health and Safety Executive (HSE) and hosted a second visit to Beech Ward. The Committee were informed that recently the HSE had written to the Trust formally to close the regulatory notices.

The Committee noted that violence and aggression towards staff is a priority in the Annual Plan.

3. **Workforce**

3.1 **NHS Peoples Plan**

The Committee received a reported that provided the key highlights from the recently published NHS Peoples Plan 2020/21. Ann Corbyn emphasised that the Plan had been heavily influenced by the experiences of the pandemic and sets out actions for employers and systems, alongside actions for the NHSE/I and HEE, in four key areas of focus.

Further work is underway to complete a full assessment of the implications for HPFT and this will be taken forward via the PODG. The Committee received

an update on the immediate actions underway including the alignment of the NHS People Plan to Trust's existing work and strategies. It was noted that the IGC would receive regular updates from the PODG.

In response to a question from Janet Paraskeva with regard to safeguards in place for training and qualifications, Jane Padmore advised that Trust has a competency framework in place for Healthcare Assistants as well as a pathway for our unregistered workforce to become registered. Ann Corbyn added that this is enhanced by significant involvement in developing the Herts Health and Care Academy.

4.2 Q1 Safer Staffing Report

It was reported that during the pandemic and in order to manage the increase in staff absence and to ensure safe staffing levels, the minimum staff levels were reviewed alongside the way nursing is delivered on the inpatient wards. New proposed minimum staffing levels were a temporary level and in fact were never enacted.

The report provided an update on the first quarter during which the number of registered nurses had not reduced; the three times daily SafeCare census check call had continued; there had been active redeployment of staff; an increase in bank shifts and induction of 56 new nurses. It was noted that the quarter two report would provide an update on the self-roster pilot. In response to Loyola Weeks' question recruitment was underway to target 'hot spots'.

3.2 **Q1 Guardian of Safe Working Report**

New Guardian of Safe Working Lead Dr Snehita Joshi presented the quarter one report and it was noted that a junior doctor would also attend the IGC for future meetings. It was reported that since September 2019 there had been no exemption reports from Junior Doctors.

It was noted that the report covered the period of the pandemic which had had a direct impact on the Junior Doctor workforce. They had stepped up to the challenge to deliver a safe rota. The report, which provided highlights, was considered by the Committee. It was noted that some doctors recruited from overseas were waiting as their visas could not be processed due to lockdown in their countries of origin.

In response to a question Asif Zia reported that the lack of exemption reports was a result of proactively engaging with Junior Doctors. It was noted that the Trust was one of the providers that scores highly in the independent Junior Doctors Feedback from GMC which is independently scored and independently evaluated.

4. **Quality Safety**

4.1 **Covid-19 Update**

The Committee were provided with a report on the Trust's response to Covid-19. It was noted that the Trust is moving into Phase III. The Committee heard that the Trust did not currently have and had not for a period of time had any

cases of Covid-19 in services and was operating a zero tolerance for any infections.

4.2 **Quarter 1: Integrated Safety Report**

The Committee received the quarter one report. The report provided assurance and the detail on the actions taken in response to safety related incidents. Key highlights were: the progress in regards to serious incident investigations; quarter two focus on the completion of SI Action Plans; rise in quarter 1 of domestic abuse; rapid reviews of Covid-19 deaths; decrease in the use of restrictive practice; high number of reports of assault on staff in Essex and IAPT SBU and very limited use of rapid tranquilisers; postponement of the formal launch of the MOSS together strategy due to the pandemic; decrease in falls. The Committee were updated with regards to a RIDDOR where a staff member was assaulted which resulted in severe harm.

4.3 Infection Prevention and Control Report

The Committee considered the report that provided detail of progress the Trust has made in relation to minimising the risks of healthcare associated infections including the actions within the 2020/21 Annual Infection Prevention and Control programme which will be prioritised in quarter two.

It was noted that the Infection Prevention and Control Team (IPCT) had agreed a number of actions such as: continued liaison with the PACE team in reviewing and enhancing current IPC audits and to develop additional IPC audits including a personal protective equipment audit; re commencing of cleaning audits; joint monthly meetings of clinical staff and Interserve; updating of all IPC policies in line with national guidance relating to Covid 19 and implement the “to dip or not to dip” campaign within older peoples services

4.4 Flu Plan

The Committee received the report for the Flu Programme for 20/21. It was noted that the CQUIN target for 2020-21 had increased to 90% of the frontline staff and the Trust was aiming for 100%. The report detailed the significant work that had been undertaken to ensure a comprehensive schedule of clinics a digital system for booking and significant increase in number of peer vaccinators. It was noted that the IGC would be receiving and approving the Board Assurance Framework for Flu at its meeting in November.

5. **Quality Effectiveness**

5.1 **Quarter 1 Continuous Quality Improvement Report**

The Committee received the quarter one report. During quarter one the CQI Team had been redeployed into key roles to support the Trust response to the COVID-19 Pandemic. At the end of quarter one the CQI Team returned to lead restoration and recovery initiatives starting with the development of new methods to assess whether to adopt, adapt or rollback new innovations that we implemented as part of the response to COVID-19.

It was noted that new virtual training programmes were developed in quarter one to build further CQI capacity in the organisation, early feedback is that greater digital enablement is making training more accessible whilst remaining

practical and comprehensive. Also following quarter one the innovation fund had been re-established.

6.3 CPAC Update

The report provided an outline of all the guidance reviewed since the last paper presented to Board Assurance Committee – Covid-19. It was noted that CPAC was still meeting, although the frequency was now monthly.

6.4 Pharmacy and Medicines Optimisation Annual Report

The Committee received the annual report that described the progress, initiatives and activities undertaken by the Pharmacy department and Trust colleagues to support the safe and effective use of medicines within HPFT across 2019/20. A key challenge for the Pharmacy department in 2019/20 had been ensuring continuity of medicine supplies in both inpatient settings and primary care with two key issues impacting the supply chain namely Brexit uncertainty and the Covid-19 pandemic.

The reported detailed that the Team had continued to improve the service user experience and safety through focussed changes and improvements in service delivery such as: Implementation of a Pharmacist led Medicines Optimisation clinic which has been shortlisted as a finalist for the 2020 HSJ Patient Safety Awards; Pharmacist led ADHD clinic; Health and Wellbeing Education Programme for Rehabilitation Service Users.

7. Quality Experience

7.1 Quarter 1 Service User and Carer Experience Update

The Committee noted there had been a pause in the complaints process in line with national guidance. Quarter one had also seen a reduction in the number of complaints as well as a dip in amount of feedback via Family and Friends Test and Having Your Say.

The Committee were updated on the planned CQI process for complaints and experience. It was noted that as part of the digital strategy the Trust would be looking at different ways to get feedback.

7.2 Operational Update

The Committee received the report that summarised the key operational issues from Trust Management Group. It was noted that performance remained strong although a “deep dive” into Delayed Transfers of Care (DTOCs) will be presented at the next TMG and work continues to improve flow throughout the Adult inpatient beds to reduce reliance on Out of Area Placements (OoAPs).

8 Recommendations

The Board is requested to receive and note the report and to note that there is one item in relation to HSE regulatory notice to be formally escalated.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item: 8**
Subject:	Quarter 1 2020/21 Integrated Safety Report	**For Publication: Yes**
Authors:	Nikki Willmott Head of Safer Care & Standards Andrew Cashmore Practice Development and Patient Safety Lead Ingrid Richardson Interim Head of Social Work and Safeguarding	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Dr Jane Padmore, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

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

Action required:

Receive: To discuss in the integrated Safety report and its implications for HPFT.

Summary and recommendations:

The Board is asked to receive and discuss the Quarter 1 Integrated Safety report and its implications. The COVID-19 pandemic has had an impact with the Trust responding swiftly to risks that emerged in relation to higher acuity on in patient wards and increases in physical health needs.

This quarter saw:

- Increase in death overall but a reduction in deaths through to be through suicide.
- Good progress in ensuring root cause analysis investigations are completed on time.
- Reduction in ligature incidents in the in-patient services but an increase in the home environment.
- An increase in head banging and work undertaken to manage this.
- The reduced number of AWOLs maintained.
- Service user to staff violence and aggression has remained at a consistent level and to service user has reduced after a sharp increase in the previous quarter.
- Restrictive practice has been used slightly less frequently but there has been an increase in the use of seclusion, primarily in relation to higher acuity in the in patient services and frustration in response to the nation lockdown.
- Increased scrutiny and review of long term segregation has been put in place ensuring MDT review, good documentation and attention to individual's human rights.
- Safeguarding has maintained business as usual and responded to the changing needs during the pandemic. The National picture of an increase in domestic abuse reports was reflected in the Trust.
- Despite the added pressures of the pandemic safety has remained a key focus for the trust

which is evidenced by the data included in the report.

- Priorities for the coming period are:
  - The Annual plan and Quality Strategy priorities
  - Launch of MOSS Together
  -A review of restrictive practice in Essex and IAPT services where there has been high levels of violence and aggression towards staff, no use of rapid tranquilisation and long periods of seclusion.
  -Continue to maintain the recent improvements in the quality and timeliness of serious incident reports and reduce the number of overdue action plans.
  -Systematically join up and build on learning from serious incidents, triangulating with other intelligence such as complaints, Freedom to Speak Up and national safety notices.

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

Relation to the Trust Risk Register:

The Trust's Risk Register has a number of risks that relate specifically to safety which are reported in the quarterly Trust Risk Register Reports. Those below have a significant impact on safety and service user harm:

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

COVID 19: Increased harm or death of service users due to mental health related illness (Risk 1273)

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

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

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

S136: Unlawful detention of service users under S136 breaches beyond 24hrs (Risk 882)

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

Relation to the BAF:

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

2. We will deliver a great **experience** of our services, so that those who need to receive our support feel positively about their experience

3. We will improve the health of our service users & support recovery through the delivery of **effective** evidence based practice

4. We will **improve, innovate and transform** our services to provide the most effective, productive and high quality care

5. We will deliver **joined up care** to meet the needs of our service users across mental, physical

and social care services in conjunction with our partners

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

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

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

There are no implications arising from this report.

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

This report sets out actions taken in Quarter 1 2020/21 as part of the Care Quality Commission Key Lines of Enquiry.

Seen by the following committee(s) on date:

This report has not been presented to any other Committees.

Quarterly Integrated Safety Report Quarter 1 2020/21

EXECUTIVE SUMMARY

The Quarter 1 Integrated Safety Report provides members with an overview of safety including incidents, mortality, harm free care, restrictive practice and safeguarding. The report provides a review of trends, themes and identified learning setting priorities for the work in subsequent quarters.

The Trust's annual plan objective for safety is:

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

Key priorities were:

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

This report is divided into the following sections:

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

The number of incidents reported in this quarter was comparable to the same period last year with an increase in those that resulted in moderate or severe harm when compared quarter on quarter which can be explained by the number of deaths resulting from COVID-19. There have been no never events nor prevention of future death reports issued by the Coroner to the Trust.

The number of serious incidents has remained at a consistent level but there have been a decrease in unexpected deaths thought to be due to suicide but an increase in deliberate self-harm. Significant progress has been made in ensuring root cause analysis investigations are completed on time and are on track to fully recover the position by the end of July 2020. There remain challenges with ensuring the action plans are completed on time and this will be a priority for the coming period. Mortality governance has focused on COVID-19 related deaths enabling swift learning and practice changes to take place. COVID-19 saw an increase in pressure ulcers nationally and this was reflected in the Trust and additional work was undertaken to address this.

There has been a reduction in ligature incidents in the in patient services for the past two quarters but an increase in ligature events in service user homes. Head banging continues to been seen increasing level in the trust and work has been undertaken to ensure neurological trauma is identified early. The number of absent without leave (AWOL) has been maintained at the reduced level that was achieved following work 18 months ago.

Service user to staff assaults have decreased after an increase and there continues to be a trend of reduced harm that was seen in Quarter 4 2019/20 with 1.9% resulting in moderate/severe harm against an annual plan benchmark of 4.9%. Service user to service user assaults mirror this pattern for Quarter 1 2020/21 after a increase between quarters 3 and 4 2019/20.

Overall, the Trust saw a decrease in the use of restrictive practice but it should be noted that Essex and IAPT SBU is the highest reporter for assaults on staff and yet have not used rapid

tranquilisation during the quarter. In addition, although there were fewer episodes of seclusion, the length of time spend in each episode is significantly higher than in other SBUs. This may be appropriate but, in quarter 2, this will be prioritised for a review.

There were no prone restraints. There was an increase in the use of seclusion which is attributed to the increased acuity in the in patient services and frustrations at the restrictions associated with the pandemic, such as visitor restrictions, isolation and being unable to go out in the same way as before the pandemic.

Increased scrutiny and review of long term segregation has been put in place with particular attention to the human rights of individuals, documentation and multidisciplinary reviews. Rapid tranquilisation use has remained consistent.

Safeguarding responded to the pandemic by ensuring that business as usual continued whilst being delivered in different ways. The Trust saw an increase in domestic abuse reported, in line with the national picture. An audit revealed that safeguarding supervision was good and consistently in place although there were a limited number of responses received.

The Quarter has maintained progress on improving safety within the Trust despite and because of the pandemic, with services responding quickly to increased acuity and different needs in physical healthcare. Priorities remain in line with the annual plan and the quality strategy. The formal launch of the MOSS together strategy was postponed due to the pandemic but will be prioritised in the next quarter.

Part A- GOVERNANCE AND ASSURANCE

1. Introduction

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

1.2. The Quality and Risk Management Committee (QRMC) reports to IGC on the work of QRMC and its subcommittees. The Safety Committee oversees all the work relating to safety and holds the safety risk register and reports into QRMC. Medicines safety, safe staffing, safeguarding, including sexual safety in Trust in patient services, feeling safe, infection prevention and control and health and safety related matters are addressed in other annual reports and so will not be addressed here. They are important and should be considered in conjunction with this report.

2 Priorities

2.1 A number of priorities were set in relation to safety in the Trust's 2019/20 Annual Plan:

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

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

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

3 Trust Risk Register

3.1 The Trust's Risk Register is reviewed regularly and has a number of risks that relate specifically to safety; those below have a significant impact on safety and service user harm:

- The Trust is unable to recruit staff to be able to deliver safe services due to national shortages of key staff
- The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services
- Implications for the Trust of differing scenarios arising from EU Exit
- Unable to provide consistent timely access to CAMHS Community Services
- Failure to respond effectively to increasing demand in Adult Community resulting in a risk to safety, quality and effectiveness.

3.2 A Trust Risk Register Report was last presented to the Trust Board on 30th July 2020 which provided additional information about the work that is being undertaken to address and to mitigate against these risks. Safety specific updates related to:

- COVID19: The Trust may not be able to sustain core operational services and maintain service user and staff safety during the COVID19 outbreak (Risk 1253)
- COVID 19: Increased harm or death of service users due to mental health related illness (Risk 1273)
- Workforce: The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff (Risk 215)
- Workforce: The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services (Risk 657)
- Changing External Landscape: The changing external landscape and wider system pressures/agenda leads to a shift of influence and resources away from mental health & Learning Disability services and from Trust (Risk 749)
- S136: Unlawful detention of service users under S136 breaches beyond 24hrs (Risk 882)
- Adult Community: Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites (Risk 773)

6 Health and Safety Executive

6.1 The Health and Safety Executive inspected the Trust from 13th to 15th May 2019. An update report is included on the agenda, separately to this paper. In summary the regulatory notices have been formally closed.

7 Safety Alerts

7.1 There were a total of 47 Central Alerting System (CAS) Alerts received between 1st April 2020 and 30th June 2020 which have been reviewed. The learning from these have been taken forward including disseminating to the relevant services accompanied by changes to policy and practice.

7.2 Based on risks reported as part of on-going learning, the following learning notes and internal safety alerts have been produced and disseminated:

- Fences: Objects propped against fences, can and do increase the risk of AWOL and possible injury associated with escape
- Sinks: Anti-ligature sinks have been reported as a risk, when towels with knots are forced into sink holes, filled with water, creating anti - ligature anchor point, as the towel swells and jams in the sink hole
- Anti - Barricade doors: Anti ligature barricade doors allow a ligature to be attached creating a risk
- Prone Restraint: An advisory alert is being sent to remind everybody of full reporting of Prone restraint no matter how short a time, by completing a DATIX
- Doors and Door Frames represent a ligature anchor point risk, the alert is to raise awareness of this risk particularly in bedrooms, isolated and unobserved areas and when associated with ligatures such as dressing gown cords.

8 Conclusion

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

Part B- INCIDENTS INCLUDING SERIOUS INCIDENTS

1 Introduction

1.1 Part B of the safety report specifically considers incidents, including serious incidents. It begins by giving an overview of reporting trends and then goes on to explore themes and trends as well as severity of harm. How the Trust meets its Duty of Candour is detailed and then specific attention is given to mortality governance and suicide rates. It concludes with never events.

1.2 This part of the report will give an overview of the incidents, mortality governance, harm free care, restrictive practice and safeguarding.

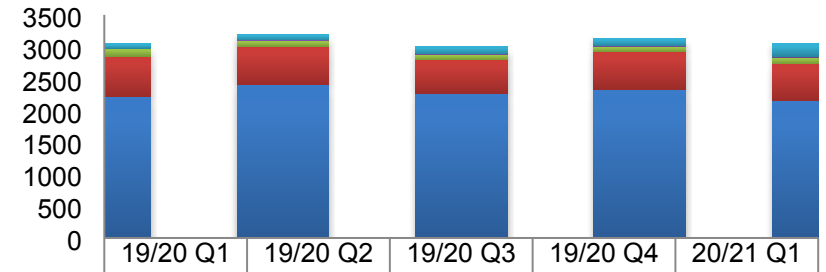
2 Incidents

2.1 Patient safety incidents are defined as *'any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting those supports the NHS to learn from mistakes and to take action to keep patients safe*.' NHS Improvement 2017. This section of the report considers the quality and type of incidents reported.

Incident profile

2.2 The total number of incidents reported on Datix has remained relatively consistent throughout the pandemic period (Chart 1) when compared to the same quarter in 2019/20 and Quarter 4 2020/21.

2.3 The number of incidents graded as moderate or severe harm increased in Quarter 1 2020/21 (120) when compared to Quarter 4 (94). 52 incidents where staff or service users had suspected or confirmed Covid 19 were reported as moderate or severe harm. This and Covid 19 deaths account for the significant increase in reported moderate or severe harm. Further analysis is included in the mortality section of this report.



	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1
Death	75	86	111	118	195
Severe Harm (permanent/long term harm)	5	8	6	7	15
Moderate Harm (short term harm/further treatment given)	125	100	90	87	105
Low Harm (minimal harm/minor treatment given)	626	597	524	591	574
No Harm (no injury sustained/apparent)	2218	2401	2269	2330	2156

Chart 1 Total Trust Incidents by Harm Q1 2019 – Q1 2020

2.4 Never Events are specific categories (determined by national guidance) of event that are serious and largely preventable safety incidents that should not occur if the available preventative measures are implemented. The Trust reported no incidents that would meet Never Events criteria.

2.5 Due to the coronavirus illness (COVID-19), and the need to release capacity across the NHS to support the response, NHS England and NHS Improvement have paused the collection and publication of official statistics including EMSA. NHS Digital EMSA submissions were suspended for Quarter 1 reporting of data for March, April and May 2020. There has been further temporary suspension of Mixed-Sex Accommodation (MSA) until August or September 2020. However, continues to be monitored this internally there have been no breaches of the regulations.

Serious Incidents

2.6 Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified' (*Serious Incident Framework 2015)*.

2.7 The Trust reported a total of 23 Serious Incidents (Table 1) external to the Trust in Quarter 1 2020, compared to 21 in the previous quarter. The number of unexpected deaths reported in Quarter 1 (7) decreased when compared to the previous quarter (12). The number of self-inflicted harm serious incidents increased in Quarter 1 (8) compared to (3) in Quarter (4) compared to (1) in the previous quarter. These self-harm incidents related primarily to unsuccessful suicide attempts. The number of violent and aggressive incidents has also risen.

StEIS Category	**Q4 2019/20**	**Q1 2020/21**
Unexpected/avoidable deaths	12	7
Apparent/actual/suspected self-inflicted harm	3	8
Disruptive/aggressive/ violent behaviour	1	4
Slip/trip/fall	1	2
Safeguarding Adults	0	1
Safeguarding Children	1	0
Unauthorised absence	0	1
Pressure Ulcer	1	0
Practice & Clinical Care	2	0
TOTAL	**21**	**23**

Table 1 Serious Incidents reported in Q12019/20 and 2020/21 by StEIS category

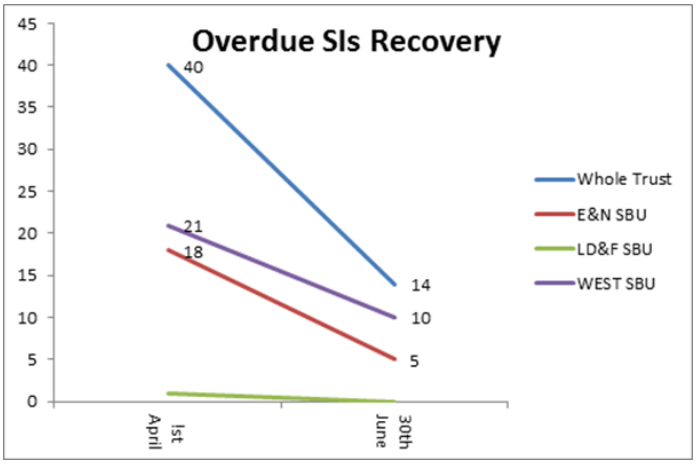
Duty of Candour

2.8 The Trust's Duty of Candour policy sets out the requirement to meet the Statutory Duty and this is assessed through the Quality Schedule. The Datix incident reporting system records when Duty of Candour has been met. A copy of the Serious Incident report is shared in full with the service user or the family and also with HM Coroner. The Trust fully embraces the principles of open and transparent communication in keeping with a just and learning culture. Discussions around whether compliance has been met for individual incidents takes place as part of the discussions at the weekly Moderate Harm panel, where decisions are made on whether a serious incident will be called or if further actions are required for individual incidents categorised as moderate harm or above.

2.9 Service users and carers are contacted routinely, and included in, the root cause analysis following an incident and a copy of the serious incident report is always shared with service users or families when the serious incident review is completed.

Serious Incident Process Improvements

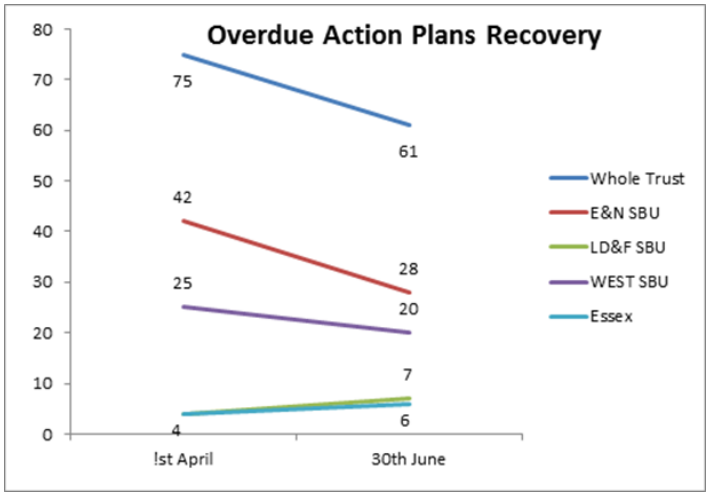
2.10 Work has continued in this reporting period to address the number of overdue serious incident root cause analysis reports (graph 1), with a total of 44 serious incident reports (April 16, May 10, June 18) being submitted to Commissioners during Quarter 1 2020/21, five of which were still within timeframe.



Graph 1: Overdue Root Cause Analysis Investigations

2.11 The plan is to reduce this further and be in a position, at the end of July, to report no overdue RCA reports (apart from exceptional circumstances, such as a homicide on a stop clock due to a criminal investigations) and no new RCAs becoming overdue.

2.12 The next stage in the improvement work is to ensure all outstanding actions following the RCA being finalised are completed and signed off in a timely way (Graph 2). This is being undertaken through a thematic review and using continuous quality improvement methodology.



Graph 2: Overdue actions

3 Mortality

3.1 This section considers the mortality within the Trust. It encompasses mortality governance including LeDeR, suicides and prevention of future death (PFD) reports.

3.2 The Trust liaises regularly with the Coroner. The number of inquests, and therefore confirmed cause of death, has reduced over this period as, on 27 March 2020, the Chief Coroner issued guidance on inquest hearings during COVID-19. As a result of this guidance, coroners were not permitted to hold physical hearings with members of the family, public, press and witnesses in attendance. If all parties are in agreement, and the Court has technology in place, hearings should take place using video calls for remote attendance. However, as inquests and pre-inquest review hearings must take place in public, coroners must conduct hearings from a court, not remotely from their homes or offices.

3.3 Inquests that were scheduled to be held after 27 March 2020, which could not be held as a documentary hearing (with no family or witnesses in attendance), or where witnesses and family could not attend remotely, were adjourned. In addition, the Chief Coroner's directed that any jury inquests of any significant length which were due to start between 31 March and 28 August, and inquests which were felt to be long or complex which required large numbers of witnesses to give evidence in person, should be adjourned.

Mortality Governance

3.4 The Mortality Governance team ensure there is a system for reviewing and learning from deaths. All deaths are considered in the mortality governance process and are screened to identify whether a Structured Judgement Reviews (SJR) should be undertaken. All deaths of people with a learning disability are referred to the Learning Disabilities Mortality Review (LeDeR) as well as undergoing an internal reviews if it meets red flag criteria for conducting a SJR.

3.5 The agreed criteria for conducting an SJR are:

- when concerns about the care are raised by family, carers or staff
- diagnosis of psychosis or eating disorder at the last episode of care
- psychiatric inpatient at the time of death or discharged from inpatient care within the last month
- under the Crisis Resolution and Home Treatment Team at the time of death
- other locally determined criteria for review or case selected at random

3.6 A total of 20 SJR's were completed. There is SBU level oversight of the SJRs and these are cascaded down to the relevant teams. A variety of approaches such as SWARMs and reflective discussions are used to aid reflection within the team involved. The Mortality Governance Team is collating themes emerging from the SJRs, which will aid shared learning across the Trust. Apart from SJRs, a review of Covid-19 deaths in inpatient units was also completed.

3.7 East & North SBU, which includes Older Peoples' Services, is the highest reporter in Q1 2020/21 (table 2). Deaths reported in Q1 2020/21 (195) increased when compared to the previous quarter (134). It should be noted that deaths can be reported retrospectively and therefore these numbers will vary over time. Mortality governance continued through the pandemic but focused on immediate learning that was required. In March 2020, NHS England and NHS Improvement developed the Covid-19 Patient Notification System (CPNS) to enable confirmed Covid-19 deaths

that occur whilst a service user is in a Trust bed, to be reported on one central system.

	East & North SBU	Essex & IAPT SBU	LD&F SBU	West SBU	Total
19/20 Q1	52	6	9	24	91
19/20 Q2	66	14	5	19	104
19/20 Q3	72	10	24	21	127
19/20 Q4	96	10	10	18	134
20/21 Q1	143	15	21	16	195

Table 2: Deaths by SBU reported on Datix by quarter

3.8 Greater numbers of deaths are expected in the East and North SBU, as that SBU includes older adult services (Table 3).

	Apr	May	Jun	Total
East and North Hertfordshire Strategic Business Unit	85	41	17	143
Essex & IAPT SBU	6	6	3	15
Learning Disabilities & Forensic Strategic Business Unit	10	10	1	21
West Hertfordshire Strategic Business Unit	10	3	3	16
Total	111	60	24	195

Table 3: Deaths in Q1 20/21 by SBU

Covid-19 deaths

3.9 In March 2020, NHS England and NHS Improvement developed the Covid-19 Patient Notification System (CPNS) to enable all confirmed Covid-19 deaths to be reported on one central system. The Trust has been submitting the returns on time and in full and will report the national findings when they are published.

3.10 A review of Covid-19 deaths and associated learning commenced in Quarter 1 to inform the quality of care across the Trust's inpatient units. Much care was good to excellent. From the findings it was evident that staff were working over and above expectation and a number of good practice themes were highlighted: Good multi-disciplinary working including SLT/dietician/ physio input

- Prompt recognition of decline and regular medical reviews
- Remote consultation with respiratory physician
- End of life medication
- Carer/relatives involvement including video consultation
- Advanced care planning for in-patients
- Physical health care monitoring including food/fluid intake
- Regular contact with staff

3.11 Emerging learning points include:

- Documentation as not all attachments were available and when available, these were at times incomplete. This was applicable for EWS charts, food/ fluid charts, bowel charts and medicine charts
- Isolation: There was variation as to when isolation began when there were concerns about deterioration of physical health.

LeDeR

3.12 The LeDeR programme is a national, time limited external Learning Disabilities review process. The Trust reported 29 deaths to the LeDeR programme in Q1, which will each be reviewed by external professionals under the LeDeR programme. The national review of this data will be reported when it is published.

3.13 The Trust is fully involved in this review and acts as a reviewer of deaths in other areas. Many individuals who are trained and participate and this is co-ordinated by NHSE.

3.14 The Trust reported a total of 13 deaths to the national system. A review of Covid-19 deaths in inpatient units was completed early on in the pandemic and this was presented to Board.

Suicide

3.15 The Annual Plan sets out a minimum of 10% reduction in the number of deaths that are thought to be as a result of suicide. In Quarter 1, the number of deaths that were thought to be as a result of suicide was 7. A 10% reduction would mean no more than 40 at year end. The Trust acknowledges that each death is one to many and continues with its zero ambition.

3.16 Suicide and Open conclusions that were recorded for deaths reported as Serious Incidents between 2005 and 2020, where the inquest has been concluded (Chart 2), shows an upward trend since 2013/14. Data for the reporting years 2017/18, 2018/19 and 2019/20 is incomplete as not all inquests have been concluded. No inquests have been held for the deaths reported as Serious Incidents in 2020/21.

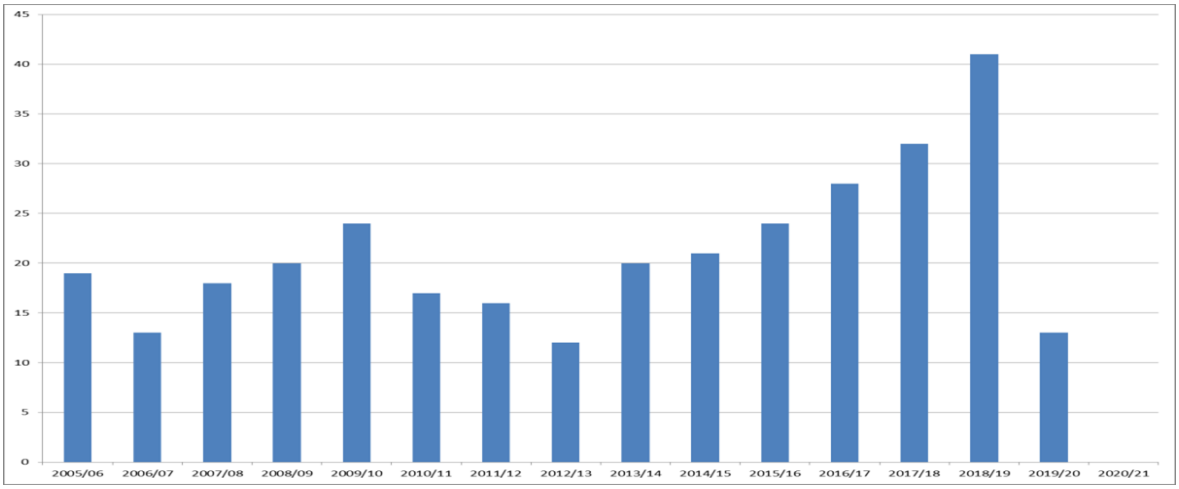


Chart 2: Suicide/Open Conclusions by Incident Date (April 2005 – June 2020)

3.17 When a death is reported and thought to be a suicide then it is included in our data set. These incidents are all investigated and they are followed through inquest to the outcome (Chart 3). The Trust errs on the side of caution and will classify as

suspected suicide until the outcome of the inquest is known. Every quarter since quarter 3 2015/16 has shown that at least one and at more 8 per quarter have been returned as not being a suicide.

3.18 The Court of Appeal, in 2019, ruled that the standard of proof for requiring a suicide conclusion should be the civil standard (on the balance of probability). The lowering of the threshold is expected to lead to an increase in deaths recorded as suicide and therefore data will not be comparable with previous years. As a result, from Quarter 2, only data from 2019/20 and 2020/21 will be reported, alongside a summary of concerns raised at the inquests of those still to be heard.

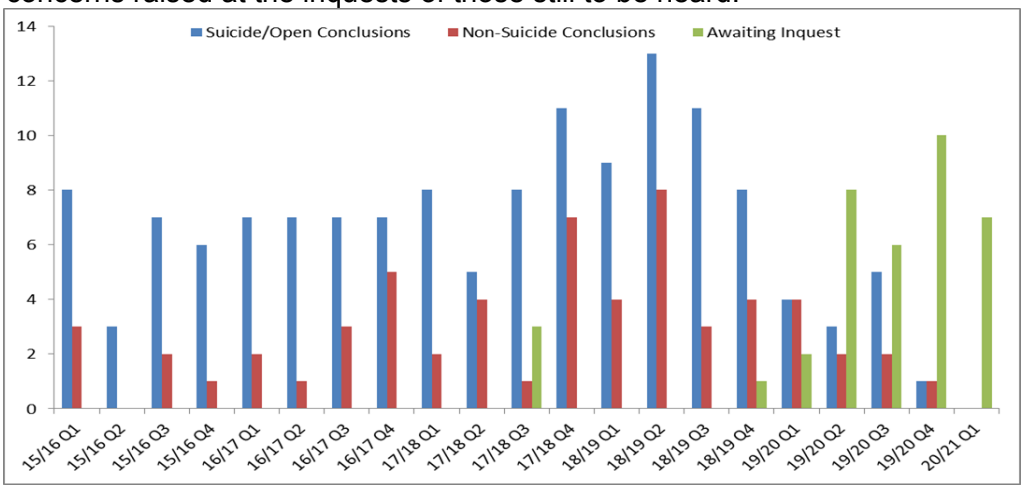
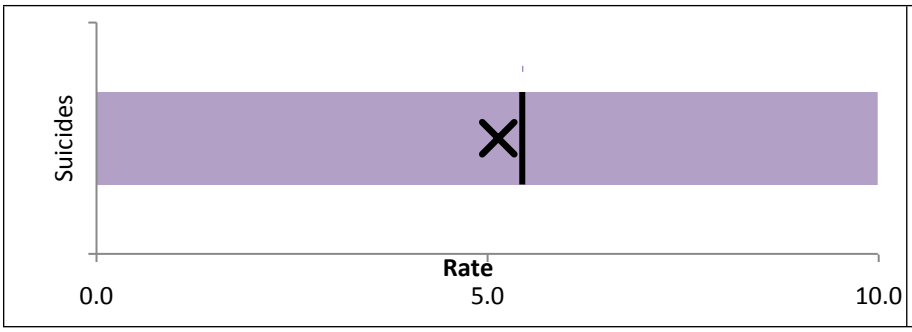


Chart 3 Unexpected Deaths by Incident Date (April 2015 – June 2020)

3.19 The Trust is represented on Hertfordshire's Suicide Prevention Programme Board which aims to provide strategic leadership and oversight of the suicide prevention programme being delivered across Hertfordshire. The vision is to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option. The Trust has contributed to the refreshed strategy which is due to be finalised in the next quarter.

3.20 The NCISH Safety Scorecard, suicide gives the range of results for mental health providers across England, based on the most recent available figures (2015-2017). 'X' marks the position of the trust.



Suicide rate

The suicide rate in HPFT was 5.14 (per 10,000 people under mental health care) from 2015-2017.

Chart 4 NCISH Safety Scorecard

3.21 The Trust's Zero Suicide Action plan is based on the principles of the NCISH 10 ways to improve safety which are: Safer wards, early follow up on discharge, no out of area admissions, 24 hour crisis teams, family involvement in learning lessons, guidance on depression, personalised risk management, outreach teams, low staff turnover, and services for dual diagnosis.

Prevention of Future Deaths Reports (PFDs)

3.22 Coroners have a statutory duty to issue a PFD report to any person or organisation where, in the opinion of the coroner, action should be taken to prevent future deaths. The report is sent to whoever the coroner believes has the power to take such action and the recipient then has 56 days to respond. In Quarter 1 2020/21, the Trust received no Regulation 28 Prevention of Future Death (PFD) reports from HM Coroners.

3.123 Whilst it is acknowledged that PFD reports only provide a snapshot of evidence heard at an inquest and therefore have some limitations, these reports provide us with an opportunity to review our own processes and systems with reflect on whether any actions are required. PFD reports are disseminated to Clinical Directors and Managing Directors in each of the SBU's, Subject Matter Experts, and are considered at the Safety Committee.

3.24 A total of 11 available from the National publications of Prevention of Future Death (PFD) reports where deemed relevant for the purposes of learning. Key areas of learning included continuity of care, risk formulation and risk management, handover of key information when a care coordinator leaves, monitoring of medication, engagement in treatment plans, multi – disciplinary working, liaison between primary and secondary care, joint working, communication, engagement with families of University students, choking risk, quality of healthcare provided in prisons, safe and appropriate disposal of latex gloves due to choking risk, delays in prescribing Lithium, use of electronic patient record systems, management of falls risk, escalation to senior clinicians, observation practice, transfer of caseload and handover during periods of leave, liaison with the GP, liaison with families, and self-discharge of informal inpatients.

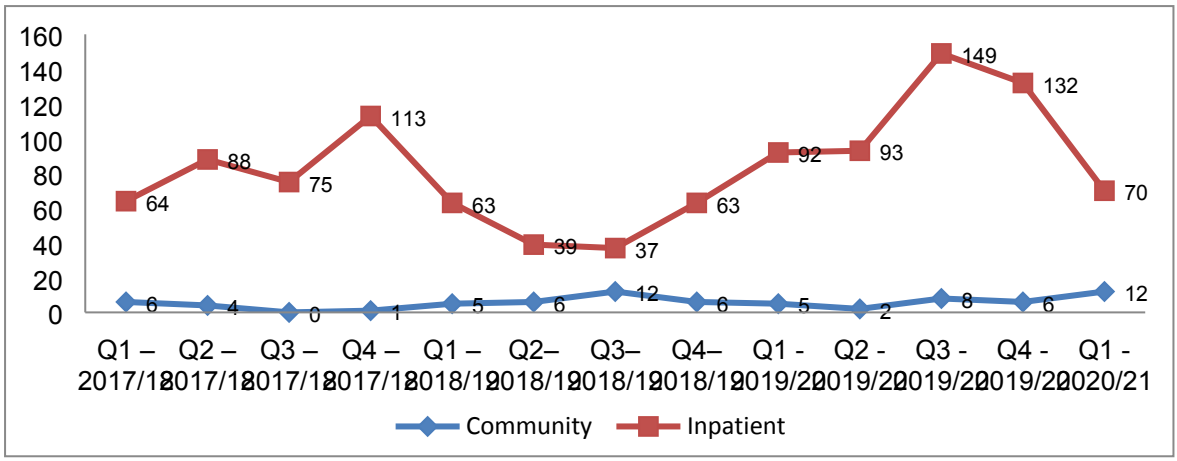
3.25 Learning from PFD reports has been discussed at the Safety Committee and SBU Quality Risk Meetings for onward dissemination and has informed suicide prevention work streams, and is used in safeguarding training.

4 Harmfree Mental Health Care

4.1 The Trust aims to deliver harm free care. Harm free care encompasses harm that could be deemed avoidable. Specifically this is in relation to ligature incidents, headbanging, AWOL, violence and aggression.

Ligature Incidents

4.5 In Q1 2020/21, there were a total of 70 ligature incidents reported across all Trust inpatient services, which is a decrease of 62 (47%) in comparison to the 132 reported in the previous quarter (Graph 3).



Graph 3 ligature incidents during Q3 2018/19 to Q1 2020/21

4.6 The service areas with the highest reported incidents in Q1 were Aston Ward (38, 54%), Robin Ward (9, 13%) and Forest House (5, 7%). There were four service users' involved in the incidents within Aston ward, with two accounting for 21/38 (55%), one service user accounted for 12 of these incidents.

4.7 Ligature incidents using clothing remains the category with the highest number of incidents of this type on the inpatient units (51/70). An internal safety alert was disseminated across Trust inpatient areas. There has since been a further decrease in the number of ligature incidents within June 2020, however this will need to be closely monitored over the coming months.

4.8 The Trust uses the ANT (Applied New Technologies) system for logging ligature audits. In Quarter 1, the pressures of the work in relation to the pandemic meant that these were not completed as consistently as required. This was identified and action taken to rectify the situation. Further work to strengthen this area of work will carry on through the year alongside the annual full ligature review which includes maps, lines of sight and risks.

4.9 Volvina the current provider and auditor for collapsible curtain rails have replaced and tested all systems in compliance with the National Alerts. The Annual audit relating to the DoH alerts requires completing for 2020/21. During Quarter 2 terms of reference for the audit criteria commissioning process will be presented to the Health Safety & Security Committee for approval.

4.10 There were a total of 12 ligature incidents reported across all Trust community services, 6 in Adult Community Mental Health Services, 2 in Wellbeing services, 3 in CAMHS community services and 1 in a Crisis Team. In keeping with the national picture around reducing access to means ligatures in people's homes or community settings remains a challenge.

Head banging

4.11 Head banging is a common form of self-injurious behaviour, with a higher correlation in learning disabilities and forensic services and with individuals diagnosed with a Personality Disorder and/or Psychosis. Head banging can be complex to manage which may involve a higher risk of restrictive practices and potential conflict.

4.12 The current head banging incidents for all reported areas can range from a mild tapping, to more extreme head banging. This quarter there has been an increase,

with Aston Ward and Forest House Adolescent Unit being the top two reporters (Chart 5).

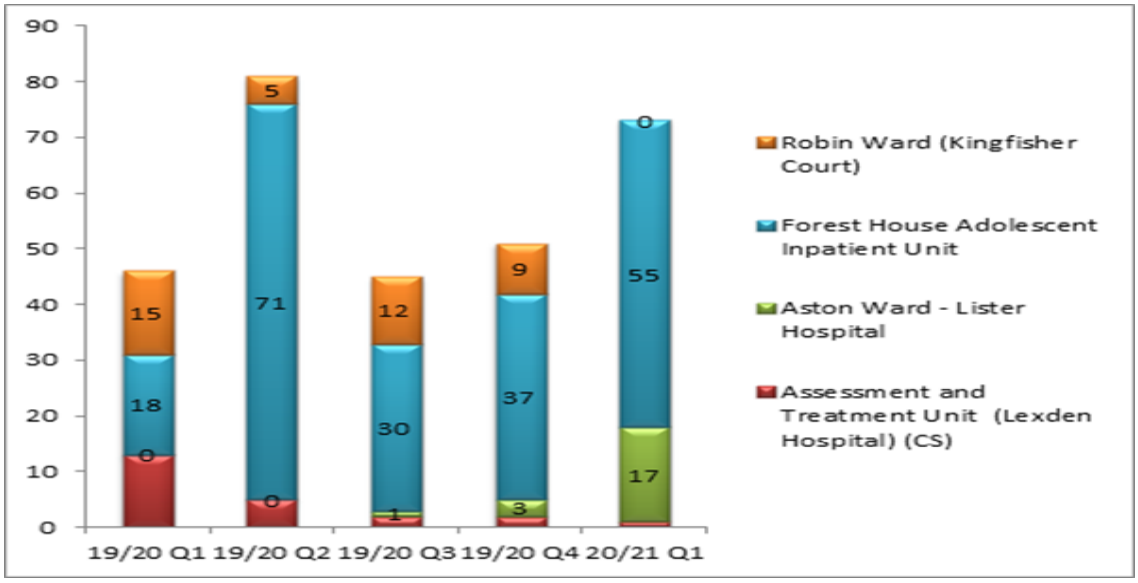
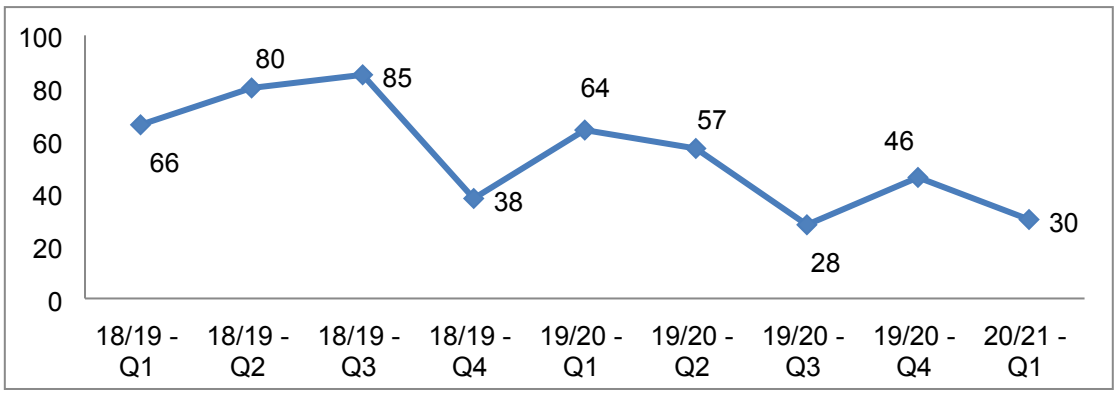


Chart 5 Head banging incidents by Quarter and Team

4.13 Previously issued guidance has been re-circulated to help clinicians assess the physical wellbeing of the service user during and following an episode of head banging based on initial assessment using ACVPU (Alert, Voice, Pain, Unresponsive) scale. Additionally psychological input contributing to work to prevent incidents of headbanging.

Absent Without Authorised Leave (AWOL) and Missing Persons

4.14 There was a decrease in the number of reported AWOL and missing person incidents (30) when compared to the previous quarter (46) (Graph 3). Since Quarter 3 2018/19, there continues to be an overall downward trend.



Graph 3 AWOL and Missing Person incidents Q1 18/19 to Q1 20/21

4.15 The Beacon (12, 40%), Hampden House (3, 10%) and Aston and Oak Wards (2 each, 7%) were the top four reporters of AWOL and Missing Person incidents. The highest reported sub-category in Quarter 1 was AWOL when detained under the MHA (47%) (not returning from Section 17 leave). The incidents at The Beacons were attributed to a single service user who required a specialised placement and, as such, was being managed using the least restrictive approach.

Violence and Aggression

4.16 As part of the assurance process each SBU is developing local approaches to reduce Conflict (violence) and Containment (restrictive practices). These alongside monthly targets for harm reduction, will support Trust targets as part of the Annual Plan (2020/21).

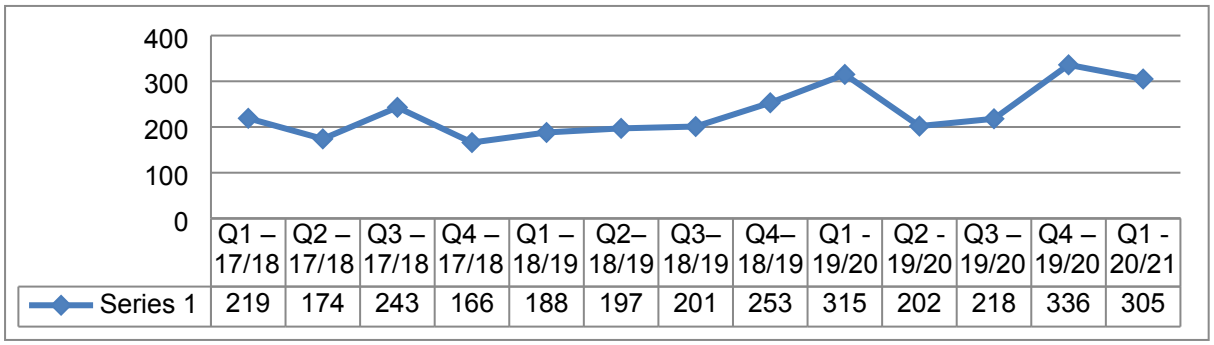
4.17 Violence and aggression incidents are reported on the Trust's Datix incident reporting system by two categories; service user to staff assaults and service user to service user assaults. Data is subject to local analysis and further in-depth analysis as part of the quarterly reporting cycle by the Practice Development & Patient Safety Team working with the Strategic Business Units. Each category shows a trend analysis for the past two years to give context to the reporting in terms of emerging trends and identify actions required.

4.18 Training in violence and aggression is a key process with regards to teaching both proactive and reactive interventions. Prior to the onset of COVID-19 the Trust received BILD accreditation for full courses, modules 4 and 5 involving physically restraint. Training as an outcome of COVID -19 has involved delivering a shortened course with reduced numbers because of COVID-19. A recovery plan is in place with modified courses, supported by NAVIGO guidance and support. Reasonable adjustments have been made so six person classes can be taught as a ratio of 6 staff to 1 instructor with 1 instructor for Module 4 refresher and Module 5 training.

Service User to Staff Assaults

4.19 There has been a steady increase in service user to staff assaults in the in patient services (chart 6) over six quarters (Q4 2017/18 – Q1 2019/20). In Q2 2019/20, there was a 36% decrease in this incident type and a large increase due to incidents on Lexden from Q3 2019/20 to Q4 2019/20. However, despite an 8% reduction from Q4 2019/20 to Q1 2020/21 there remains specific challenges within Lexden where six service users accounted for the total number of assaults, three of whom accounted for 141/150 incidents.

4.20 There are two CQI projects within Older Adults inpatient services. The first is to increase incident reporting in relation to violence and aggression during personal care and the second to understand the issues relating to meeting personal care needs and the risk of violence and aggression towards staff during these interventions.



	Q1 – 17/18	Q2 – 17/18	Q3 – 17/18	Q4 – 17/18	Q1 – 18/19	Q2– 18/19	Q3– 18/19	Q4– 18/19	Q1 - 19/20	Q2 - 19/20	Q3 – 19/20	Q4 – 19/20	Q1 - 20/21
Series 1	219	174	243	166	188	197	201	253	315	202	218	336	305

Chart 6 Service user to staff assault data Quarter 1 17/18 to Quarter 1 20/21 Inpatient Services

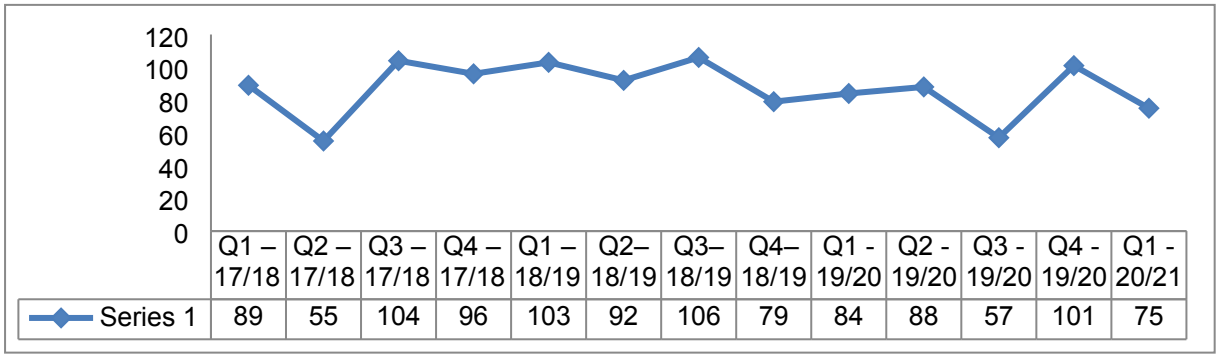
4.21 Of the total number of service user to staff assault incidents reported by in patient services 162 (53.9%) resulted in no harm, 137 (44.2%) resulted in low harm, 6 (1.9%) resulted in moderate harm and 0 (0%) resulted in severe harm.

4.22 Under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) the Health and Safety Executive (HSE) requires organisations to report accidents resulting in an employee being away from work, or unable to perform their normal work duties, for more than 7 consecutive days as the result of their injury. Support was put in place for those staff. Seven RIDDORs were reported within inpatient services in Q1, five of which were within the Learning Disabilities & Forensic SBU (Broadland Clinic 3 and Warren Court 2).

4.23 There were a total of five incidents reported, three of which resulted in no harm and one of which resulted in low harm. One staff assault incident in PATH west resulted in severe harm and was reported as a serious incident.

Service User to Service User Assaults

4.24 There was a decrease (23%) in service user to service user assaults (chart 7) when compared to Q4 2019/20. Of the 75 service user to service user assaults 0 (0%) resulted in moderate or severe harm. 58 (77%) of service user to service user assaults resulted in no harm and 23% (17) resulted in low harm. The top three reporters of service user to service user assaults in Q1 were Dove Ward (14), Owl Ward (12) and Albany Lodge (8).



	Q1 – 17/18	Q2 – 17/18	Q3 – 17/18	Q4 – 17/18	Q1 – 18/19	Q2– 18/19	Q3– 18/19	Q4– 18/19	Q1 - 19/20	Q2 - 19/20	Q3 - 19/20	Q4 - 19/20	Q1 - 20/21
Series 1	89	55	104	96	103	92	106	79	84	88	57	101	75

Chart 7 Service user to service user assaults Quarter 1 17/18 to Quarter 1 20/21 Inpatient Services

5 Harm free physical health care

5.1 The Trust aims to deliver harm free care. Harm free physical healthcare encompasses harm that could be deemed avoidable. Specific attention is given to pressure ulcers and slips, trips and falls.

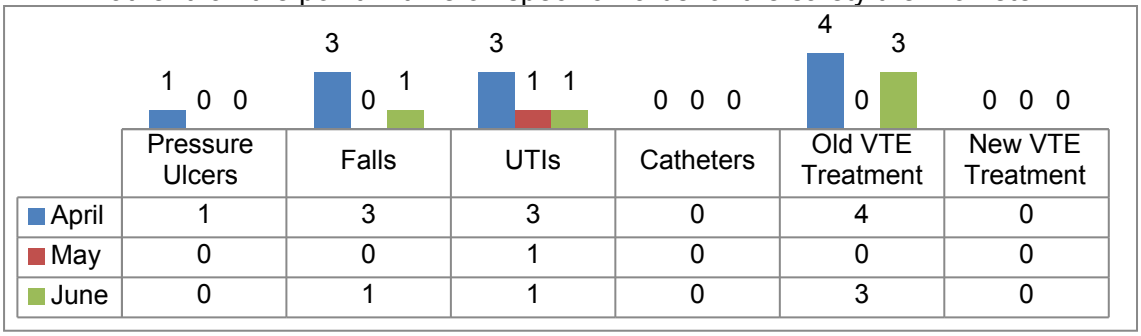
5.2 The NHS Safety Thermometer was a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care at a single point in time. The tool measures five high-volume service user safety issues. All national data collection for the 'classic' Safety Thermometer and the 'next generation' Safety Thermometers ceased after March 2020. The introduction of nationally produced replacement data was planned, but has been temporarily paused due to the national response to Covid-19. There is currently no further update on nationally produced replacement data.

5.3 Data collection has continued in the Trust until an alternative is in place. The Safety Thermometer data was collected on single points in time on 15th April, 20th May and

17th June 2020 (Chart 8). The return rate was not as high as expected and usual, due to the conflicting demands of the pandemic

5.4 Harm free care' was calculated on the number of service users receiving harm free care and the number of service users who have had harm in the following areas- a pressure ulcer of any category acquired anywhere, a fall which resulted in any degree of harm within the previous 72 hour, a new venous thromboembolism (VTE) of any type acquired under your care and treatment for a Urinary Tract Infection with a urethral urinary catheter.

5.5 The key areas are taken in turn, considering the whole trust and reporting period rather than the point in time on specific wards for the safety thermometer.



	Pressure Ulcers	Falls	UTIs	Catheters	Old VTE Treatment	New VTE Treatment
April	1	3	3	0	4	0
May	0	0	1	0	0	0
June	0	1	1	0	3	0

Chart 8 Safety Thermeter Results Q1

Pressure Ulcers

5.6 Four category 2 pressure ulcers were reported which were acquired whilst in the Trust care. Three on Seward Lodge and one on Victoria Court. There were 4 moisture associated skin damage incidents reported, which occurred during hot weather and were all resolved with appropriate treatment; one on Logandene, one on Lambourn Grove, one on Owl ward and one on The Beacon.

5.7 Of the category 2 pressure ulcers that occurred within trust care on Seward Lodge and Victoria Court both service users were COVID-19 positive and acutely unwell. Both were on pressure relieving mattresses, turning charts, and had heel protectors in place. Both service users were agitated with decreasing oxygen levels and were transferred to the acute hospital. There were no apparent omissions in care.

5.8 One female service user who was immobile was admitted to Seward Lodge; she was restless and resistive to care. She had a urinary tract infection, poor fluid and food intake despite staff promoting on oral nutritional supplements; her mattress was upgraded to a dynamic mattress. She developed a category 2 heel pressure ulcer. Heel protectors were put in place once the pressure ulcer developed.

5.9 National trends are showing an increase in moisture associated skin damage and pressure ulcer incidents due to sudden deteriorating physical health caused by COVID-19. The trust has seen two incidents of pressure damage related to COVID-19 and both service users were admitted to General Hospital as acutely unwell. Learning has been shared across the Trust.

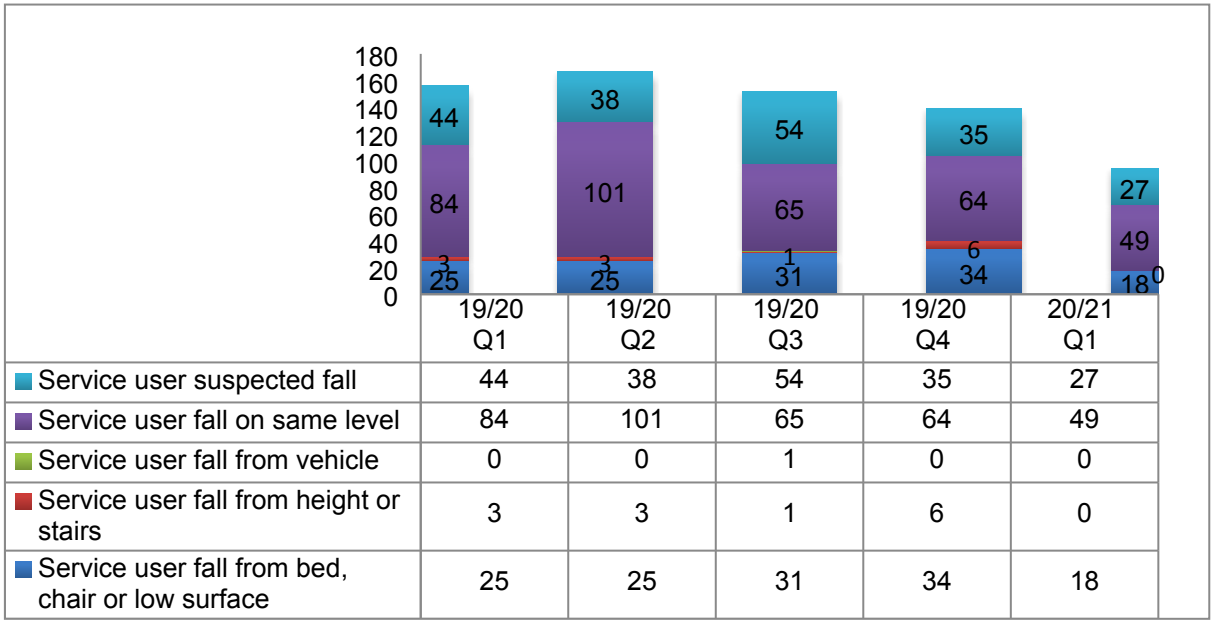
Slips, Trips and Falls

5.10 The Trust remains committed to reducing harm from falls is part of the STP (Sustainability and Transformation Partnership) Frailty Pathway work to inform good practice and innovation around frailty and falls prevention. The work is overseen

internally by the Falls Group and Slips, trips and falls by service users is detailed in this report, whereas those affecting staff and visitors are reported in the Health and Safety Report.

5.12 The number of falls decreased by 32% when compared to Quarter 4 and by 40% when compared to the same reporting period in 2019/20 (Chart 9). This reduction should be considered alongside the corresponding increase in services users who were physically unwell and in bed due to Covid19.

5.13 The top three reporters of slip, trips and falls incidents were Older Adults Inpatient Services (56) Adult Acute Inpatient Services (14) and Specialist Residential Services (11).



	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1
Service user suspected fall	44	38	54	35	27
Service user fall on same level	84	101	65	64	49
Service user fall from vehicle	0	0	1	0	0
Service user fall from height or stairs	3	3	1	6	0
Service user fall from bed, chair or low surface	25	25	31	34	18

Chart 9 Service user slips, trips and falls Q1 2019/20- Q1 2020/21

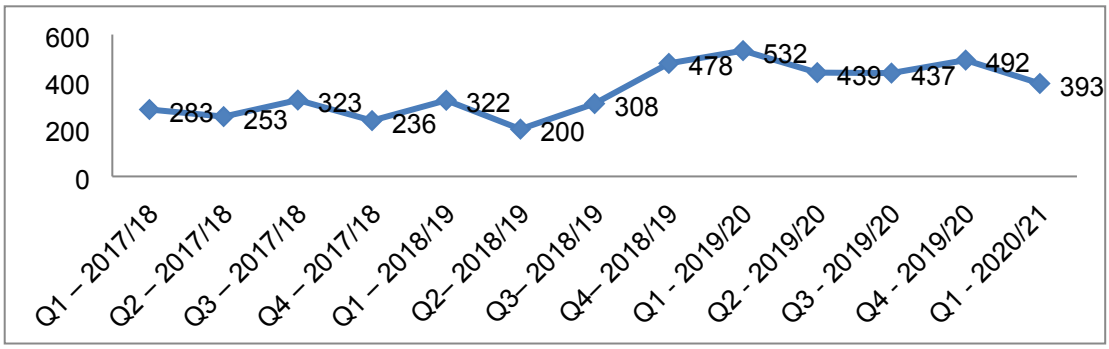
5.14 Of the 14 falls in Acute Inpatients units all resulted in no harm and were spread across five different units; two service users accounted for three falls each. Of the 12 falls in Specialist Residential Services (SRS) all resulted in no or low harm and seven involved the same service user. SRS has dedicated physiotherapy support and staff training on falls prevention and physical frailty has been delivered. Service users are receiving a low dose of vitamin D to support bone strength, with those at higher risk being screened for a higher dosage. In Older Peoples' Inpatient services there were 56 falls, two of which resulted in fractures and were reported as Serious Incidents.

6 Least Restrictive Care

6.1 The Trust aims to provide care to service user's that is least restrictive. Restrictive practice includes restraint, seclusion, long term segregation and rapid tranquillisation. It also includes blanket restrictions.

6.2 Over the past two years, there has been a consistent level of use of restraint up to Quarter 2 2018/19, followed by an increase from Quarter 3 2018/19 to Quarter 1 2019/20 (Graph 4). This Quarter there has been a decrease by 18% in overall use of restraints since Quarter 4 2019/20.

6.3 This section will consider restraint, long term segregation, seclusion and rapid tranquillisation finishing with information relating to training.



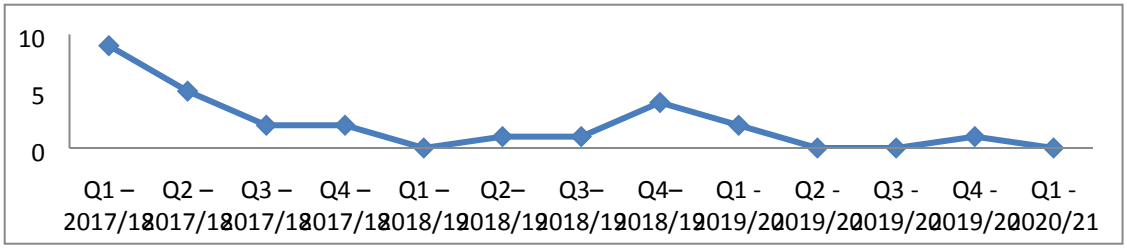
Graph 4 Restraint Quarter 1 2017/18 to Quarter 1 20/21 Inpatient Services

6.4 The report shows that Essex and IAPT SBU is the highest reporter for assaults on staff and yet have not used rapid tranquilisation during the quarter. It also shows that, although there are fewer episodes of seclusion, the length of time spend in each episode is significantly higher than in other SBUs. This may be appropriate but, in quarter 2, this will be prioritised for a review.

Restraint

6.4 The top three areas accounted for 204 of the 393 incidents (52%) and were Forest House (95, 24%), Lexden Unit (66, 16%) and Oak Unit (43, 11%). Three services users accounted for 68 of the 393 total numbers of restraints across all the SBUs, two on Lexden Unit (14%) and one on Forest House Adolescent Unit (3%).

6.5 Prone restraint is when a person is held chest down, whether the service user placed themselves in this position or not. Each case is subject to a comprehensive review, by a subject matter expert, at the time of reporting. There were no prone restraint reported in this quarter. Overall, there are a low numbers of prone restraint incidents (Graph 5).



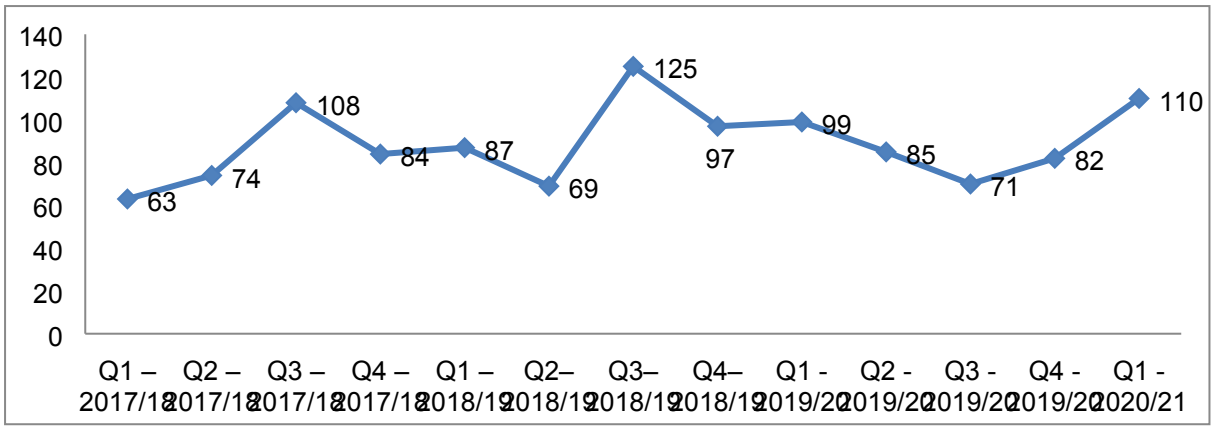
Graph 5 Prone restraint Q1 17/18 to Q1 2020/21 Inpatient Services

Seclusion

6.6 Both Seclusion and LTS are the most restrictive forms of restrictive practices and it is essential that individuals, get the right care, which is proportional and as a least restrictive possible, whilst respecting their Human Rights.

6.7 The use of seclusion peaked in Quarter 3 2018/19 (Graph 6), which related to Astley Court (57), Broadland Clinic (30) and Dove ward (30). There was an 18% reduction in the overall use of seclusion in Q3 2019/20 with a a downward trend until Quarter 4 2019/20 where there was a slight increase that further increased in this quarter. This

has been attributed to the complex current Covid-19 situation whereby a small number of service users' have been secluded due service users in our in patient services being more and well and the frustrations at the pandemic restrictions.



Graph 6 Seclusion data Quarter 1 17/18 to Quarter 4 20/21

6.8 This quarter seclusion was used within all four SBUs. Learning Disabilities and Forensic (79), West (24), Essex and IAPT (6) and East & North SBU (1). Whilst Learning Disability and Forensic SBU had more seclusion incidents, the average time spent in seclusion (Table 4) was lower when compared to the other SBU's. It should be noted that, within the same period, there were no Long Term Segregations within East & North SBU. The table below shows the baseline for the annual plan objective of reducing the length of time in seclusion.

Time	**SBU**				
	West	**LD&F**	**East**	**Essex**	**SBU's Total**
Total Time Mins	39591	62409	2685	40534	145219
Mean Time Mins	1650	790	2685	6756	1320

Table 4 Seclusion *Total and Mean Time in Minutes per SBU*

Long Term Segregation (LTS)

6.8 At quarter end there were 4 individuals in LTS (table 5).

Unit	**Detention status**	**Start Date**
2 Forest Lane	3	18 02 2010
Dove Ward	3	20 12 2018
Oak	3	05 06 2020
Lexden	3	25 06 2020

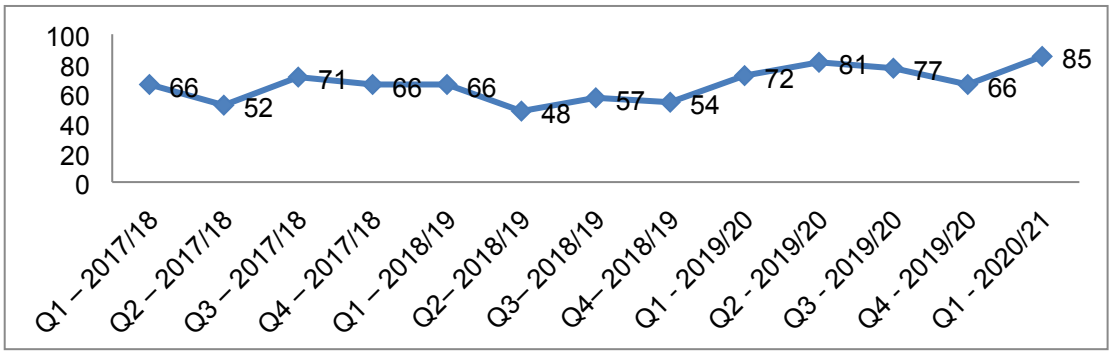
Table 5 LTS by unit, detention status and start date Q1 2020/21

6.9 This quarter has seen increased scrutiny and assurance in relation to LTS and attention to the individuals' human rights, improved documentation and reporting.

Rapid Tranquillisation

6.10 Rapid Tranquilisation is the use of psychotropic medication to address disturbed behaviour (Graph 7). There has been little variation in its use over time up until the

end of the last reporting year but peaked in this quarter at 85 instances. Most of these incidents occurred within in Forest House Adolescent Unit (table 5). At the time, there were two service users who were very unwell, requiring PICU and head banging and there were challenges, due to the pandemic, to finding beds for them. There were also a small number of young people with a first episode of psychosis and required rapid tranquilisation. The rapid tranquilisation policy has been rewritten to include CAMHS and a CAMHS specific Algorithmic has been developed.



Graph 7 Rapid tranquilisation data Quarter 117/18 to Quarter 1 20/21

SBU	April	May	June	Q1 20/21
West	19	9	11	**39**
LD&F	6	4	9	**19**
East and North	5	10	12	**27**
Essex	0	0	0	**0**
TOTAL	30	23	32	**85**

Table 5 Rapid Tranquilisation by SBU and month Quarter 1 2020/21

6.11 The top three areas accounted for 54 of the 85 incidents (64%); these were Forest House 27 (32%), Oak Ward 15 (18%) and Hathor Ward 12 (14%). In Forest House 5 service user's required rapid tranquilisation and 3 service users accounted for 22 of the 85 incidents (26%).

7 Safeguarding

7.1 The declaration of a global pandemic on March 11th 2020 and subsequent measures taken by the Government continue to pose significant changes and challenges in service delivery, both within HPFT and wider system in which it operates.

7.2 In Quarter 1, the COVID-19 pandemic raised inevitable challenges around continuing to ensure the safety of service users and their families, whilst at the same time maintaining physical distancing and adherence to lockdown guidance. The Corporate Safeguarding Team instigated a business continuity plan which allowed for a 'business as usual' approach to ensure consistent oversight of Safeguarding Adults and Children's concerns and processes.

7.3 Adoption of technology such as MS Teams has created opportunity in terms of staff development. The Corporate Safeguarding Team has delivered online seminars on a range of topics including Domestic Abuse, Self-Neglect and Gangs. More sessions are planned for Quarter 3. This is a model which can hopefully be adopted to allow a more varied training programme in the future.

Safeguarding Children

7.4 Safeguarding children remains high priority in HPFT, with clear systems in place there for scrutiny and monitoring of safeguarding children incident reporting. The safeguarding team remains committed in supporting frontline staff on all aspect of child safeguarding concerns and queries.

7.5 There has been an increase in referrals for Quarter 4 2019-20. CAMHS teams make the majority of the safeguarding children referrals. This shows the pressures of the COVID-19 have not prevented clinicians from identifying and reporting abuse. The number of referrals made in Quarter 1 2020-21 has decreased from Quarter 4, in line with the peak of the pandemic having being reached & business as usual beginning to return. The Quarter 1 referrals rate was higher than Quarter 1 of the previous financial year.

7.6 The number of referrals for emotional abuse increased in Quarter 4 (Chart 10). This could be linked to the national increase in domestic abuse cases, being reported since the COVID-19 lockdown commenced. Additionally, it may correlate to the psychological impact the pandemic has had on children & young people. However, the Quarter 1 categories of abuse show the referrals made for emotional abuse have returned the average rate, as last seen in Quarter 3 2019-20, before the pandemic.

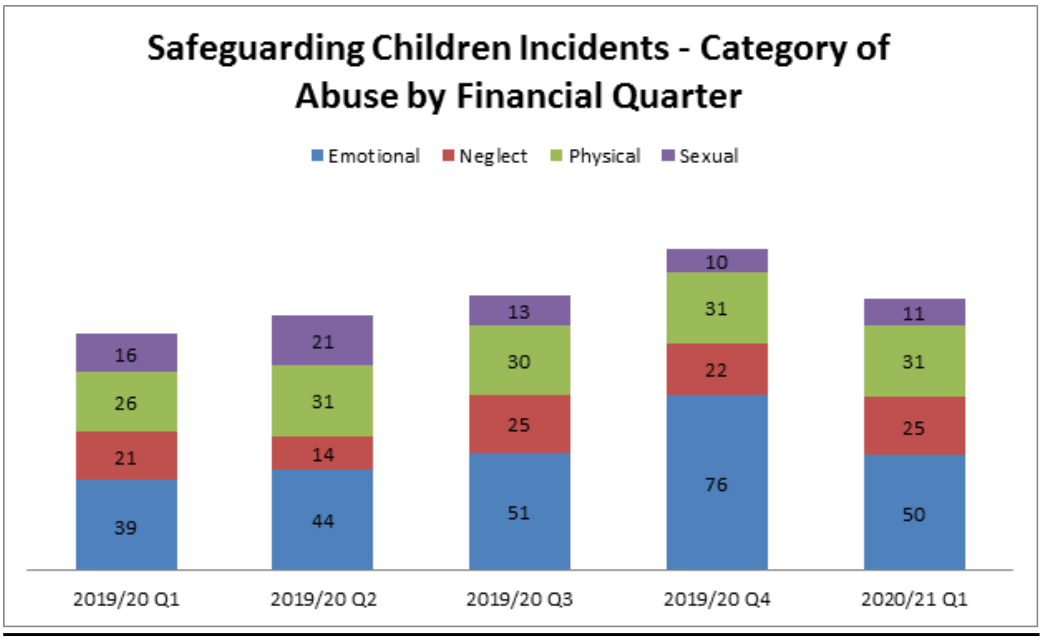


Chart 10 – Child safeguarding by category of abuse

7.7 A review has taken place of the Safeguarding Children Policy in relation to 16 & 17 year old who report sexual assaults by a stranger. This was reviewed in response to an incident raised by CAMHS whereby the child did not give consent to information sharing with the police or her mother regarding an alleged assault, however, a child safeguarding referral was made and Hertfordshire Police made an unannounced visit to the child's home. The draft policy has been discussed at the CCG Whole Systems meeting and at the CCG hosted Health & Children's Services meeting. This will be further reviewed at the HSCP Policy, Practice & Procedures sub-group.

7.8 The historic abuse guidance has been updated in response to feedback from Synergy, a sexual assault support organisation in Essex, relating to incidents where

services have reported historic abuse to the police, without consent or the knowledge of the victim. The new guidance makes it clear that a victim's consent should only be overridden, if there is reason to believe there may be a child or vulnerable adult at risk of the alleged perpetrator today. A working party will be established to produce a Standard Operating Procedure, to ensure as much consistency regarding reporting across the county.

Safeguarding Activity for Adults

7.9 The number of Trust wide Safeguarding Adult incidents remained steady across the previous three financial quarters, with 363 recorded although this is a lower number of concerns raised than in previous years for that Quarter. Overall, Safeguarding incident reporting has dropped slightly from the peak of 489 in Quarter 4 17/18. It is important to note that there was a change in practice from the end of 2017 when all seclusions outside a designated seclusion area were reported as a Safeguarding concern. This led to an increase in concerns being raised in Hertfordshire, where Dove ward had no seclusion area. Work was undertaken with the local authority and these are no longer reported as a safeguarding concern and may explain the gradual drop in incidents.

7.10 In Quarter 4 19/20 the Safeguarding Team reminded investigating teams in Hertfordshire that Datix should be completed when they receive safeguarding concerns from external This was following a result of a spot check which found that some staff were not following this process. In Quarter 1 a detailed audit was carried out in Hertfordshire which found that Investigating Teams were failing to raise an incident report when they had received a Safeguarding referral from outside the Trust, in particular, from private hospitals. An action plan is in development around this for completion throughout Quarter 2.

7.11 Reports of domestic abuse rose from 58 incidents in Quarter 4 to 83 in Quarter 1 which was in line with trends reported nationally reflecting the increased risks associated with the COVID-19 lockdown which commenced in March 2020 (Chart 11). In response, the Trust Corporate Safeguarding Team disseminated COVID-19 guidance to staff supporting service users and colleagues who may be experiencing domestic abuse. The Safeguarding Team have also developed a programme of domestic abuse seminars delivered to staff via MS Teams which have been recorded and are available to view on The Hive.

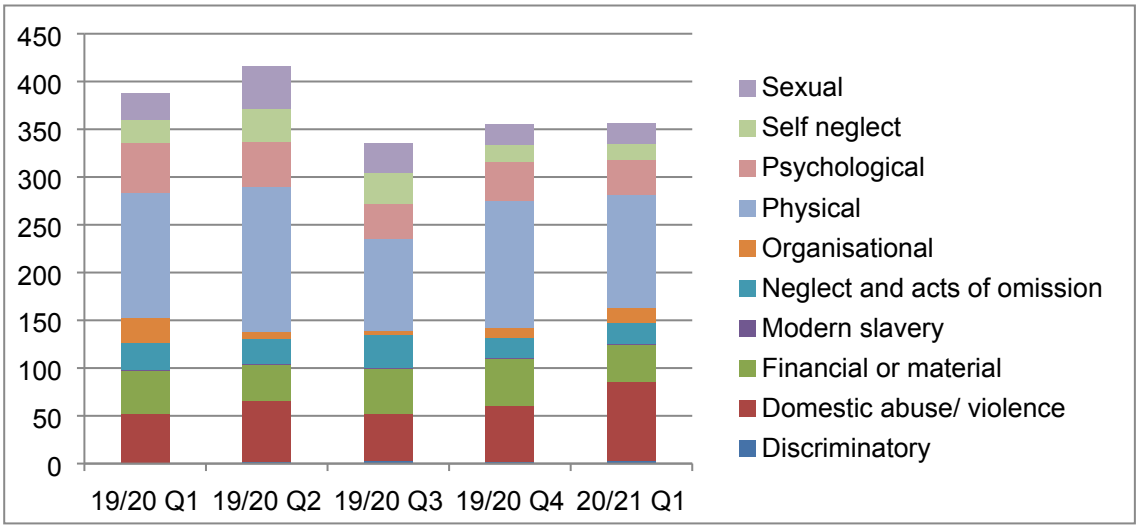
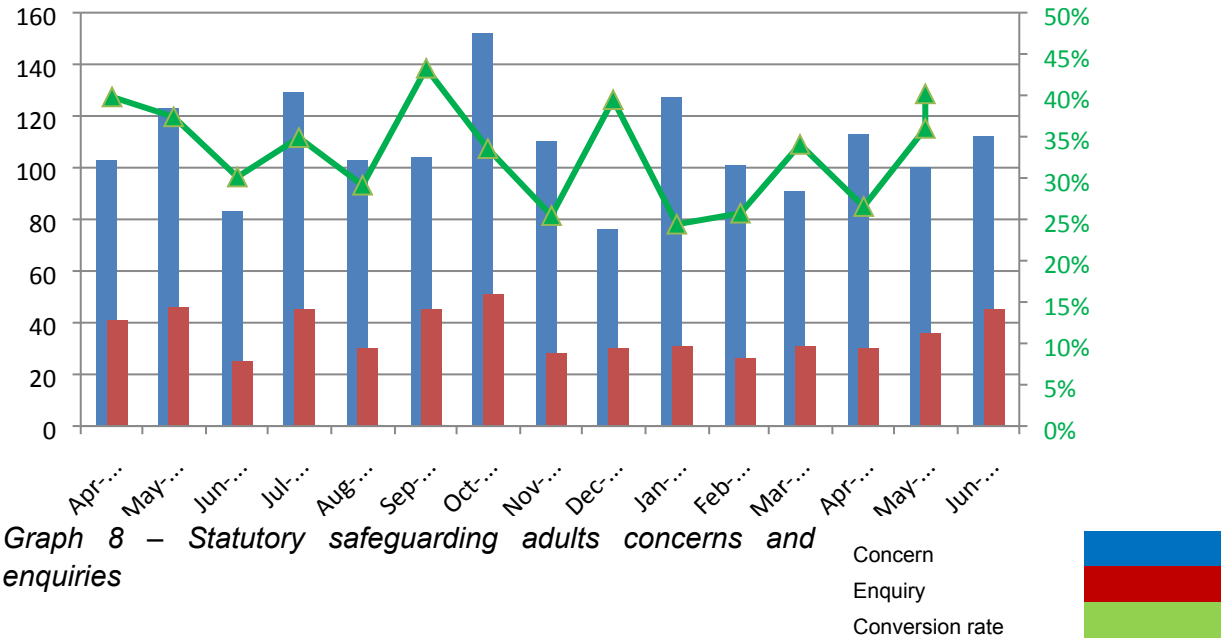


Chart 11 – Safeguarding adult's incidents by category of abuse

7.12 It should be noted that since April 2019, staff have been unable to access Safeguarding Training from Hertfordshire County Council. Dates have now been offered and a list of priority staff to be trained have been identified.

Statutory Safeguarding Adults in Hertfordshire

7.13 Statutory safeguarding relates to the cohorts of service users for whom the Trust have additional statutory safeguarding responsibilities (adult safeguarding for people with functional mental illness residing, or placed, in Hertfordshire). Safeguarding adult concerns have recovered from an initial decrease at the beginning of the COVID-19 pandemic, as was in line with the national picture (graph 8).



Graph 8 – Statutory safeguarding adults concerns and enquiries

7.14 The Trust has been working to improve the conversion rate (the rate of concerns 'converted' to enquiry) following concerns that too few investigations were taking place. Audits revealed that, while individuals were being kept safe, enquiries were not being recorded according to the Trust process, with staff relying on case notes to record their actions. This means that data was not able to be drawn from the Safeguarding Adults forms. There were also overall concerns about decision making, with some managers not understanding that a strategy discussion can constitute an enquiry.

Sexual Safety Collaborative

7.15 As reported previously, and as part of Trust's response to the CQC Sexual Safety on Mental Health Wards report, a successful bid was made to join the Sexual Safety Collaborative which is hosted and facilitated by the National Collaborating Centre for Mental Health (NCCMH), with Swift ward as the pilot.

7.16 This project was suspended by the NCCMH at the start of lockdown, however, it is expected to recommence in Quarter 2 20/21. At the point of suspension, the project was at the initial data gathering phase. Wards will be making changes in line with the information gleaned from short surveys of patients, carers and staff to improve sexual safety.

Prevent and Channel Panel

7.17 No referrals to Prevent, however, individuals known to the Trust are frequently discussed at Channel Panel in Hertfordshire. The Corporate Safeguarding Team are key members of the Hertfordshire Panel and attend all meetings. In light of the fact that there have been no referrals to Prevent in Hertfordshire for some time, the Prevent team will run an awareness raising session via Microsoft Teams in Quarter 2.

7.18 The Channel Panel is now held virtually, monthly in light of the COVID-19 pandemic to ensure a multi-agency risk management approach is taken to support individuals at risk of grooming and exploitation by extremist groups.

COVID-19 Domestic Abuse Response

7.19 The Corporate Safeguarding Team developed guidance for staff to support both service users and colleagues if they disclose domestic abuse during lockdown. This guidance was devised with the involvement of the IDVA service in Hertfordshire and also with reference to the Safe Lives recommendations for reducing risks to victims and is available on the Hive. It includes links to online resources, however, all domestic abuse services remained open during lockdown, including refuges, with business continuity plans in place.

7.20 In Hertfordshire, the Domestic Abuse Strategic Partnership instigated a range of meetings to provide oversight of domestic abuse during lockdown. The HPFT Corporate Safeguarding Team were key members of the Provider Response Group and the MARAC COVID-19 Group.

7.21 As part of the COVID business continuity plan, Refuge ceased all external co-locations in Quarter 1, including the co-location in HPFT. This is under review as lockdown eases.

Audits

7.22 The CAMHS Not Brought In (NBI) audit has been deferred, due to the cessation of all non-urgent work, during the COVID-19 response.

7.23 The results have recently been received from a HSCP Multi-Agency Supervision Audit, completed in January 2020. Responses were collected via an online survey. The survey was emailed to approximately 800 clinicians across HPFT, 35 responses were received. Just over 50% of the surveys were completed by CAMHS Specialist Teams, 14% by CAMHS Community Quadrant Teams & 11% by the Community Perinatal Team. 17% were recorded as ‘other’ teams. The response rate to this survey was disappointing and there is a need for further consideration of ways to increase uptake for any future surveys.

7.24 91% of surveyed clinicians said they receive supervision. When exploring the comments entered by the three clinicians who stated they do not receive supervision, it became clear that they are receiving safeguarding supervision integral to other case discussions e.g. high risk pathway discussions, MDTs, clinical supervision or patient safety meetings. Therefore 100% of clinicians who responded do receive safeguarding supervision.

7.25 Overall the audit illustrates Trust clinicians are receiving regular safeguarding supervision that provides a safe place & sufficient time to discuss complex cases, provide challenge & helps to formulate agreed action plans. This should be considered with caution due to the low response rate.

8. Conclusion

8.1 This section of the report has given an overview of incidents reported in Quarter 1 2020/21. The report demonstrates that there have been significant improvements in some areas whereas others require more focus into Quarter 2.

8.2 The number of unexpected deaths thought to be due to suicide has reduced. This quarter cannot be viewed without consideration of the global pandemic, which has resulted in an increase in deaths on the older adult mental health wards. Rapid reviews were undertaken and immediate learning implemented with good affect.

8.3 The Trust has made significant progress with the SI recovery work and 44 reports were submitted to Commissioners but further work is needed to address the outstanding action plans.

8.3 There has been an increase in the use of restraint but a decrease in the use of prone restraint. Seclusion use has slightly decreased and the use of rapid tranquilisation has remained at a similar level. Long term segregation is not used often but, when it does, the processes of assurance have been strengthened. Additional work considering the Human Rights Act will continue into 2020/21.

8.4 Safeguarding work has been responsive to the changing needs during the pandemic, tailoring training and ensuring referrals do not decrease.

PART C LEARNING FROM INCIDENTS AND CHANGING PRACTICE

1 Introduction

1.1 Learning from incidents, Serious Incidents, complaints, feedback and mortality reviews, is integral to the Trust's safety culture. The Trust has various ways in which to share learning including, reflective learning sessions, local and Trust patient safety meetings, SBU Quality Risk Meetings, case study presentations and learning notes.

1.2 Improvements are made based of intelligence from many sources including incidents, serious incidents, complaints, claims, Freedom to speak up, national publications, such as prevention of future death reports, research, Clinical Alert System (CAS) alerts, multiagency reviews and guidance.

1.3 The primary approach to improving safety is through continuous quality improvement and fostering a culture of safety. This part of the report will therefore summarise some, but not all of the initiatives that have taken place in Quarter 1. Significant work was undertaken in relation to improving safety within the context of Covid19 and this has been reported in separate reports to the Board.

2 Learning Themes and actions

2.1 The Trust has a suite of measures to discuss and share learning from incidents and serious incidents which includes Swarms, Continuous Professional Development (CPD) sessions, local governance meetings, use of learning notes, reflective learning events, suicide prevention partnerships, internal safety alerts and regional action learning sets.

2.2 A virtual Adult Community Learning Event was held in June facilitated by the Clinical Directors in East & North and West SBU's. This provided a way in which to share learning from Swarms, incidents and serious incidents and has been well received. Learning and good practice from incidents discussed in the learning event highlighted positive practice. Learning was shared in relation to

- Physical healthcare and recognising the early signs and symptoms of Covid19
- The importance of considering a wide range of risk factors prior to discharge from a Community Treatment Order (CTO).
- A learning event regarding the impact of changes to practice following lockdown and the significant mental health impact on people due to COVID -19.
- Carer involvement in the care and treatment of family during lockdown.

2.3 Recent cases discussed at the Moderate Harm Panel, some of which have been reported as serious incidents, have highlighted that further work is needed around support for staff on risk formulation and safety planning. An Education Task & Finish Group reviewed practice and policy relating to risk formulation. The work of the group informed a successful business case for funding for an HPFT Simulation Training Hub. The training strategy and oversight around the work on setting up the training hub and case scenarios are being developed.

2.4 Diagnostic overshadowing has also featured in case discussions in Swarms and the moderate harm panel when a team reflected on a family's view that not eating and drinking was a manifestation of the service user's mental health rather than a sign that they may be physically unwell due to COVID- 19.

2.5 Other learning themes have included bad news mitigation, managing endings and transitions, liaison with primary care, physical health monitoring and liaison and joint working with CGL Drug & Alcohol Services.

2.6 Actions taken in response to learning from our serious incidents have included:

- Refresher training session for the team on the carers pathway delivered by the senior social worker, the Carer Network representative and the carer support worker.
- Quadrant based monthly joint meetings with CGL to support joint working and clear lines of communication to discuss referrals
- Local team refresher session on risk formulation and how to manage treatment packages in complex cases.
- Update of Operational policy to provide clarity on contact that contact with the GP, private professional or prescribers to understand the rationale for the medication, who is monitoring the medications/side effects and to understand the treatment plan.
- A learning session delivered by HPFT Safeguarding Team covering recognition and intervention for domestic violence particularly coercion and control, effective engagement strategies and communication and joint working with other involved professionals in a service user's case.
- Continuous Quality Improvement project to improve adherence to Depot Standard Operating Procedure and service users engagement with Depot Services
- CTO refresher training session including shared decision making principles and carer involvement

3 Incident Reporting

3.1 The use of Datix, the information technology system for managing incidents, has been developed in response to changing needs, for example COVID-19, and user feedback. The aim of these changes is to ensure it supports the Trust's quality and safety agenda. Datix Dashboards are used at team and service level to monitor data and compare over time and highlight where actions may be needed. Datix training has been delivered virtually to local teams during COVID-19 period which has been well received by teams.

4 Suicide Reduction

4.1 The Trust's Suicide Prevention Group refreshed membership and the terms of reference in the quarter. This group are leading in putting on a virtual Suicide Prevention Conference on World Suicide Prevention Day, on 10th September, with external speakers. This will coincide with World Suicide Prevention Day and have a variety of speakers with lived experience, key partners including Public Health and British Transport Police, a Schwartz round and a session on risk formulation.

4.2 For the remainder of the year, a number of initiatives are being taken forward as part of the Trust's commitment to reduce suicides and the Suicide Prevention Group work plan. This includes a joint initiative with the Samaritans to provide support to service users following discharge and between appointments, crisis plans in place for everyone on the Personality Disorder pathway, introduction of risk formulation meetings for every team across the pathway to discuss high risk cases needing risk formulation, launch a module on Risk Assessment and Management using a Simulation Based Approach, and pilot a new community service framework using personalised care planning and risk formulation approach replacing the CPA framework.

4.3 The Trust is engaged in work being led by Public Health on improving bereavement support in Hertfordshire. Support for the Bereaved by Suicide is a continued priority

into 2020/21 as part of the Hertfordshire Suicide Prevention strategy. Signposting to bereavement support and local resources is included in the Duty of Candour letters sent to families when serious incidents are called. Work is ongoing commissioned by the IHCCT looking at Bereavement Services in Hertfordshire.

5 Mortality Governance

5.1 It is envisaged that data from the National Spine will be used to ensure that the Trust will be aware of all deaths under its care as promptly as possible. This will make death reporting more contemporaneous, both avoiding unnecessary appointments and abortive visits.

5.2 Continue to improve communications with a particular focus on sharing learning across SBUs.

6 Avoidable harm

6.1 Various CQI projects are currently being undertaken to address risk within the Trust. These include projects on Safe and Supportive Observations, Search, Violence & Aggression and Personal Care as well as

- The use of safety pods on Forest House has led to good clinical outcomes for our service users.
- Consultation for a new lone working device contract has been concluded and a pilot will commence in the next quarter.

6.2 Ligatures continue to offer a challenge as they are readily available, easily modified and also hidden about the person. Work on Search procedures and the production of a standardised Operating Procedure is in progress and will continue in to the next quarter.

6.3 Due to COVID-19 all face to face training with the Tissue Viability Nurse (TVN) was cancelled, with virtual training being offered as an alternative. Advice on treatment plans was provided by the TVN. Recruitment of a TVN support worker is taking place in Quarter 2 to support the HPFT prevention agenda and commitment to avoidable harm.

6.4 In East & North SBU a trial of a SEM (sub epidermal moisture) scanner took place on one of the continuing care units. The SEM device picks up pressure damage before it is visible to the eye, allowing intervention to be put in place sooner. The trial concluded in December 2019 and the results were presented to staff by the company. No further work with the scanners is being undertaken due to current pandemic. The TVN, team leader and company have written an article for publication which is being put forward to the European Pressure Advisor Panel on the results of the trial. The findings will be presented at the Safety Committee in September 2020.

6.5 The Trust continues to promote a learning and just culture and ensures that incident investigation adheres to these principles, staff are supported through this process with a focus on learning and improvement.

7 Least Restrictive Practice

7.1 Using the least restrictive practice is a complex and multi-faceted issue where progress in one area can have unintended consequences in another. The different types of restrictive practice are considered together when understanding the outcome of any initiative in this area.

7.2 The Trust's MOSStogether Strategy underpins the Quality Strategy and supports and builds on the Trust's Making Our Services Safer (MOSS) Strategy and sets the direction for providing safe and effective services, enabling a positive experience for those who receive our services. The launch of the strategy and its implementation action plan were postponed due to the pandemic but will be taken forward into quarter 2 2020/21

7.3 Oversight and assurance has been strengthened with guidance developed through policy and newly developed reporting systems on PARIS including a weekly MDT review of care and treatment with specific reference to their Human Rights.

7.4 The implementation of HOPE model has been deferred until the end of September 2020 due to the availability of the trainers. Segregation is potentially damaging and traumatic having the potential to impact on the human rights of service users with a impact on staff as well. The process of Long-Term Segregation (LTS) may result in increased social, mental health and physical health difficulties and can result in further social exclusion and secondary symptoms because of extended isolation. The HOPE(S) clinical model of care, reviews factors which prevent or improve patient's progress as they integrate out of LTS.

7.5 Prior to COVID-19 a range of Continuous Quality Improvement (CQI) initiatives were being undertaken to consider issues relating to or supporting restraint and seclusion, which require re-visiting, as lockdown measures are relaxed. Professor Joy Duxbury has recently cited (The Cochrane Collaboration, 2009, 2011, 2013) that '*no control studies exist that evaluate the value of seclusion or restriction in those with serious mental illness … requiring alternative ways to be developed'.*

7.6 The projects that were paused in response to the pandemic that are being restarted are:

- Personal Care (Mental Health Services Older People Inpatient)
- Recording of violence and aggression incidents during personal care (Mental Health Services Older People)
- Safe and Supportive Observations (Head of Nursing Learning Disability & Forensics Strategic Business Unit)
- Use of the Brøset Violence Checklist (Psychiatric Intensive Care Unit)
- Seclusion (Psychiatric Intensive Care Unit)
- Search (Head of Nursing- West Strategic Business Unit)
- Dove Ward Restrictive practices
- Warren Court Restrictive practices - Safety Huddles.

8 Conclusion

8.1 This section of the report has set out some but not an exhaustive account of the response to learning and quality improvement initiatives that have taken place in this quarter in relation to safety. Some reviews and innovations have been paused due to the pandemic response but are set to restart in quarter 2.

9 Priorities

9.1 Building on the work from 2019/20 a number of priorities have been set for 2020/21. The pandemic has meant that some progress has been stalled but, significant work has been undertaken in other areas.

Annual Plan

9.2 Continue our drive to prevent suicides through collaborative working with key partners including Public Health

9.3 Reduce avoidable harm experienced by service users and staff

9.4 Ensure our service users and staff feel safe

9.5 Ensure least restrictive practice is appropriately used to support service user recover

Strategy

9.6 Continue with the priorities set out in the Quality Strategy and Making our Services Safer Together (MOSStogether) as detailed in Part A of this report with its focus on Just and learning culture, safety culture and providing safe care in top quality environments.

9.7 CQI methodology is embedded in the Trust when considering safety.

Governance

9.8 Further improvements and embedding of the Safety Dashboard on Spike 2
Improve the timeliness of completing investigations and reporting on action plans

9.9 Continue to maintain the recent improvements in the quality and timeliness of serious incident reports and reduce the number of overdue action plans.

9.10 Systematically join up and build on learning from serious incidents, triangulating with other intelligence such as complaints, Freedom to Speak Up and national safety notices.

Other

9.11 Review of restrictive practice in Essex and IAPT

Board of Directors PULBIC

Meeting Date:	24 September 2020	**Agenda Item: 9**
Subject:	Quarter 1 Safer Staffing Report	**For Publication:**
Authors:	Heads of Nursing, and Jacky Vincent, Deputy Director of Nursing and Quality/DIPC	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety/Chief Nurse
Presented by:	Dr Jane Padmore, Executive Director Quality and Safety/Chief Nurse	

Purpose of the report:

This report provides the Board with the data for quarter 1, 2020/21 on nurse staffing for the Trust. In addition, the report provides information that sets the context for the published data including recruitment, retention and vacancies of nursing staff and cross referenced with patient safety data. The purpose of this report is to provide information and assurance of the governance processes for rostering and ensuring the appropriate level and skill mix of nursing staff.

Action required:

The Board are asked to consider and note the contents of the report and discuss any point of clarification. To also receive assurance of the governance process for rostering and safe staffing.

Summary and recommendations to the Committee:

The direct care nurse staffing data was analysed according to total hours worked per ward for RN and HCA, divided into day and night time hours and includes additional duties. Quarter 1 showed a number of shifts which were over 120% and 4 which were below 80%. The Heads of Nursing are focusing on their weekly scrutiny meetings to ensure close monitoring and management of the skill mix and staffing levels. Increased focus on agency usage continued during the quarter with targeted plans for the SBUs.

Challenges with inconsistency in the use of SafeCare within all inpatient services with daily SafeCare calls are being addressed to ensure safe staffing and effective use of our staffing resources across the Trust.

Targeted work in the SBUs continues for quarter 2 includes:

- Ensuring best practice is applied in the review and management of therapeutic engagement and observation levels on the wards (for example, reviewing in each shift to ensure the level of observation is in line with the level of risk presented by the service user
- Use of alternative interventions including SafeWards to be relaunched and refreshed in all inpatient wards – as part of the MOSS*together* Strategy
- eRoster management of bank bookings, management of annual leave and ensuring staff working to contracted hours and ensuring fairness
- Ensuring all RNs are conversant with the dependency levels in utilising SafeCare census to enable consistency in its application
- Team Leaders and Matrons aware of budgets and spending on additional shifts (and attending the training sessions on offer from Finance)
- Ensuring unutilised hours are addressed
- A review of all skill mix establishments for the inpatient services as part of the formal 6 monthly review as well as in consideration of the 56 appointed clinical extended placement students.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

Staffing – there is a need for regular review of staffing establishment

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

N/A

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

Potentially all of the above

Seen by the following committee(s) on date:

QRMC 14th August 2020

Quarter 1 Safer Staffing Report 2020/21

1. Introduction

1.1 This report serves to provide the information and analysis of the quarter 1 nurse staffing data to enable the Quality and Risk Management Committee (QRMC) to have assurance in relation to the nurse staffing in the Trust's inpatient services.

1.2 This report also provides supporting data in relation to vacancies.

2 Trust expectations in relation to inpatient nurse staffing levels

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

2.2 Where the skill mix and the numbers of staff who actually work is lower than planned, this may indicate a safety concern. There is an agreed escalation process for reporting any safety concerns associated with nurse staffing, as detailed in previous QRMC reports.

2.3 In the event that a shift remained unfilled, this is reported to the Heads of Nursing and recorded as a safety incident on Datix, again as detailed in previous reports.

2.4 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 Matrons.

2.5 Although all efforts are made to ensure the right skill mix, staff sometimes prefer to work with a regular Healthcare Assistant (HCA) to ensure continuity of care rather than seek a Registered Nurse (RN) through the Bank Bureau office or as agency.

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

2.7 *SafeCare* continues to be well embedded within all in-patient services with daily *SafeCare* calls held to ensure safe staffing and identifying any hotspots. This allows for effective use of our staffing resource across the Trust.

3 Summary of findings for quarter 1 nurse staffing data collection

3.1 The analysis from the safe staffing returns has been broken down by month to provide detailed information about the services; detailed analysis is provided on services with fill rate under 80% in red and those over 120% in purple.

3.2 Care Hours Per Patient Day (CHPPD) data submitted by the Trust, reflects the increased staffing utilised in many of the services as a result of increased acuity and also the stand alone units where CHPPD is high. **Appendix 1** provides detailed data for each inpatient or quarter 1, which includes data in a separate column the data relating to the Registered Nurse Associates (RNA). This quarterly report includes 4 months' data as March was not submitted during last year's quarter 4 report due to Covid-19. There are a number of shifts which were over 120% and 4 which were below 80%. The Heads of Nursing are focusing on their weekly scrutiny meetings to ensure close monitoring and management of the skill mix and staffing levels.

3.3 During March, and at the onset of the Covid-19 pandemic, maintaining safe staffing levels was on the Covid-19 and the Trust risk register. In order to manage the increase in staff absences from work, whilst ensuring safe staffing levels, the minimum staff levels were reviewed alongside the way nursing is delivered on the inpatient wards. The proposed minimum staffing levels were a temporary level and reviewed throughout the time Covid-19 impacted on staffing levels.

3.4 To underpin this work, a set of principles were developed:

- New reviewed minimum levels are a minimum and, should the unit be able to staff at pre-COVID-19 levels, this should be done
- The number of RNs on a shift cannot be reduced and should be met through the movement of staff across the Trust or through Team Leaders and Matrons working on shift
- All units will continue to engage in the three times daily SafeCare census check calls and will work, across the Trust, to ensure the effective deployment of staff
- Two senior nurses seconded to form a team that oversees safe staffing across the Trust, co-ordinating where and how staff are redeployed and reporting into Tactical Command. SafeCare is used by them as it is well embedded within all in-patient services
- Daily census checks (SafeCare calls) held to ensure safe staffing and to identify and manage any hotspots, allowing for effective use of staffing resource across the Trust
- Professionals, including community nurses and those of other professions, redeployed to work in the inpatient services and receive refresher training to enable this
- If the number of beds that are used fall overall, these, where possible, should be consolidated so that units can be shut, to enable the most effective use of staff. The units that should initially be considered for closing should be the standalone services.

3.5 The minimum staffing levels were reviewed weekly, taking into account which units are closed and the plans to cohort service users.

3.6 March's data submission was suspended during the Covid-19 pandemic and will therefore be included in the next quarterly report. The data now includes the Registered Nurse Associates (RNA) and Student Nurse Associates (SNA).

Essex and IAPT SBU

3.7 Staffing levels were temporarily increased in consideration of the increase in acuity and supporting staff as a standalone unit. There have been three individual service users with complex individual needs and displaying behaviours which challenge; two are fit for discharge.

3.8 There have been a number of reported incidents on service user to staff assaults which continue to be closely monitored and also reviewed via the SBU's Quality Review Meetings.

East and North SBU

3.9 Staffing levels continue to be closely monitored by the senior nursing staff. The Covid-19 pandemic had a significant impact on the staff across the SBU services, with a high proportion of community staff redeployed into the inpatient services.

3.10 The SBU has three Matrons currently in an interim positon which will be reviewed after the proposed Clinical Matron consultation. Furthermore, during the Covid-19 pandemic, two Team Leaders were working from home; additional staff were provided to ensure local leadership was visible and maintained.

3.11 The Head of Nursing has increased their scrutiny and providing support to the Matrons to manage challenges, review practice and implement solutions. Also, a 06:00am call was established across the SBU to help in identifying staff levels and redeploy staff accordingly.

West SBU

3.12 The Covid-19 pandemic was also a challenging time cross the West SBU in the frontline services with a continual demand for beds and high acuity. As the SBU works towards recovery and restoration, plans to recommence the Continuous Quality Improvement (CQI) projects including the use of enhanced safe and supportive observations as a key intervention.

3.13 The SBU are supporting the Matrons and Team Leaders in ensuring an improvement on eRoster production timescales and management, continued recruitment and retention work and recommencing CQI projects.

Learning Disability and Forensic SBU

3.14 The SBU also reported challenges and the impact on staffing in the inpatient services during the Covid-19 pandemic. Some inpatient staff were redeployed to areas outside of the SBU for support during the pandemic.

3.15 The provision of training during the pandemic is being addressed to mitigate any risks relate to staff competencies.

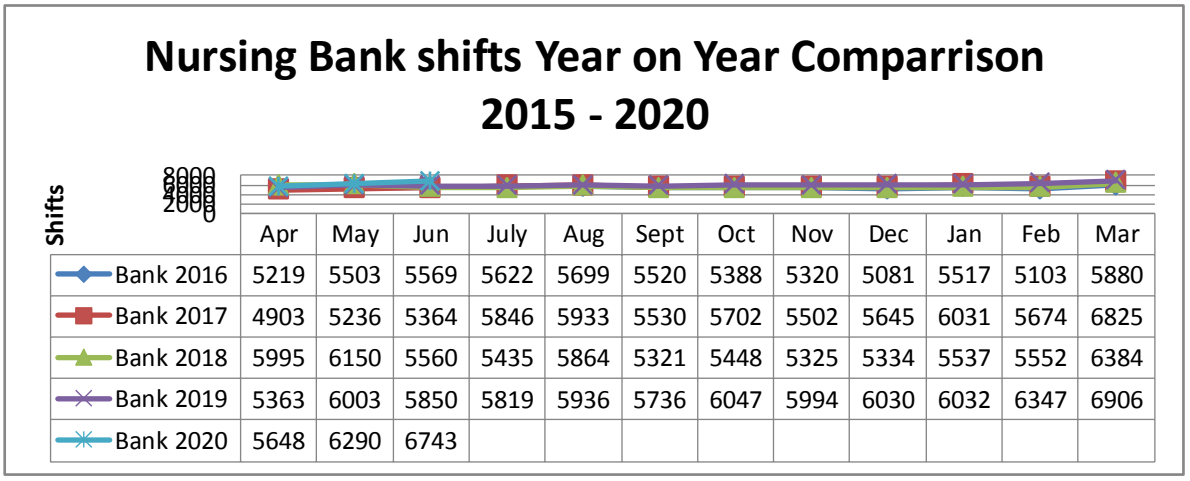
3.16 Although the eRoster Scrutiny meetings were held weekly during the quarter, the scrutiny was not as robust owing to limited attendance as the Matrons and Team Leaders were supporting the services during the pandemic. These have recommenced with full attendance as part of the recovery.

4. Bank and Agency

4.1 The overall bank and agency usage for quarter 1 is provided as a total number of shifts, over a 5 year period as shown in **table 1.** Furthermore, **graphs 1** and **2** shows the bank and agency use month on month for this financial year.

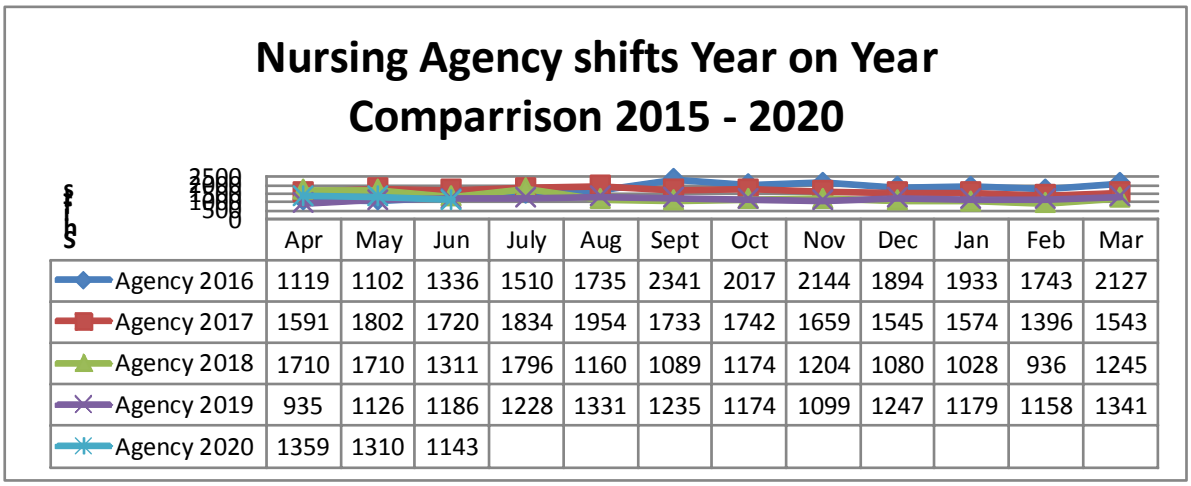
		April	May	June
2016	**Bank**	5219	5503	5569
	Agency	1119	1102	1336
2017	**Bank**	4903	5236	5364
	Agency	1591	1802	1720
2018	**Bank**	5995	6150	5560
	Agency	1710	1710	1311
2019	**Bank**	5363	6003	5850
	Agency	935	1126	1186
2020	**Bank**	5648	6290	6743
	Agency	1359	1310	1143

Table 1



	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Bank 2016	5219	5503	5569	5622	5699	5520	5388	5320	5081	5517	5103	5880
Bank 2017	4903	5236	5364	5846	5933	5530	5702	5502	5645	6031	5674	6825
Bank 2018	5995	6150	5560	5435	5864	5321	5448	5325	5334	5537	5552	6384
Bank 2019	5363	6003	5850	5819	5936	5736	6047	5994	6030	6032	6347	6906
Bank 2020	5648	6290	6743									

Graph 1



	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Agency 2016	1119	1102	1336	1510	1735	2341	2017	2144	1894	1933	1743	2127
Agency 2017	1591	1802	1720	1834	1954	1733	1742	1659	1545	1574	1396	1543
Agency 2018	1710	1710	1311	1796	1160	1089	1174	1204	1080	1028	936	1245
Agency 2019	935	1126	1186	1228	1331	1235	1174	1099	1247	1179	1158	1341
Agency 2020	1359	1310	1143									

Graph 2

4.2 The bank shifts completed increased by 453 shifts from May into June and in comparison from June 2019 to June 2020, there shows an increase of 896 shifts worked.

4.3 The agency shifts completed has decreased by 167 shifts from May to June and again, in comparison from June 2019 to June 2020, has decreased by 43 shifts. In consideration of the reasons for bookling, the highest 3 are vacancy, safe and supportive observations and then the Covid-19 pandemic.

4.4 The actions previously discussed at the Safer Staffing Group meetings therefore continued, including:

- Keeping agency use to an absolute minimum and ensuring that all agency use goes through the correct authorisation process
- Ensuring all agency shifts are confirmed on a weekly basis to ensure clear sight of usage
- Reviewing processes to ensure that the potential to convert agency to permanent staff is maximised.

5. Vacancies

5.1 The Trust continues to have challenges with recruitment in quarter 1 as detailed in **Table 3**, which remains a focused priority with the SBUs and the corporate nursing services.

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex and IAPT	13.00	9.33	3.67	28
Learning Disability & Forensic	173.21	139.86	33.35	19
East and North	124.17	97.32	26.85	22
West	126.43	100.43	26.00	21
Total	**436.81**	**346.94**	**89.87**	**21**
Unregistered Nursing				
Essex and IAPT	15.00	15.43	-0.43	-3
Learning Disability & Forensic	213.71	207.79	5.92	3
East & North	196.93	183.12	13.81	7
West	140.19	128.40	11.79	8
Total	**565.83**	**534.74**	**31.09**	**5**

Table 3

5.2 The Trust continues to work with the local universities ensuring that student nurses feel part of the Trust family at the start of their training and meeting senior nurse leaders during their training. The Deputy Director of Nursing and Quality/DIPC meets monthly with the University of Hertfordshire's Head of Nursing, Health and Wellbeing to build on the work with the students' placements, ensuring regular contact as their future employee and enabling a more smooth transition from student to registered nurse with the Trust being their employment area of choice.

5.3 Six monthly meetings with all learning disability and mental health student nurses continue with the Deputy Director of Nursing and Quality/DIPC and the Heads of Nursing to maintain contact with them, discuss their opportunities and also ensure they feel welcomed and part of the Trust.

5.4 **Appendices 2** and **3** provide a breakdown of vacancies in the inpatient and community services respectively.

5.5 A significant risk remains for the Trust regarding the profile of RNs who are able to retire, detailed in **Table 4**. Work continues to support them and explore their options to remain in the workforce.

Area	55-59			60-64			65+		
	HCA	RN	Total	HCA	RN	Total	HCA	RN	Total
Essex and IAPT	1	3	4	2	0	2	1	0	1
LD and F SBU	32	23	55	19	10	29	5	0	5
E and N SBU	30	13	43	16	12	28	6	2	8
West SBU	21	8	29	12	3	15	4	6	10
Total	**84**	**47**	**131**	**49**	**25**	**74**	**16**	**8**	**24**

Table 4

5.6 The previous agreement for the Trust to lead on the Health and Care Academy, working with Health Education England (HEE) was plaed on hold during the Covid-19 pandemic. Led by the Deputy Director of Nursing and Quality/DIPC, this is aimed at supporting and developing young people and encouraging them into health-related careers, supporting the pipeline of individuals joining the NHS.

5.7 The Academy concept allows the Trust to 'grow its own staff', linking with colleges and schools to recruit local people/students who may not have previously considered careers in healthcare. A Lead has been appointed to oversee the development of an interactive programme to support development into careers such as nursing as well as broaden knowledge and understanding of the NHS.

5.8 Working with the Talent Academy, the original plans to pilot two programmes starting as a summer school with 20-25 students for 5 days, with lesson plans focusing on mental health and learning disability are being reviewed with a view to start in the autumn and using more virtual training and meetings.

5.9 Although the Deputy Director of Nursing and Quality/DIPC continues to lead on the Student Nursing Associate (SNA) working group, on behalf of the STP, a SNA Pipeline post has been recruited to for a one year contract to oversee all future SNA recruitment. Challenges with current SNA cohorts returning to their studies having been paused during the Covid-19 pandemic are being considered between the partner organisations and the University of Hertfordshire.

5.10 At the onset of the Covid-19 pandemic, the Chief Nursing Officer for England commissioned a proposal to implement Clinical extended Placements for final year student nurses. The Trust supported this and, as a direct outcome, have

offered 56 individuals to substantive posts. Work in quarter 2 to review the skill mix and establishments is planned to consider the new posts and enable a significant positive impact on the reduction of agency and bank.

5.11 The self-rostering pilot initiative, which commenced to implement a team-based rostering system for nursing staff, aims to be reinstated in the future, postponed owing to the Covid-19 pandemic. This pilot is aimed at increasing nurses' input into their working patterns and improving work-life balance in the Trust and provides the nursing team with autonomy and permission to negotiate the eroster, in the context of being open and transparent. Inpatient services from each of the SBUs are participating in the pilot.

6. Conclusion

6.1 This report sets out to brief the QRMC in relation to the quarter 1 position for safe nurse staffing within inpatient services. The report also includes community nursing staffing and the vacancy rate.

6.2 In addition, the report details the work the Trust is currently undertaking in order to run safe and effective services whilst being compliant with the safer staffing requirements, to ensure the Trust has the right staff, in the right place, with the right skills, at the right time.

6.3 Challenges with inconsistency in the use of SafeCare within all inpatient services with daily SafeCare calls are being addressed to ensure safe staffing and effective use of our staffing resources across the Trust.

6.4 Targeted work in the SBUs continues for quarter 2 includes:

- Ensuring best practice is applied in the review and management of therapeutic engagement and observation levels on the wards (for example, reviewing in each shift to ensure the level of observation is in line with the level of risk presented by the service user
- Use of alternative interventions including SafeWards to be relaunched and refreshed in all inpatient wards – as part of the MOSS*together* Strategy
- eRoster management of bank bookings, management of annual leave and ensuring staff working to contracted hours and ensuring fairness
- Ensuring all RNs are conversant with the dependency levels in utilising SafeCare census to enable consistency in its application
- Team Leaders and Matrons aware of budgets and spending on additional shifts (and attending the training sessions on offer from Finance)
- Ensuring unutilised hours are addressed
- A review of all skill mix establishments for the inpatient services as part of the formal 6 monthly review as well as in consideration of the 56 appointed clinical extended placement students.

6.5 The QRMC is asked to note this report and discuss any point of clarification

Appendix 1 - Nurse Staffing fill rate data

Please refer to the Appendix Pack, Item 08.

Appendix 2 - Vacancies breakdown by in-patient services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Essex and IAPT SBU				
Lexden	13.00	9.33	3.67	28
Total	**13.00**	**9.33**	**3.67**	**28**
Learning Disability and Forensic SBU				
4 Bowlers Green	9.00	6.80	2.20	24
Beech Ward	14.20	11.00	3.20	23
Broadland Clinic	25.70	17.40	8.30	32
Dove Ward	12.00	10.13	1.87	16
Gainsford House	10.80	8.40	2.40	22
Hampden House	10.80	8.28	2.52	23
Astley Court	12.00	8.60	3.40	28
Warren Court	27.80	22.00	5.80	21
SRS Bungalows	17.00	13.00	4.00	24
The Beacon	11.31	10.28	1.03	9
Total	**150.61**	**115.90**	**34.71**	**23**
West SBU				
Albany Lodge	13.50	11.50	2.00	15
Aston Ward	15.00	11.59	3.41	23
Oak Ward	14.00	10.00	4.00	29
Owl Ward	11.00	8.00	3.00	27
Robin Ward	11.60	11.60	0.00	0
Swift Ward	18.00	17.00	1.00	6
Thumbswood	7.67	6.53	1.14	15
Total	**90.77**	**76.22**	**14.55**	**16**
East & North SBU				
Forest House	14.00	10.44	3.56	25
Lambourn Grove	11.04	9.77	1.27	11
Logandene	12.01	10.76	1.25	10
Seward Lodge	12.00	9.80	2.20	18
Victoria Court	12.64	10.50	2.14	17
Wren	11.14	10.61	0.53	5
Total	**72.83**	**61.99**	**10.95**	**15**
Overall Total	**327.21**	**263.33**	**63.88**	**20**
NON-REGISTERED NURSING				
Essex and IAPT SBU				
Lexden	15.00	15.43	-0.43	-3
Total	**15.00**	**15.43**	**-0.43**	**-3**
Learning Disability & Forensic SBU				
4 Bowlers Green	11.02	10.65	0.37	3
Beech Ward	14.00	16.20	-2.20	-16

Broadland Clinic	41.60	39.68	1.92	5
Dove Ward	13.89	17.49	-3.60	-26
Gainsford House	5.40	7.80	-2.40	-44
Hampden House	5.00	7.80	-2.40	-48
Astley Court	11.40	11.00	0.40	4
Warren Court	37.00	36.00	1.00	3
SRS Bungalows	56.00	42.47	13.63	24
The Beacon	8.00	8.60	-0.60	-8
Total	**203.31**	**197.19**	**6.12**	**3**
West SBU				
Albany Lodge	21.80	20.80	1.00	5
Aston Ward	16.08	15.00	1.08	7
Oak Ward	18.00	15.84	2.16	12
Owl Ward	15.53	13.53	2.00	13
Robin Ward	17.40	16.73	0.67	4
Swift Ward	17.40	13.91	3.49	20
Thumbswood	9.60	9.60	0.00	0
Total	**115.81**	**105.42**	**10.39**	**9**
East & North SBU				
Forest House	25.50	16.47	9.03	35
Lambourn Grove	32.62	31.43	1.19	4
Logandene	27.72	26.79	0.93	3
Seward Lodge	22.13	22.05	0.08	0
Victoria Court	34.90	33.40	1.50	4
Wren	18.80	20.01	-1.21	-6
Total	**161.67**	**150.15**	**11.52**	**7**
Overall Total	**495.79**	**468.19**	**27.60**	**6**

Appendix 3 - Vacancies breakdown by Community Services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	0.00	0.00	0.00	0
Continuing Care & Placement Team	2.60	3.60	-1.00	-38
Criminal Justice & Forensic	1.00	0.00	1.00	100
Criminal Justice Mental Health	2.00	5.00	-3.00	-150
LD SLDS A&T E/N Team	8.00	7.36	0.64	8
LD SLDS A&T West Team	9.00	8.00	1.00	11
Total	**22.60**	**23.96**	**-1.36**	**-6**
East & North SBU				
AMHCS Centenary & Jubilee	14.60	8.91	5.69	39
AMHCS Cygnet House	9.40	5.10	4.30	46
AMHCS Holly Lodge	5.00	4.00	1.00	20
AMHCS Saffron Ground	9.34	6.40	2.94	31
AMHCS Oxford House	2.00	1.00	1.00	50
AMHCS Rosanne House	11.00	10.03	0.97	9
Total	**51.34**	**35.44**	**15.90**	**31**
West SBU				
AMHCS NW Herts Dacorum	8.80	5.80	3.00	34
AMHCS NW Herts St Albans	6.98	5.33	1.65	24
AMHCS SW Herts	1.40	1.40	0.00	0
AMHCS SW Herts Borehamwood	7.10	5.60	1.50	21
AMHCS SW Herts Watford	11.38	6.08	5.30	47
Total	**35.66**	**24.21**	**11.45**	**32**
Overall Total	**109.60**	**83.61**	**25.99**	**24**
NON-REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	0.00	0.00	0.00	0
Continuing Care & Placement Team	0.00	1.00	-1.00	0
Criminal Justice & Forensic	0.80	0.00	0.80	100
LD SLDS A&T E/N Team	4.00	2.00	2.00	50
LD SLDS A&T West Team	5.60	6.60	-1.00	-18
Total	**10.40**	**10.60**	**-0.20**	**-2**
East & North SBU				
AMHCS Centenary & Jubilee	8.04	8.36	-0.32	-4
AMHCS Cygnet House	7.06	6.56	0.50	7
AMHCS Holly Lodge	4.50	4.50	0.00	0
AMHCS Saffron Ground	5.97	5.40	0.57	10
AMHCS Oxford House	2.69	1.35	1.34	50

AMHCS Rosanne House	7.00	6.80	0.20	3
Total	**35.26**	**32.97**	**2.29**	**6**
West SBU				
AMHCS NW Herts Dacorum	5.89	6.89	-1.00	-17
AMHCS NW Herts St Albans	5.40	5.40	0.00	0
AMHCS SW Herts	3.00	3.00	0.00	0
AMHCS SW Herts Borehamwood	2.49	2.49	0.00	0
AMHCS SW Herts Watford	7.60	5.20	2.40	32
Total	**24.38**	**22.98**	**1.40**	**6**
Overall Total	**70.04**	**66.55**	**3.29**	**5**

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item: 10**
Subject:	Guardian of Safe Working Report	**For Publication:**
Authors:	Dr Snehita Joshi Guardian of Safe Working	**Approved by:** Dr Asif Zia Executive Director for Quality and Medical Leadership
Presented by:	Dr Asif Zia Executive Director for Quality and Medical Leadership	

Purpose of the report:

This is the mandatory assurance report to the Board from the Guardian of Safe Working for Junior Doctors

Action required:

The Board are asked to note the report.

Summary and recommendations:

- This is the Quarterly Guardian Report, covering April to June 2020.
- During this quarter there were 0 exception reports raised by trainee and Trust doctors.
- The Trust has not received any exception reports since September 2019. This is a direct result of forward planning on the rota as well as vacant shifts being sent in a timely manner to doctors.
- There has been an increase in both vacancies and locum spend since the previous report. This is due to the Covid-19 pandemic- Covid-19 related absences, shielding and withdrawal of Foundation year 1 trainees being the main reasons for this.
- The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of exception reporting process.

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

Quality and 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: (Strategic objectives, only leave those that apply)

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

2. We will deliver a great **experience** of our services, so that those who need to receive our support feel positively about their experience

3. We will improve the health of our service users & support recovery through the delivery of **effective** evidence based practice

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

6. We will deliver **joined up care** to meet the needs of our service users across mental, physical and social care services in conjunction with our partners

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

There are no exception report being raised but the gaps in the junior doctor on-call rota are covered by locum and agency cover which has cost implications for the trust.

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

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

Seen by the following committee(s) on date:

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 11
Subject:	Annual Quality Assurance for Responsible Officer and Revalidation 2019/2020	**For Publication:** No
Author:	Abiemwense Giwa-Osagie, Revalidation Co-Ordinator	**Approved by:** Prof Asif Zia, Executive Director of Quality & Medical Leadership
Presented by:	Prof Asif Zia, Executive Director of Quality & Medical Leadership	

Purpose of the report:

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

Action required:

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

Summary and recommendations to the Board:

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

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, to improve the quality and safety of care provided to patients, and lead to increasing public trust and confidence in the medical system.

The Executive Director – Quality & Medical Leadership/Responsible Officer, oversees the process for HPFT. As part of medical appraisal and revalidation within HPFT, a robust appraisal system for doctors incorporated with trained appraisers and a bespoke IT system. All relevant policies updated with COVID_19 guidance from the NHSI, GMC and the Academy of Medical Royal Colleges.

This report informs HPFT Board of its statutory responsibilities to ensure that all doctors linked to HPFT keep up to date with their clinical knowledge and remain fit to practise. Annual quality assurance for the responsible officer and revalidation report inform the

committee that systems are in place to monitor that regular appraisals are taking place.

This report reports on quality assurance for responsible officer and revalidation carried out by the Trust till 31st March 2020. Out of the 185 doctors linked to HPFT, 130 doctors completed their appraisal. The remaining outstanding of 40 attributable to sickness, maternity leave, leaving the Trust and 17 due to challenges of COVID-19.

Thirty-nine doctors due for revalidation during 2019/2020 within HPFT, 36 doctors with positive recommendation completed on time and the three remaining – two due to insufficient evidence, later revalidated within two months and one deferred for a third time due to long term sickness has retired.

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

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

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

N/A

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

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

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

Seen by the Executive Committee on 24th Septemeber 2020.

Hertfordshire Partnership University NHS Foundation Trust

Guardian of Safe Working Hours Quarterly Report (Q1) April to June 2020

1) Executive summary

- This is the Quarterly Guardian Report, covering April to June 2020.
- During this quarter there were 0 exception reports raised by trainee and Trust doctors.
- The Trust has not received any exception reports since September 2019. This is a direct result of forward planning on the Rota as well as vacant shifts being sent in a timely manner to doctors.
- There has been an increase in both vacancies and locum spend since the previous report. This is due to the Covid-19 pandemic- Covid-19 related absences, shielding and withdrawal of Foundation year 1 trainees being the main reasons for this.
- The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of exception reporting process.

2) Time allocation for Guardian of Safe Working Role

• Amount of time available in job plan for guardian to do the role:	2 PA's
• Admin support provided to the Guardian (if any):	Medical Staffing
• Amount of job-planned time for clinical supervisors:	0.25 PAs per trainee

3) High level data for Junior Doctor posts

- Data below gives the number of trainees of different grade 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.

- All training posts (junior doctor posts) except trust doctor posts are part funded by the Deanery and the Regional Post Graduate Dean, Health Education East of England has oversight of their training and education.

- There are currently 75 doctors of different grades in training in the trust. Most of the trainee posts are in Hertfordshire. Although included in the training post, Trust Doctors posts have been recruited from overseas against posts that were left vacant after national recruitment.

- The time that each grade spends within the trust varies considerably. Core psychiatric trainees and Specialist trainees are training grades for psychiatrist and spend between 3-6 years respectively completing their psychiatrist training. Other grades work for up to 4 months in psychiatry and then rotate between different hospitals/ specialties and primary care.

April 2020

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	24	1	0	0	24
Specialist Registrars	9	1	0	0	10
FY2 trainees	7	0	0	0	7
FY2 (WAST)	1	0	0	0	1
FY1 trainees	2	0	0	0	2
GPST	19	0	0	0	19
Innovative GPST	0	0	0	0	0
Trust	14	0	1	1	16
Total	76	2	1	1	79

May 2020

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	23	1	0	0	23
Specialist Registrars	9	1	0	0	10
FY2 trainees	7	0	0	0	7
FY2 (WAST)	1	0	0	0	1
FY1 trainees	2	0	0	0	2
GPST	19	0	0	0	19
Innovative GPST	0	0	0	0	0
Trust	14	0	1	1	16
Total	75	2	1	1	78

June 2020

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	23	1	0	0	22
Specialist Registrars	8	1	0	0	9
FY2 trainees	7	0	0	0	7
FY2 (WAST)	1	0	0	0	1
FY1 trainees	2	0	0	0	2
FiY1 trainees	1	0	0	0	1
GPST	17	0	0	0	17
Innovative GPST	0	0	0	0	0
Trust	14	0	1	1	16
Total	73	2	1	1	75

Number of doctors in training on 2016 TCS (total):

80 trainee doctors (including LTFT/ Trust doctors)

79 trainee doctors (including LTFT/Trust doctors)

77 trainee doctors (including LTFT doctors)

4) Vacancies

- The number of vacancies increased in this Quarter. This is to a large extent due to Covid-19 pandemic with shielding trainees and the withdrawal of Foundation year 1 trainees to acute trusts being the primary reasons.

- April 2020- 12 WTE (including 3 long term sickness absence, 1 maternity leave,F1 gaps from Deanery)

- May 2020- 12 WTE (including 2 long term sickness absence, 1 maternity leave, F1 gaps from Deanery)

- June 2020- 14 WTE (including 2 long term sickness absence,1 maternity leave, F1 gaps from Deanery)

- The issue mentioned in previous reports of a number of specialist trainee posts that are being filled by a junior doctor of a lower training grade continues to present challenges.

5) Exception reports (with regard to working hours)

- As part of Junior Doctor Contract review process, in 2016, DoH and BMA agreed that junior doctors who are asked to work outside their work schedule (e.g. Work carried out after working hours) and or when asked to cover additional work (e.g. cover for sickness or Rota gaps) would be able to raise an Exception report. A secure electronic portal system was set up for the reporting purposes and role of Guardian of Safe Working was established to monitor and report to the trust Board on number of exception reports being raised.

- On 30th March NHS Employers agreed a joint statement with the British Medical Association on the application of the 2016 terms and conditions of service contract limits

for the duration of the COVID-19 pandemic and fines were suspended for the period covered by this report.

- There were no exceptional reports raised by the junior doctors in this Quarter.

- In Q1 the trust implemented a 4th on call Rota to deal with the increased demands on our services during the Covid-19 pandemic.

- During this quarter out of a total of 138 gaps in the Rota 116 were successfully covered by using bank & Agency locums, 21 were covered by cross covering with other on-call doctors and there was 1 instance where step down was required. This resulted in a total cost for bank locums of £26,733 for the 1st on call Rota and £16,170 for the second on call.

  All doctors doing locums completed the 48 hour opting out declarations.

- There are currently 9 exception reports from previous quarters that are going through a review by the Guardian of Safe Working. All junior doctors who still have open exception reports have been contacted for further update for their exception report now being resolved.

- HPFT has one of the lowest numbers of exception reports in the region. We have not had an exception report since September 2019.

6) Work schedule reviews

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

7) Fines

- Following the joint statement by NHS Employers and British medical association, fines were suspended for the period covered by this report.

8) Locum work by HPFT doctors for other NHS Trusts

- Did any HPFT doctors do locum shifts for other organisations?

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

9) Effect of Covid -19 on Junior doctor workforce

- Recruitment: There are at least 2 LAS doctors and one MTI trainee recruited from overseas who are unable to take up their posts due to visa restrictions and delays.

- In April 2020 Foundation year 1 trainees were retained by the acute trusts in response to the pandemic resulting in a temporary increase in vacancy rates.

- There has been an increase in locum spend and bank use as a result of Covid-19 related sickness and shielding.

- In order to cope with the increased pressure on services, the first on call Rota was increased to 4 first on call doctors, resulting in a frequency of 1 in 12. The 2nd on call remains 1:10 with x7 SAS doctors underpinning the Rota for the time period April- June 2020. In light of the ongoing uncertainty with the pandemic, the arrangements for 4 first on call Rota's will remain in place until February 2021 with the frequency of on calls increasing to 1 in 15 from August 2020.

Summary

- This quarterly report provides data on the safe working hours for junior doctors.

- The 1st on call Rota is currently 1:12 and 2nd on call is 1:10 with x7 SAS doctors underpinning the Rota for the time period April to June 2020.

- There are 2 doctors shielding and 1 doctor on maternity leave within the junior doctor workforce.

- There have been no exception reports in this quarter which links directly with the reduction in cross cover requirements.

- Sickness absence has increased in this Quarter as a result of Covid-19 pandemic.

- Most of the gaps have been covered by Bank locums with some agency bookings; Cross Cover has only been implemented if bank/ agency cover has not been able to be sourced.

- Effect of Covid-19: This has resulted in recruitment challenges, increased sickness cover as well as changes in Rota frequency for the junior doctor workforce.

Dr Snehita Joshi

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4th April 2014

Updated: September 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

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

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

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

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

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

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

Designated Body Annual Board Report

Section 1 – General:

The Board of Hertfordshire Partnership University NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year submitted.

Date of AOA submission: 24th September 2020.
Action from last year:
Comments: The AOA report due in May 2020 postponed due to COVID-19.
Action for next year:

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

Action from last year:
Comments: The Executive Director – Quality & Medical Leadership is the Responsible Officer (RO) in the Trust and was confirmed as such by the Board of Directors on 28th June 2017.
The Deputy Medical Director is the Lead Appraiser and are both supported by the Revalidation Co-ordinator, who has responsibility for the appraisal system for all non-training grade medical staff (including NHS locums but excluding agency locums).
Action for next year:

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

Yes
Action from last year:
Comments: There is a designated resource of the revalidation co-ordinator assigned to the RO for the Trust.
Action for next year:

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

Action from last year:

Comments: During 2017/2018, the Trust changed its appraisal software provider from Premier IT to Allocate the following quality assessment of the current provision of the GMC national guidelines. It enables both medical job planning and appraisal to have the robust systems in place for future years and ensure that all the necessary elements of appraisal and job planning completed before an appraisal and job plan are signed off. An appraisal portfolio of individual doctor undergoes screening for quality assurance against recognised national standards.

Before the RO makes a revalidation recommendation, the Revalidation Co-ordinator and the RO check the inputs and outputs of the appraisal to ensure that all relevant information is available.

Action for next year:

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

Action from last year:

Comments: The Medical appraisal and Revalidation policy in 2018; however, ratified with COVID-update.

Action for next year:

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year:

Comments: In October 2018 RSM Tenon, (the Trust's auditors), carried out a full audit of the appraisal and revalidation processes within the Trust. The finding of the audit presented to the Board in December 2018, ensured the completion of actions. (see Q6 effective appraisal).

Action for next year:

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

Action from last year:

Comments: The Trust offers the same support network of appraisal, revalidation and governance to all short term Locum placement doctors.

Action for next year:

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Comments: The period of 2019/2020, 235 doctors at different times linked to HPFT for appraisal and revalidation during 2019/2020. However, as of 31st March 2020, only 185 doctors linked to HPFT for appraisal and revalidation for 2019/2020. The 50 doctors difference, 22 doctors were due for an appraisal with HPFT because were employed more than nine months following the National guidance, and 28 doctors did not require an appraisal for the year because were employed by the Trust for less than nine months. In line with the National Guidance from Professor Stephen Powis dated on 19th March 2020, to suspend all medical appraisal until further notice, unless on exceptional circumstances agreed by both the appraisee and the appraiser (See Appendix A). One hundred seventy (170) appraisals were due during 2019/2020 within HPFT, 130 doctors completed their appraisals with the remaining outstanding of 40 attributable to sickness, maternity leave, leaving the Trust and 17 due to challenges of COVID-19. In light of COVID-19, the RO postponed all medical apprisals due between March 2020 to August 2020 by six months and intends to resume the process of medical appraisal by September 2020. Action for next year:

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

Action from last year: Comments: In the year 2018/2019, the Trust reported a total number of doctors who had an incomplete or missed appraisal. Three doctors did not have an appraisal due to sickness and therefore, a percentage of 97.6% compliance. Action for next year:

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

Action from last year:

Comments: The medical appraisal policy has been approved and ratified with JLNC on 03/12/2018.
Action for next year:

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

Action from last year:
Comments: The Trust currently has 55 fully trained appraisers during 2019/2020, as 22 new appraisers trained in December 2019.
Action for next year:

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

Action from last year:
Comments: Appraiser network meetings for all appraisers held twice a year, chaired by the Deputy Medical Director with an update from the RO, learning from good practice including appraiser feedback, local audit data, appraiser top-up/refresher training, job planning workshop and practice improvement.
Action for next year:

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

Action from last year:
Comments: In October 2018, RSM Tenon, the Trust's auditors, carried out a full audit of the appraisal and revalidation processes within the Trust. The finding of the audit presented to the Board in December 2018, ensured the completion of three actions highlighted.
The Board receives a copy of the appraisal compliance reports.
Action for next year:

Section 3 – Recommendations to the GMC

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

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

Action from last year: Comments: There were thirty-nine doctors (39) due for revalidation during 2019/2020 within HPFT, 36 doctors with positive recommendation completed on time and the three remaining – two due to insufficient evidence, later revalidated within two months and one deferred for a third time due to long term sickness has retired. In light of COVID-19, Teresa Cook, Employer Liaison Advisor (South Midlands) on behalf of GMC informed the RO on 18th March 2020, that GMC took action to defer all revalidation due between March 2020 to March 2021 by one year (See Appendix B). Action for next year:

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

Action from last year: Comments: The RO will firstly have conservation with the relevant doctor with reasons in regards to the decision to defer or non-engagement. Action for next year:

Section 4 – Medical governance

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

Action from last year: Comments: All doctors must include the complaint and SUI report sent to individual doctors for inclusion in their appraisal. The appraiser feedback report is generated yearly by the Revalidation Co-ordinator and sent to each appraiser to include in their current appraisal portfolio. Action for next year:

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

Action from last year:

Comments: The Trust Appraisal and Revalidation policy updated in 2018 in line with the national standards. The appraisal is not a performance tool but may include performance information which doctors need to reflect upon during appraisal meetings. Effective medical appraisal and subsequent revalidation will both satisfy the requirements of Good Medical Practice and support the doctor's professional development.

The performance of all our doctors monitors on an ongoing basis through the key performance indicators, complaints and SUIs within the three SBUs. There is a mechanism for ensuring that individual doctors include the relevant complaint and SUI data in the appraisal portfolio for discussion. MSF 360 feedback from both colleagues and patients is conducted at least once during a five-year revalidation cycle (in line with GMC requirements) and may repeat the process more frequently if felt to be necessary.

Action for next year:

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

Action from last year:

Comments: The Trust has a Remediation, Rehabilitation and Re-skilling for Medical Staff policy, which applies to all Trust doctors, the key focus of which is on doctors about whom practise raised concerns. In some extreme specific cases, the exclusion of a doctor from work or subject to disciplinary action and a performance assessment is the last result. Further training is just one option on a range of measures to address concerns about the practice.

The purpose of this policy is the process and protocol of detecting early concerns of any Trust doctors following the appropriate procedures, legislation and policies, to help medical practitioners with performance-related issues to return to a safe practice while ensuring the safety of patients and the integrity of services.

Action for next year:

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

Action from last year:

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

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

The performance of all our doctors monitors the ongoing basis through the key performance indicators, complaints and SUIs within the three SBUs. The MSF 360 feedback from both colleagues and patients is conducted at least once during a five-year revalidation cycle (in line with GMC requirements) and may require a repeat of the process more frequently if felt to be necessary.

The Trust Appraisal and Revalidation policy was updated and ratified in December 2018 in line with national standards.

Action for next year:

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

Action from last year:

Comments: There are RO to RO meetings and discussions held promptly should a concern arise. An example could be an agency Doctor with some concerns is taken forward with the Agency RO by Trust RO.

Action for next year:

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

Action from last year:

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

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

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

Action for next year:

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

Section 5 – Employment Checks

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

Action from last year: Comments: The Medical Staffing Team undertakes all pre-employment checks. Action for next year:

Section 6 – Summary of comments, and the overall conclusion

Please use the Comments Box to detail the following: **Appraiser Top-Up/Refresher training was scheduled in June 2020 to ensure that all appraisers are up to date with national and local information, cancelled due to COVID-19. However, the tutor sends a presentation with guidance from the Academy of Royal Medical Colleges to support the appraiser on the 2020 appraisal format.** **Despite the presence of good appraisal systems, it is possible to recommend a doctor for revalidation who subsequently has difficulties with conduct or capability.** **Overall conclusion:** **The Board is required to note the report, comment and accept (if appropriate). The report will be shared with the higher level (regional), Responsible Officer.**

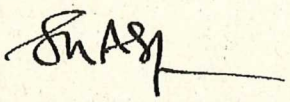
Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

(Executive Director – Quality & Medical Leadership)

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



Name: Prof Asif Zia. Signed:

Role: Executive Director of Quality and Medical Leadership.

Date: 24/09/2020.

To: All Responsible Officers and Medical Directors in England

Professor Stephen Powis
National Medical Director
Skipton House
80 London Road
SE1 6LH

19 March 2020

Dear Colleague

Covid-19 and professional standards activities (including appraisal and revalidation)

I am writing about changes to professional standards activities in light of the latest Government advice on managing the Covid-19 outbreak. Professional standards activities safeguard patient safety and quality of care, support professional development and ensure that action is taken when concerns arise. However, in the current situation it is entirely appropriate to free up capacity to maintain essential care and minimise spread.

Medical Appraisal

As National Responsible Officer for NHS England and Improvement and the person who delegates the Senior Responsible Owner function for The Medical Profession (Responsible Officers) Regulations 2010 (amended 2013) in England I strongly recommend that appraisals are suspended from the date of this letter until further notice, unless there are exceptional circumstances agreed by both the appraisee and appraiser. This should immediately increase capacity in our workforce by allowing appraisers to return to clinical practice.

Until reinstated, Responsible Officers (ROs) should classify appraisals which are affected as 'approved missed' appraisals. For clarity, affected appraisals will be regarded as cancelled, not postponed.

Revalidation decisions

The GMC has now issued guidance that doctors who are due to revalidate before the end of September 2020 will have their revalidation date deferred for one year. This will be kept under review the GMC will make further deferrals as necessary.

This decision has been made to give doctors more time to reschedule and complete appraisals, and to avoid the need for ROs to make revalidation recommendations during this time.

The GMC has started making changes to its systems so that notifications about

revalidation dates aren't issued. They will continue to send notifications when doctors move on and off GMC connect lists so ROs can keep track of prescribed connections.

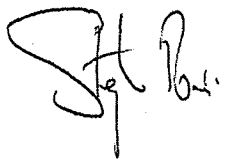
Framework for Quality Assurance for Responsible Officers and Revalidation
In keeping with the need to minimise non-direct quality improvement activities, we have decided to cancel the 2019/2020 Annual Organisation Audit, which we had planned to launch on 6 April.

Mandatory training and other activities
Other measures to release clinical capacity and allow focus on the current priority include amending local requirements for mandatory training and other CPD and quality improvement activities not directly relevant to the current outbreak. I encourage ROs to work within their organisations to make sensible changes in these areas.

Responding to concerns about a doctor's practice
Oversight of professional concerns must continue, but as the situation evolves, our priority will be those concerns that are assessed as high risk.

I know that you and your teams are working hard to prepare for the challenge of the coming weeks and months and hope that these measures will help you and your clinicians to focus on best possible care for patients for the duration of this outbreak.

Yours sincerely,



Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

General Medical Council

Regent's Place
350 Euston Road
London NW1 3JN

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: 0161 923 6602
Fax: 020 7189 5001

18 March 2020

Dear colleague

Coronavirus (COVID-19) - our plans for revalidation

I'm writing to let you know that from 17 March 2020, doctors who are due to revalidate before the end of September will have their revalidation date deferred for one year. We will keep this under review and make further deferrals as necessary.

We have made this decision to give you and your doctors more time to reschedule and complete appraisals, and to avoid the need for ROs to make revalidation recommendations to us during this time.

We have started making changes to our systems so that notifications about revalidation dates aren't issued. This may take a few days to come into effect, but we are working on this as quickly as possible. We will continue to send you notifications when doctors move on and off your GMC connect lists so you can keep track of your prescribed connections.

We'll update stakeholders about this decision, and add relevant information to our website, later today. And we'll write to the wider profession before the end of the week.

We hope that this action will support the health service in prioritising frontline clinical care for patients during this challenging time.

Best wishes

Teresa Cook
Employer Liaison Advisor (South Midlands)

General Medical Council

Regent's Place
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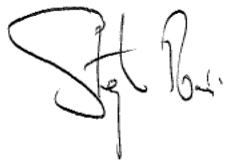


Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 12
Subject:	Report from Finance & Investment Committee – 18 August 2020	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	David Atkinson, Non-Executive Director Chair – Finance & Investment Committee	

Purpose of the report:

This paper provides a summary report of the items discussed at the Finance & Investment Committee meeting on 18 August 2020.

Action required:

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

Summary and recommendations:

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

The Board is asked to note that this is the first meeting of the FIC since March 2020, following the cessation of interim corporate governance arrangements.

Recommendation:
To receive and note the report and to note that there is one item in relation to HWE Procurement Business Case formally escalated to the Board for noting.

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

Controls & Assurance – reporting key matters considered by the Finance & Investment Committee to the Trust Board.

Summary of Financial, IT, Staffing & Legal Implications:

Finance – achievement of the planned surplus and Use of Resources Rating.

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

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

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

1. **Introduction**

1.1 The latest Finance and Investment Committee (IGC) was held on the 18 August 2020 in accordance with its terms of reference and was quorate.

2. **Deep Dive – CAMHS**

The Committee received a deep dive presentation from Nikki Richards, the Service Line Lead for CAMHs. She outlined to the Committee the background to HPFT's model to support tier 4 services as a result of transformation. The presentation also provided detail on the use and availability of inpatients beds. It was reported that dduring the Covid 19 period there has been a change in presentation of young people, they has been an increase in those previously not known to services, they are generally more acute and complex cases.

It was noted that a business case had been produced to propose the refurbishment of the environment in Forest House Acute Unit to provide 2 HDU beds. The new beds will rreduce the need to use HDU beds outside of HPFT, provide the ability to nurse cases that might otherwise be sent to PICU and ensure a better environment supporting disturbed young people.

The Committee also gained an insight with regard to the next steps for CAMHS services as part of the New Car Models Collaborative.

In response to questions it was confirmed that all young people out of county were regularly reviewed as the team were sensitive to the disruption to families. It was confirmed that the financial forecasts were based on modelling on current acuity, but it was noted that the specialist beds are small numbers and can be volatile in their distribution across the year.

3. **Commercial Update**

The Committee received a commercial update and it was noted that normal commercial activity had been resuming after being suspended since March 2020. The meeting was presented with the expected major pieces of commercial activity, up until the end of 2020-21, noting that they varied in complexity, scope of work, and the associated risk for the Trust.

The Committee welcome the national message that commissioners are emphasising the need for the Mental Health Investment Standard to be honoured and the associated service improvements to be progressed.

The Committee received detailed information on the key pieces of work ranging from the contract with Herts commissioners and IAPT contracts in Essex, as well as new opportunities in LD services.

It was noted that extensive work was under way to support the planning process for the Trust that included regional and national submissions for restoration and recovery, the detail of which was covered later in the meeting.

In response to Tanya Barron's question regarding the risk rating for the Collaborative, Karen Taylor outlined that the rating was linked to the complexity of the number of issues all interacting with each other at the same time.

4. **New Care Models Update**

The Committee considered an update report on the New Care Models Collaborative. It was reported that the Collaborative was working towards an April 2021 Business Case submission and "go live" date for delegated commissioning arrangements for CAMHS Tier 4, eating disorders and forensic specialised commissioning services, which was a new date released by NHSEI.

The Committee were informed that the Collaborative had appointed Deloitte to undertake an independent review of the financial offer made by NHSEI. The review process is complete and has been fed back to Trust CEO and SROs. The Committee discussed the initial findings of the review and were updated that the Trusts within the Collaborative have committed to undertake a comprehensive review of the offer to fully understand the potential risks for each Trust and the system as a whole.

It was noted that an initial proposed Provider Collaborative structure has been has been agreed in principle, with some of the costs be partly funded from NHSE.

In response to David Atkinson's question Karen Taylor reported that the Collaborative was looking to secure up to date data to analyse and inform decision making. The opportunity the Collaborative brings to make services changes was emphasised and would need to be considered when the Board reviews next steps.

5. **Covid-19 – Phase 3**

The Committee were updated with regard to a letter received from NHS Chief Executive, Sir Simon Stevens and Chief Operating Officer Amanda Pritchard that detailed the expectations of local health systems during the third phase of the NHS response to Covid 19 for the remainder of the 2020-21 year.

The expectation related to the stepping down the national incident to a level three and three key priorities: accelerating the return to near-normal levels of non-Covid health services; preparation for winter demand pressures, alongside continuing vigilance with regard to Covid and taking into account of lessons learned during the first Covid peak. The Committee discussed the specific activity expectations for Mental Health services.

It was reported that there is a renewed focus on the establishment of the local system architecture and system wide planning. The Committee received an update on the assumptions being made with regard to the planning and required submissions.

In response to Tanya Barron's question Sandra Brookes confirmed that services were going into schools to encourage referrals into CAMHs, as well as implementing digital solutions.

6. **Financial Summary – Period to the end of July 2020**

The Committee considered the financial summary for the period ending July 2020. It was reported that the Trust has achieved an overall break-even position for the month and year to date as required under the current financial arrangements. The Committee discussed the Covid-19 reimbursement, in particular what it related to noting that to date the Trust had performed strongly; there has been no requirement for extra income beyond COVID-19 reimbursement.

It was noted that the current financial arrangements which ensure that the Trust achieves financial balance were being be extended for the first five to six months of the year, but noted that it remained unclear is the detail of the changes that will be made from September or October onwards. It was also noted that the new regime from October onwards will see the retention of the block approach and will not require formal contracting.

The Committee were updated that going forward there were clear risks in terms of the level of demand and its complexity and the actions being taken to manage the financial risks.

7. **Delivering Value Progress Report**

Background to the establishment and 'ask' of the Delivering Value programme was supplied, including the impact that Covid-19 had had on the revised target for 20/21. It was reported that the programme continues to be developed and monitored through the Delivering Value Management Group. The Committee were updated on the work to date and progress against the list of schemes, which are at differing levels of maturity.

The risks to delivery of the programme were discussed as well as the mitigating actions in place or planned. The need to maintain momentum was noted.

8. **Capital Investment Programme 20/21**

The Committee heard that the 2020/21 capital programme is significant in terms of the level of investment and the intended disposals. The Committee considered a detailed paper that summarised the Programme, the progress to date and the key next steps.

It was noted that the current net spend is projected to meet the plan and that there were several variations against the original plan principally with a reduction in disposal proceeds in year offset by a delay in the commencement of the intended Oak ward refurbishment. The Committee noted that two key projects being progressed in the coming weeks related to refurbishment of Oak ward and the new inpatient unit in East & North.

In response to Tanya Barron's question it was reported that the business case for Forest House was near completion. It was noted that the programme was ambitious and that the East and North Case would be coming to Board and FIC in 2020.

9. **Performance: Period to end of July 2020**

It was note that the Quarter one report had been considered by the Board at its meeting on 30 July 2020. The committee received a report that covered the period of July and in particular: restoration of services to 'near-normal' pre-COVID levels and key performance indicators associated with service delivery.

The report summarised that referral volumes into SPA are circa 10% below pre-COVID levels however this is expected to continue to rise as services in the system, particularly primary care, also continue to return to near-normal. And that overall, performance remains strong across most services and forward looking waiting lists are clear.

There had been specific focus on: IAPT; CAMHS and EMDASS, to encourage referrals and with regard to EMDASS to manage a backlog in cases. It was reported that there remained issues with regard to out of area beds. The Committee were informed that the Trust had in quarter 1 over reported the number of out of area beds, and that additional processes had been put in place to ensure the submission of validated data. The Committee welcomed the positive position with regard to the maintenance or significant number of performance metrics.

10. **Herts and West Essex Procurement Business Case**

The Committee considered and approved the business case for Herts and West Essex Procurement Service. It was noted that the Trust's existing procurement arrangements would benefit from changing and that the proposed FBC would address the areas for improvement. It would do this by providing a significantly enhanced central function with the scale and resource necessary to operate at the level required. It was noted that this was a STP wide business case and would see the retention of the specific skills sets and the dedicated resource need for mental health and Learning Disability services as well as a reduction in costs. It was reported that NHSI/E were supportive of the business case

Recommendation:
To receive and note the report and to note that there is one item in relation to HWE Procurement Business Case formally escalated to the Board for noting.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 13
Subject:	Report of the Audit Committee – 15 September 2020	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Catherine Dugmore, Non-Executive Director, SID & Audit Committee Chair
Presented by:	Catherine Dugmore, Non-Executive Director, SID & Audit Committee Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 15 September 2020.

Action required:

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

Summary and recommendations to the Board:

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

The Board are asked to note that the Committee agreed the revised Audit plan for 20/21.

There following matters are for formal escalation to the Board;

· Error in reporting of bed days information for Out of Area Placements for quarter one

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

None

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

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

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

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

Not applicable.

1. Introduction

The Audit Committee was held on the 15 September 2020 in accordance with its terms of reference and was quorate.

2. Matters Arising

2.1. In addition to reviewing the matters arising schedule the Committee received a specific update on three items. The first of these was the regarding how the Trust is working with RSM, internal audit partner to ensure that the cycle of the Audit Plan programme is managed effectively, that the reports are completed to the agreed timetable and that the actions identified are followed through and implemented effectively. It was confirmed by Executive Directors that the updated processes were helping to ensure robust follow up of outstanding actions and provided an opportunity for the triangulation of the audit findings with other assurance sources. It was confirmed that the Clinical Audit programme had restarted and progress would be reported to the IGC in November 2020.

2.2. Next the Committee received an update on Lone worker devices. It was reported that following a consultation with staff a new provider had been identified and a pilot was underway. It was noted that a system was in place with the current provider that enabled managers to monitor levels of use. It was noted that the decision with regard to the new provider would be reported to the IGC.

2.3. Keith Loveman reported that in future the Committee would be receiving quarterly reports on information governance breaches. It was also agreed that a formal report on Cyber security would be brought back to the next meeting. It was noted that any issues that emerged from either of these areas would be dealt with in a timely way and would not wait for reporting to the Committee for them to resolve.

3. Minutes from Other Committees

3.1. The Committee recieved the notes form the Finance and Investment Committee meetings held on 16 January 2020 and 17 March 2020.

3.2. The Committee received the notes of the Integrated Governance Committee meetings held on 15 January 2020 and 6 April 2020.

3.3. A report was provided for assurance regarding the minutes from Board Assurance Committee: Covid-19 meetings held on: 14 May 2020; 11 June 2020; 9 July 2020.

4. Risk Topic Presentation

Reflections on Covid-19

The Committee received a comprehensive joint presentation on “Reflections following Covid-19 pandemic”. The presentation took the Committee through the approvals, compliance, business support and reporting processes in place in the

Trust during the Covid-19 pandemic. As well as a description of the processes the Committee were provided with examples of how this had worked in practice. The presentation also described key reflections and lessons learnt. The main

areas focused on the continued use of the established financial systems; concerted effort to secure income and additional capital. As well as the use of internal audit and counter fraud services to provide review and assurance. It was noted that there had been a higher level of waivers used and the actions that had been identified to ensure robust systems were in place.

The clear continuation of business support was discussed in such areas as supplies, payment, the capital programme and Trust core work streams. The thorough reporting systems were covered both internal and with NHSI/E. These included cash flow, reimbursement for Covid costs and capital.

RSM provided details of their reflections across all the sectors, offering areas that the Trust may wish to reflect on, such as: phishing and cyber security threats; controls in place in relation to purchase orders, payments, and capital expenditure; future operating models considering the change in requirements for office space; continued need to assess the Board Assurance Framework and/or risk registers through the lens of Covid -19 and EU Exit; review Business Continuity Plans to identify lesson learnt; ensure engaging with staff to gather staff thoughts in relation to the way in which the Trust handled the pandemic; liaise with their supply chain to ensure continuation of availability of goods and services.

RSM noted the benefit of a flexible and responsive approach to using internal audit and ensure the impacts of Covid-19 are assessed during each audit.

KPMG welcomed the continuation by the Trust of the established financial systems. They stressed the importance of support for staff welfare and noted that the pandemic had pushed system working to the fore.

Following the presentation it was agreed that it would be helpful to pull together a similar review for other functions at the Trust including lessons learnt and reflections from service users and carers. It was noted that in line with Regional guidance the Trust may be subject to spot audit check of Covid costs.

5. Risk/Governance Matters

5.1. Trust Risk Register Review

The Committee received the QI Risk Register that had previously been received by IGC and the Board. It was noted that the cycle for TRR had got out of sync so this report felt very out of date as prepared at the end of June. The Committee were informed that a thorough review of the Register was currently being undertaken, including a re-working of the HR risks and risks identified in the COVID deep dive presentation. The Committee challenged management to escalate the speed of the review to respond to the fast paced changing environment and bring the TRR back into sync with the Trust Board and committees.

Keith Loveman reported that the senior leadership team were meeting to plan for the second wave and this would include a review of the Trust's Business Continuity Plan.

It was noted that it would be helpful to undertake some scenario planning including interruption to the IT network.

5.2. Board Assurance Framework Review

The Committee noted that the Business Assurance Framework was currently being reviewed and updated. The report detailed the most significant change which relate to the rewording of the principle risks, which had been reviewed by both the Executive Team and RSM, who were supportive of the changes. The Committee approved the reworded principle risks with one amendment. It was noted that the next stage of the review would include the feedback and recent briefing document from RSM and would be reported to a future IGC and Board. It was agreed that future Committee deep dives would link with the principle risks as described.

5. External Reports

5.1. **Internal Audit Progress Report**

The Committee received the Internal Audit Progress report and noted that three final audits were included, the fieldwork for three was underway and the remaining audits were booked. RSM reported that they were confident they would be able to deliver the 20/21 programme. It was noted that the NHSI/E internal requirements had not changed.

The agreed changes to the internal audit programme were noted and approved.

5.2. Internal Audit Action Tracker Exception Report

The Committee received the Audit Action Tracker Exception Report which detailed the progress made, it was noted that 22 actions had been closed and there were a number of overdue items, due to Covid-19. RSM reported that they were comfortable with the progress being made but urged vigilance with regard to ensuring they were completed. It was noted that an update on patient monies, and data protection would come to the December meeting.

5.3. Internal Audit- Benchmarking Report

RSM presented the benchmarking report. It was noted that due to the Trust's approach of having a risk based audit plan was reflected in the data. RSM reported that they were not unduly concerned with the data and confirmed that they would flagg directly with the Trust if they had any concerns.

5.4. Counter Fraud Progress Report

A report outlined the Counter Fraud work undertaken in first five months of 20/21 was received. The work included preparations for the National Fraud Initiative, benchmarking report, supporting the Trust with self-assessment and developing plans for sampling within higher risk areas and finally preparations for Fraud Awareness month in November.

The Committee noted the new referrals received and that they would receive an update when relevant. In response to a question regarding issues of conflicts of interest and members of staff highlighted in a case investigated by LCF, Ann Corbyn confirmed that this is included in our training and lessons learnt will be picked up. It was also confirmed that secondary employment would be one of the areas to be sampled.

5.5. Diagnosis Fraud Benchmarking Report

It was noted that across the NHS that working while sick was the highest area of fraud, and the same trend was seen at the Trust. Andrea Deegan clarified that the data had been used to inform the counter fraud plan areas for 20/21.

5.6. External Audit: Progress Report

The Committee welcomed Dean Gibbs, from KPMG as a new Director working with the Trust. It was noted that he would continue to be supported by Jess Hargreaves as the audit manager. The Committee received the External Audit progress report and noted the changes to the Value for money audit for 21/22. It was agreed that the

December Committee meeting receive an assessment of impact of any changes to the accounting manual as well as the external audit plan for 20/21 year end.

6. Other Matters

6.1. **Use of Waivers Quarter 1**

The Audit Committee received a reporting detailing the Waivers for quarter 1. It was informed that there had been 20 waivers totaling £712k and considered the detail in the report including a report on three waivers over the value of £100k. The Committee noted that there had been almost a doubling in number and value, as against Quarter 1 2019/20.

The Committee welcomed the update on the actions in place to ensure robust management of the procurement process, such as review of Trust contracts register, additional training and increased communications for staff.

6.2. Standards of Business Conduct Compliance Report

The Committee received an update regarding compliance against the new Standards of Business Conduct process that commenced in January 2020. It was reported that the Trust has implemented the new policy and returns process, which includes reporting to the relevant Director and Executive Team meeting. The report detailed a high level of compliance and that the annual process for updating Declarations of Interest will be starting in January 2020.

6.3. Annual Review of Committee Effectiveness

The Committee agreed the annual self-assessment process which will start in October, the results of which will be reported to the December Committee meeting.

7. Any Other Business

7.1. **Out of Area Placements**

The Committee were informed that the Trust had recently found an error in the number of bed days it had been reported centrally for out of area placements in Q1. The error had meant an over reporting of the days and NHSI/E have been made aware. The Committee noted the concern that this may cast doubt with regard to data quality at the Trust and the actions that were in place to ensure there was not a recurrence of the error. It was agreed that this would be escalated to the Board. It was noted that would be considered as a matter arising at the next Committee meeting.

7.2. **EU Exit**

The Committee noted that the risks linked with EU Exit were being identified and actions identified to mitigate the risks. It was noted that the plans for EU Exit would be considered at FIC and Board in October and November.

8. Matters of Escalation

The Board are asked to note that the Committee agreed the revised Audit plan for 20/21.

There following matters are for formal escalation to the Board;

- Error in reporting of bed days information for Out of Area Placements for quarter one.

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 14
Subject:	Financial Position to 31st August 2020	**For Publication:** No
Author:	Sam Garrett, Interim Deputy Director of Finance	**Approved by:** Paul Ronald, Director of Operational Finance
Presented by:	Paul Ronald, Director of Operational Finance	

Purpose of the report:

The report sets out the financial position to 31 August 2020 under the exceptional financial arrangements applied initially during the first four month period and then extended to end of September. The report seeks to both inform the Board of the current position and further to project the financial position for the full year in the light of the anticipated changes to be made for the period from October onwards.

Action required:

To review the detailed provided on the current and projected financial position and assess the Trust's ongoing response to the evolving financial arrangements.

Summary and recommendations

The Trust has achieved an overall break-even position for the month and year to date as required under the current financial arrangements. The position pre-COVID-19 costs is a shortfall of £1.3m in month and £4.7m year to date as per A in the table below, with break-even achieved (D in the table below) after allowing for COVID-19 reimbursement, and top-up income for new services (B and C in the table below).

	In Month Actual	Year to date Actual
Income	21.9	109.5
Expenditure	23.2	115.5
Total (A)	**(1.3)**	**(6.0)**
COVID-19 reimbursement (B)	1.3	5.9
Income for new service/s (C)	0	0.1
Income Top Up	0	0
Revised Total (D)	**0**	**0**

COVID-19 reimbursement at £1.3m has remained higher than expected due to several backdated amounts being claimed due to a recalculation of bank hours being claimed and a claim made on behalf of the ICS for staff working on ICS schemes seconded to work on COVID-19 during the peak period. Income for new services has been claimed at £39k in month (£20k for Prison in-reach and £19k for Astley Court over-activity). It has not been necessary to claim any additional top-up to support a break-even position.

The current financial arrangements which ensure that the Trust achieves financial balance have been

extended for the first six months of the year. Changes are to be made from October onwards as NHSE/I seek to bring in more certainty and grip to the system, at the time of writing notification of expected values has just been received and is being worked through.

To date the Trust has performed strongly; there has been no requirement for extra income beyond COVID-19 reimbursement, with the level of this reimbursement below the regional average; and top-up income for new services (for which contracts and rates had been agreed, but for which invoices cannot be raised under current arrangements). However going forwards there are clear risks in terms of the level of demand and its complexity. This has been evident through August and into September with a high requirement for specialist CAMHS inpatient beds, and also continued demand for Adult Acute and PICU beds.

To manage the financial risk the Trust continues to:

- Work with commissioners and the region to ensure the promised new investment is made
- Progress work within the restoration work streams to further grow IAPT and community capacity
- Progress its Delivering Value programme linking this to the opportunities being identified within the Shaping our Future work
- Accelerate its capital programme which sees investment both within the estate and technology
- Continuing the work on managing the level of need for external bed capacity which had previously been very successful.

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

Summary of Financial, IT, Staffing & Legal Implications:

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

N/A

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

Financial Management

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

1. Summary

1.1. As per the current national reporting arrangements the Trust reported a break-even position for Month 5 and for the year to date. In doing this the Trust has reclaimed £5.9m of COVID-19 costs in the period, of which all that is due has been paid. No further top-up was required to achieve break even.

1.2. Main figures for the month and year to date as shown below:

	In Month Actual	Year to date Actual	Year to date Draft Plan
Income	21.9	109.5	110.1
Pay	15.2	74.7	71.5
Secondary Commissioning	2.9	14.8	13.8
Non Pay	4.2	21.4	20.1
Financing	0.9	4.6	4.6
Total before COVID-19 reimbursement	**(1.3)**	**(6.0)**	**0.1**
Incl. Supplementary Income:			
COVID-19 reimbursement	1.2	5.9	0
Income for new services	0.1	0.1	0
Income Top Up	0	0	0
Revised Total	**0**	**0**	**0.1**

1.3. Compared to the draft Plan submitted in March excluding the COVID-19 costs and related reimbursement:

1.3.1. Income – £600k less than Plan year to date which reflects new investment not yet available offset by the national income adjustments

1.3.2. Pay – £350k more than Plan as many vacancies have been filled and due to new Liaison and Diversion service starting in July (c. £150k pay cost to date), as well as Annual Leave "Buy-back" scheme paid or accrued at c. £170k to date

1.3.3. Secondary Commissioning – overspent by c. £500k reflecting additional adult beds required in the last few months and an increase in CAMHS T4 both in bed prices and more specialist (therefore more expensive) beds being needed

1.3.4. Overheads – underspent by c. £900k with savings on travel and other support costs, as well as some project delays where not related to COVID-19; these costs did though start to increase again from Month 4 as the Trust moved back to Business as Usual

1.4. The Trust's Use of Resources (UoR) framework rating is not being reported to NHSE/I under the current financial arrangements and due to the fact that Trusts are reporting a consistent break-even position. The Trust's own assessment against the previous criteria would report as 1.

2. Background

2.1. This year has seen fundamental changes to the normal contracting and financial reporting processes and is set within the context of the overarching objective of Finance to support and facilitate the clinical response to COVID-19. All NHS Organisations have been directed to report a break-even position in each of the first four months with income being made available to fully match expenditure. The specific arrangements are:

2.1.1. Provider Trusts are fully reimbursed for the costs incurred. This amount is largely paid in 3 payments: an initial block amount, a "Top-up" to provide a balancing figure to break-even, and a "True-up" if needed for cash purposes; the top-up comprises several elements:

2.1.1.1. A Fixed amount in HPFT's case £288k per month

2.1.1.2. Any additional amount for new or expanded contracts where an amount has been agreed and a service is being delivered but HPFT cannot invoice due to current arrangements; this applies to the change in commissioner for the Prison in-Reach service for HPFT in 2020/21 (£20k per month)

2.1.1.3. Any other amount due from the centre such as Medical pay award due to be claimed in September

2.1.1.4. Any additional amount needed to break-even, HPFT has not needed recourse to this to date and does not expect to

2.1.2. The contracting process for 2020/21 was suspended.

2.1.3. The Annual Planning process was also suspended. NHSE/I have used a proxy budget based on 2019/20 for reporting purposes.

2.1.4. No new revenue business investments should be entered into unless related to COVID-19 and approved by NHSE/I.

2.2. This arrangement has provided a monthly block payment to HPFT of £18.3m, and a number of additional payments including Social Care of c. £3.0m. There is then an additional Top-up payment, calculated based on 2019/20, as well as further Top-up payments in respect of COVID-19 costs (see below), and any others as needed. It is unlikely the Trust would need to utilise the True-up process.

2.3. Guidance to detail new arrangements from Month 7 has now been published and new block amounts disclosed, the full impact of this is being worked through but it is clear that:

2.3.1. There will be a cap on COVID-19 reimbursement (likely to be £800-900k/month for HPFT versus average of £1.2m/month claimed to date, and with additional items to fund) and it will be paid via the ICS so the full amount HPFT has requested may not be available

2.3.2. Funding will be provided to the STP/ICS System as a whole

2.3.3. Transformation (SDF) funding will be allocated separately to the block payments

2.3.4. MHIS monies will be paid at c. £4.5m

These arrangements could present an element of risk to HPFT and therefore it is important to manage COVID-19 costs down where possible, and ensure the full range of financial control is in place.

2.4. As part of the new guidance, a number of key returns are to be submitted; an initial finance return was submitted on 14th September and a further iteration is now due on 5th October with a Plan for the remainder of the year.

3. Key Variances

3.1. These variances are reported excluding the impact of COVID-19 costs.

Income

3.2. For the year to date there is £400k less income than Plan, as explained above this is due to the current method of payment, and is partly mitigated by the top-up payment process. CQUIN is to be included for the year with no penalties. Within the position an amount of £330k (£66k per month) is raised for Cambridge and Peterborough CCG which has not yet been paid, though they have confirmed agreement to pay via IHCCT. There is also an amount of c. £70k per month relating to the re-phasing of Social Care Savings by Hertfordshire County Council; this has been agreed but not yet formally confirmed yet.

3.3. From Month 4, an additional contract for Liaison & Diversion services was added at £1.1m per year (£92k per month); this is a sub-contract via East London NHS Foundation Trust and has been invoiced directly, though it is possible that this will switch to the Top-up method of reimbursement.

3.4. There remains a significant level of new investment due in year from the MHIS (c. £4.5m), Year 2 of SDF (Transformation, c. £3.0m, with the majority likely to be deferred) and any New Care Models investments.

Pay

3.5. Year to date Pay is now above Plan by c. £350k due to significant recruitment over recent months (see below) including for the new Liaison and Diversion Service, and an increase in costs for Therapists moving from trainee posts, as well as a regular accrual for Annual Leave “Buy-back” in 2020/21 (buy-back also allowed for days carried forward from 2019/20 but this was accrued last year). Recruitment has been primarily to new roles not previously covered so substantive pay costs have increased without a commensurate decrease in bank or agency costs.

Period	Starters	Leavers	Net
Dec & Jan	**114**	**-61**	**53**
February	**48**	**-33**	**15**
March & April	**72**	**-65**	**7**
May	**32**	**-21**	**11**
June	**39**	**-15**	**24**
July	**65**	**-24**	**41**
Total	**370**	**-219**	**151**

Of the 370 starters above, c. 50 fte relate to Student Nurses who have joined the workforce early at Band 4, they should mostly join as Band 5 Nurses in the autumn when they become qualified, and at that stage will reduce agency and bank spend accordingly.

3.6. There are c. 60 individuals with start dates confirmed over the coming months, and a further 90 offers out to external candidates, in addition to the expected c. 50 newly qualified nurses mentioned above. Substantive pay therefore is likely to increase by between £150k-200k per month by October providing the level of leavers remains low. This is before any significant impact of new or expanded services funded via MHIS or New Care Models.

3.7. Agency spend having increased during the latter part of 2019/20 has reduced a little during 2020/21, most notably Medical locums have reduced from a high last year of 12 to between 5 and 7 more recently. The highest use of agency remains qualified nursing roles in inpatient settings and all qualified roles in the community; the former in particular as stated above is expected to reduce from September / October as the newly qualified nurses take up vacancies. Focus is now on increasing the conversion of agency staff highlighting the benefits of more secure employment.

3.8. As these savings occur agency spend should then reduce to between £500k and £550k on a consistent and recurrent basis.

Secondary Commissioning

3.9. Secondary Commissioning is overspending by c. £100k per month, £500k for the year to date, excluding activity being reclaimed via the COVID-19 process. A snapshot* of activity at the end of each month, shown alongside target numbers for the year, is shown below:

End of Month	Target	April	May	June	July	August	Current
CAMHS OOA	8	10	10	15	18	17	18**
Acute OOA	2	10	12	3	2	1	9
OA Acute	0	0	0	0	0	0	0
PICU OOA	2-4	4	4	3	4	4	6
Health L/T	30-32	36	35	35	35	35	34

*this is a snapshot only and may not reflect full average activity for the month
**2 CAMHS T4 OOA funded by COVID-19 reimbursement currently

3.10. The key areas are:

3.10.1. CAMHS Tier 4 out of area placements reported at £367k for August which was a further increase on Quarter 1 and £167k higher than the average of £200k per month in 2019/20. The majority relates to additional placements (now at 18 versus average of 8 in the latter part of 2019/20), and these placements being in more expensive settings such as Low Secure and PICU, rather than General Adolescent. These numbers have continued at a high level into August and September, despite 2 service users turning 18 in late August. All are reviewed on a weekly basis by HPFT CAMHS clinicians.

3.10.2. PICU out of area placements during July and August reduced to between 2 and 4 from a high of between 6 and 8, resulting in cost reductions, though they have since increased to 6 again in September. Similarly whilst there were savings on Acute in months 4 and 5, in September these have increased again and there remains significant pressure. These placements continue to be clinically reviewed regularly by a Consultant Psychiatrist to ensure appropriate care and discharge, and a weekly Acute Pathway Restoration meeting also has oversight.

3.10.3. Main Health placements have reduced to 34 which is still higher than the low of 30 in 2019/20, but starting to come down following a high of 36 earlier in 2020/21. A trajectory to return to 32 maximum has been agreed and will be achieved by Quarter 4.

3.10.4. MHSOP CHC Placements had been decreasing by c. £100k per month, having already made significant savings in the latter part of 2019/20. “Pipeline” assessments have started to increase again and signal additional cost, which is being accrued, but cost still remains in line with the latter part of 2019/20.

3.10.5. Social Care placement costs haven’t changed significantly, though Personal Budgets have reduced a little. There was some impact in both areas from COVID-19 (c. £20k per month) but this has largely reduced now.

Overheads

3.11. Overheads are underspent by c. £900k for the year to date once costs related to COVID-19 are removed, due to savings particularly on travel and on project spend unrelated to COVID-19 being delayed. However in month for July and August spend has returned to Plan, largely as the result of return to Business as Usual, with additional costs relating in particular to IT, and Education and Training costs.

4. COVID-19

4.1. As stated above there is a COVID-19 cost reimbursement process in place via the top-up arrangements and HPFT has claimed a total of £5.9m in year with all

due to date now paid. Just under £1.0m was already claimed and paid for March.

4.2. These costs relate to a number of areas such as sickness and isolation cover; Student Nurses on placement; on call; some placement costs; refurbishment works; cleaning; additional catering during lockdown; security for Diversion Hubs and PPE store; fit testing for masks; Perspex screens; uniforms and a number of other smaller costs. Some costs have started to reduce but this needs more significant reduction to be seen in September.

4.3. It is expected that additional scrutiny will be applied to this area of expenditure and reclaims going forward and it will be important to reduce costs where appropriate, and to continue to apply the same levels of governance and financial control as would be usual for the Trust. The Trust is seeking to reduce spend wherever possible in particular:

4.3.1. Investigation of continued high levels of bank and agency charged to COVID-19 costs and whether these can be reduced given levels of sickness are now very low; ensure all additional costs to be claimed by managers have now been claimed

4.3.2. Review of security at the A&E Diversion centres which were high cost at over £100k per month but have been significantly reduced in September

4.3.3. Ensure Student nurses who have joined early are able to cover HCA shifts from August when funding can no longer be claimed for them; to date all are still awaiting pins

4.3.4. Cost of SMS text messages to be halved from July saving at least £5k per month following advice to reduce characters

5. Delivering Value Programme

5.1. The original 2020/21 requirement was calculated at £6.0m or £500k per month. This represented circa 2.3% of the cost base and was a stretching target, reflecting the non-recurrent shortfall in 2019/20 and the much higher level of saving being applied by Hertfordshire County Council for Social Care.

5.2. The Trust has recommenced work on the programme and as services are restored those schemes previously developed will either begin to be implemented or be reassessed if necessary.

5.3. In addition there have been several cost reductions such as travel cost savings, continuing reduction in Continuing Healthcare placements and reduced Medical locum agency cover.

5.4. The target at £6.0m was set on an annualised basis, until 31st July the application of 1.1% efficiency has been suspended, so the target is £4.0m for the period from August but with a £6.0m annualised basis.

5.5. The list of developed schemes, plans in progress and opportunities for efficiency, identifies potential recurrent savings totalling £6.0m with c. £4.8m likely in 2020/21. It should be recognised that c. £1.0m of that relates to undeveloped opportunities, and that there is an element of volatility in relation to some of the more developed schemes

Level of Maturity	Indicative Annual Value £000
Developed Schemes	4,129
Proposals	826
Identified Opportunities	1,045
Current Programme total	6,000

5.6. Work is underway to ensure that the key work streams are now implemented at the pace required. The main areas being proceeded with relate to Social Care (Connected Lives); Agency; out of area placements; Corporate Review; Procurement; and a number of smaller schemes across each SBU and Corporate Services.

6. Balance Sheet and Cash Flow

6.1. Main movements in the month and since the year end are as follows:

6.1.1. Receivables increased by £2.8m due to awaiting payment on invoices sent to Hertfordshire County Council, mainly relating to the Social Care Block; a reconciliation has been sent out and payment is expected imminently.

6.1.2. Payables and accruals increased by £3.0m in the month predominately related to an increase in accruals for social care placements, Interserve invoices, EPUT direct contracts, and the IESO contract.

6.1.3. Deferred income decreased by £300k in month related to an increase in Health Education Income received and deferred.

6.2. Cash balances have increased by £900k in month 5, this relates to the sale of Alexandra Road (£500k) and £400k increase in cash from operations and increase in accruals.

7. Capital

7.1. Cumulative net capital spend year to date for 2020/21 is £2.1m, £100k in month, including sale proceeds for Alexandra Road (which completed in August) of £500k.

7.2. There is a further £178k of revenue spend year to date, £31k in the month. This primarily relates to the running costs for empty buildings and the dilapidation costs for Trust leased buildings.

7.3. The main areas of capital spend planned for 2020/21 are: Safety Suites (£5.5m), new 54 bed Inpatient Unit (£3.5m), the Digital Strategy (£2.4m), and Forest House refurbishment (£900k).

7.4. The current year plan includes the disposal of The Stewarts and Harper Lane properties. St. Pauls is now likely to be delayed until 2021/22 whilst the Trust pursues the option of selling with planning permission.

7.5. The Trust is still awaiting confirmation whether its capital bid in relation to windows for several wards on the Kingsley Green site (which need replacing due to COVID-19) has been successful nationally. 3 bids totalling c. £700k for replacing bathrooms as part of work to end Dormitory provision nationally have been agreed.

7.6. Capital spend is forecast to continue to increase as the year progresses in particular at the point construction begins on the Safety Suites in Quarter 3 and potential land is acquired in Quarter 4 for the Inpatient Unit.

8. Risks and Mitigations

8.1. There is increasing scrutiny over COVID-19 costs going forwards and a clear expectation that these will reduce from an average of c. £1.2m per month in the first part of the year to under £900k going forwards. Some costs are starting to reduce and action is being actively taken to review and reduce however there are also some costs to add such as for the Diversion Hubs.

8.2. New guidance has just been received on the revenue arrangements for the period from October and is being analysed. The additional MHIS has been included at c. £4.5m for Hertfordshire, though not all of this will be available for HPFT

8.3. As pay costs continue to increase finances will come under more pressure, and top-up funding may no longer be available. Mitigation is to monitor these costs carefully and work with HR to forecast future spend accurately.

8.4. Areas of Secondary Commissioning continue to overspend, most notably Tier 4 CAMHS where placements have currently almost doubled in addition to cost of each placement increasing; and both PICU and Acute out of area where although numbers do go down this is not sustained for a long period.

9. Forward Look

9.1. For the period to end of September the position will be break-even, with some increase in pay costs and CAMHs external bed requirements.

9.2. The position for the second part of the year is more difficult to predict given the lack of detail. The Trust will see an increase in income from the MHIS for IAPT and Crisis services,.

9.3. It is not yet clear whether any other funding may be available to mitigate but these matters will be kept under continual review.

9.4. The mitigation to this uncertainty is to continue its work at pace on service restoration and redesign and with pushing forward the Delivering Value programme.

9.5. The Trust continues to expect to achieve break even for the year given its current performance and its current planning and progress on key actions.

Current Trading - Income Statement for Period Ended 31-August-2020

Description	2020/21 Plan	Month Aug - 20 Actual	Plan	Variance	Year to Date Aug - 20 Actual	Plan	Variance
Number of Calendar Days	365	31	31		153	153	
Contract #1 Hertfordshire IHCCT	193,520	15,739	16,190	(451)	78,697	80,655	(1,958)
Contract #2 East of England	22,944	1,912	1,912	(0)	9,558	9,560	(2)
Contract #3 Essex LD	16,911	1,471	1,409	61	7,353	7,046	307
Contract #4 Norfolk (Astley Court)	2,256	202	188	14	1,010	940	70
Contract #5 IAPT Essex	8,417	733	701	32	3,666	3,507	159
Contract #6 Bucks Chiltern CCG	3,783	317	315	1	1,583	1,576	6
Contracts	247,831	20,374	20,716	(342)	101,866	103,285	(1,419)
Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	808	100	68	32	358	339	19
Education and training revenue	3,399	276	283	(7)	1,522	1,416	106
Misc. other operating revenue	7,449	385	372	13	1,477	1,865	(387)
Other - Cost & Volume Contract revenue	5,106	418	426	(7)	2,178	2,128	50
Other clinical income from mandatory services	2,234	91	186	(95)	463	931	(468)
Research and development revenue	308	11	26	(15)	156	128	28
COVID Top Up Income	(0)	1,605	(0)	1,605	7,465	(0)	7,465
Total Operating Income	**267,135**	**23,259**	**22,076**	**1,183**	**115,485**	**110,091**	**5,394**
Employee expenses, permanent staff	(150,497)	(12,667)	(12,563)	(104)	(62,890)	(61,972)	(919)
Employee expenses, bank staff	(17,000)	(2,026)	(1,416)	(610)	(9,038)	(7,076)	(1,962)
Employee expenses, agency staff	(5,800)	(548)	(483)	(65)	(2,812)	(2,417)	(396)
Clinical supplies	(271)	(52)	(23)	(29)	(300)	(113)	(187)
Cost of Secondary Commissioning of mandatory services	(33,090)	(2,896)	(2,805)	(91)	(14,850)	(13,863)	(987)
Other Contracted Services	(10,682)	(908)	(890)	(18)	(4,537)	(4,451)	(86)
Drugs	(3,085)	(312)	(257)	(55)	(1,492)	(1,285)	(207)
Total Direct Costs	**(220,424)**	**(19,409)**	**(18,437)**	**(972)**	**(95,919)**	**(91,175)**	**(4,743)**
Gross Profit	46,711	3,851	3,640		19,566	18,915	
Gross Profit Margin	17.49%	16.56%	16.49%		16.94%	17.18%	
Overheads							
Consultancy expense	(112)	(16)	(9)	(7)	(46)	(47)	1
Education and training expense	(1,294)	(86)	(108)	22	(423)	(539)	116
Information & Communication Technology	(4,922)	(424)	(410)	(14)	(2,160)	(2,051)	(109)
Hard & Soft FM Contract	(6,387)	(600)	(532)	(68)	(3,246)	(2,661)	(585)
Misc. other Operating expenses	(8,940)	(586)	(443)	(144)	(3,296)	(2,819)	(477)
Other Contracts	(2,005)	(312)	(167)	(145)	(1,081)	(835)	(245)
Non-clinical supplies	(446)	0	(37)	37	(581)	(186)	(396)
Site Costs	(7,028)	(654)	(586)	(68)	(3,070)	(2,928)	(142)
Reserves	(1,192)	(14)	(99)	85	(14)	(497)	483
Travel, Subsistence & other Transport Services	(4,061)	(248)	(338)	90	(1,097)	(1,692)	595
Total overhead expenses	**(36,388)**	**(2,940)**	**(2,730)**	**(210)**	**(15,014)**	**(14,255)**	**(759)**
EBITDA	**10,323**	**911**	**910**	**1**	**4,552**	**4,660**	**(108)**
EBITDA Margin	3.86%	3.91%	4.12%		3.94%	4.23%	
Depreciation and Amortisation	(6,000)	(545)	(550)	5	(2,724)	(2,749)	25
Other Finance Costs inc Leases	(589)	(24)	(50)	26	(119)	(246)	127
Gain/(loss) on asset disposals	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Interest Income	366	(0)	31	(31)	(0)	153	(153)
PDC dividend expense	(4,100)	(342)	(342)	(0)	(1,708)	(1,708)	(0)
Net Surplus / (Deficit)	**0**	**0**	**(1)**	**1**	**0**	**109**	**(108)**

Board Report

Meeting Date:	24 September 2020	**Agenda Item:** 15
Subject:	NHS People Plan 2020/21 Summary and Implications for HPFT	**For Publication:**
Author:	Ann Corbyn, Exec Director, People and OD	**Approved by:** N/A
Presented by:	Ann Corbyn, Exec Director, People and OD	

Purpose of the report:

To present a summary report on the key themes and actions within the NHS People Plan 2020/21 to the Board.

Action required:

To receive the report and note the key implications for HPFT.

Summary and recommendations to the Board:

This paper presents a summary of the key themes and actions contained within the recently published NHS People Plan 2020/21.

The plan is titled 'We are the NHS; People Plan 2020/21' and was published on 30th July 2020; it outlines the actions that organisations, employers and staff will need to take in the coming months. The plan has clearly been heavily influenced by the experiences of the pandemic and sets out actions for employers and systems, alongside actions for the NHSE/I and HEE, amongst others.

The plan focuses on:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on the discrimination that some staff face
- **New ways of working** – capturing innovation, much of it led by our NHS people
- **Growing for the future** – how we recruit, train and keep our people, and welcome back colleagues who want to return

Work has been completed to assess the implications for HPFT and the resulting actions will be led by the People and OD team and reviewed by the People and OD Group (PODG). The immediate actions required are:

- From September 2020, every member of the NHS should have a health and wellbeing conversation and develop a personalised plan. As part of this conversation, line managers will be expected to discuss the individual's health and wellbeing, and any flexible working requirements, as well as equality, diversity and inclusion.
- From October 2020, employers should ensure that all new starters have a health and wellbeing induction.
- By October 2020, employers, in partnership with staff representatives, should overhaul recruitment and promotion practices to make sure that their staffing reflects the diversity of their community, and regional and national labour markets. This should include creating accountability for outcomes, agreeing diversity targets, and addressing bias in systems and processes. It must be supported by training and leadership about why this is a priority for our people and, by extension, service users.
- By the end of 2020, the expectation is that 51% of organisations will have eliminated the

gap in relative likelihood of entry into the disciplinary process. For NHS trusts, this means an increase from 31.1% in 2019.

The alignment of the NHS People Plan to our existing work and strategies places us in a strong position to meet the actions and strategic themes of the Plan.

Members are asked to note the key themes and implications for HPFT.

Relationship with the Business Plan & Assurance Framework:

Links to Strategic Objective 4: we will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment

Summary of Implications for:

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

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

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

The Executive Team received this report on 12th August 2020 and a similar report was presented to IGC on 19th August 2020.

We are the NHS: People Plan 2020/21
Summary and Implications

1. Introduction and Background

We are the NHS: People Plan 2020/21, the NHS People Plan was published on 30th July 2020 and outlines the actions that organisations, employers and staff will need to take in the coming months. The plan has clearly been heavily influenced by the experiences of the pandemic and sets out actions for employers and systems, alongside actions for the NHSE/I and HEE.

The plan focuses on:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on the discrimination that some staff face
- **New ways of working** – capturing innovation, much of it led by our NHS people
- **Growing for the future** – how we recruit, train and keep our people, and welcome back colleagues who want to return

2. The Key Themes and Actions within the We are the NHS; People Plan 2020/21

The plan includes 'Our People Promise' which outlines the behaviours and actions that staff can expect from their leaders and colleagues to improve the experience of working in the NHS for everyone. It is central to the plan for the coming 9 months and in the longer term and has been developed to help embed a consistent and enduring offer to staff. The Staff Survey has been redesigned to align with the 'Our People Promise' from 2021.

The practical actions within the plan fall under nine headings, all of which have specific actions associated with them. The actions are attributed to the employer, NHSE/I, the CQC, HEE or systems and a timeline is referred to but is not always detailed:

- ✓ **Health and Wellbeing** - The actions in this section range from 'put in place effective infection prevention and control procedures' to 'all new starters should have a health and wellbeing induction' – the section has 23 actions in total, 5 attributed to NHSE/I and 18 attributed to the employer

- ✓ **Flexible Working** – The actions in this section range from 'be open to all clinical and non-clinical permanent roles being flexible' to 'board members must give flexible working their focus and support' – the section has 11 actions in total, 6 attributed to NHSE/I and 5 to the employer

- ✓ **Equality and Diversity** – The actions in this section range from 'overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets' to 'publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce' – perhaps surprisingly, this section has only 6 actions in total, 2 attributed to NHSE/I and 4 to the employer

- ✓ **Culture and Leadership** – The actions in this section range from 'Promote and encourage employers to complete the free online just and learning culture training and accredited learning packages, and take demonstrable action to model these leadership behaviours' to 'place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion, as part of the well-led assessment – this section has 15 actions in total, 11 attributed to NHSE/I, 1 to CQC, 1 to all NHS Organisations and 2 to NHSE/I plus HEE

- ✓ **New Ways of Delivering Care** – the actions in this section range from 'use guidance on safely redeploying existing staff, developed in response to COVID-19 by NHSE/I and key partners, alongside the existing tool to support a structure approach to ongoing workforce transformation' to 'support the expansion of multidisciplinary teams in primary care' – there are 6 actions in this section, 2 attributable to employers, 1 attributable to employers and organisations and 3 attributable to HEE

- ✓ **Growing the Workforce** – the actions in this section range from 'increase the number of training places for clinical psychology and child and adolescent psychotherapy by 25% (with 734 starting training in 2020/21)' to 'employers should fully integrate education and training into their plans to rebuild and

restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and providing an increased focus on support for students and trainees, particularly those deployed during the pandemic' to 'establish a £10m fund for nurses, midwives and allied health professionals to drive increased placement capacity and the development of technology-enhanced clinical placements' – there are 16 actions within this section, 13 attributable to HEE and 3 attributable to employers

- ✓ **Recruitment** - the actions in this section range from 'increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles' to 'encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response' – there are 9 actions within this section, 2 attributable to employers, 1 attributable to employers and systems, 2 attributable to systems, 1 attributable to NHSE/I, 1 attributable to HEE and 2 attributable to NHSE/E and HEE

- ✓ **Retaining Staff** – the actions in this section range from 'design roles which make the greatest use of each's person's skills and experiences and fit with their needs and preferences' to 'strengthen the approach to workforce planning to use the skills of our people more effectively and efficiently' – there are 10 actions within this section, 3 attributable to systems, 3 to HEE and 4 to employers

- ✓ **Recruitment and Deployment across Systems** – the actions in this final section range from 'actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers' to 'when recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reduce the use of 'off framework' agency shifts during 2020/21' – there are 5 actions in this section, with 3 attributable to systems, 1 attributable to employers, systems and primary care networks and 1 to NHSE/I

3. Implications for HPFT:

The plan is designed to foster a culture of inclusion and belonging across the NHS – something that HPFT has already committed to taking increased action on within its Annual Plan for 2020/21. Indeed, there is close alignment with our existing plans and strategies, which places us in good position to take forward this work.

There is significant focus on growing and training the workforce and working differently, with more emphasis on expanding non-traditional roles such as clinical health workers. There is also a focus on attracting talent from diverse communities, encouraging the exploitation of the significant increase in focus on the NHS to address recruitment challenges. It is important to note that no new funding commitments in respect of growing the workforce are made within the plan.

Each local system will be asked to develop a 'People Plan' in response to the national plan – something that our local system is already doing – these system plans will be reviewed by local and regional 'People Boards'. Metrics are likely to be developed by September/October and there is a commitment to use the NHS Oversight Framework to track progress. There is a clear focus on systems in the National Plan and this is a marker about the increased role for systems to understand the workforce requirements and support the attraction and deployment of staff within its system – we will need to ensure a strong voice for MH/LD workforce needs within our own system.

Individual organisations are encouraged to devise their own plan to support the commitments of the People Plan. It is recommended that we use the People and OD Group (PODG) to review our People Priorities plan against the national People Plan and track progress. The Trust has already reviewed its own People Plan to ensure that we are focusing on the right things; the current focus is on further review of our recruitment and selection processes in order to build on the work that has resulted in a significant reduction in the WRES differentials in appointment from shortlist for BAME candidates. This work will be led by the People and OD team but with co-production from our staff side colleagues and members of our BAME staff network.

Of note, there are significant pieces of work for NHSE/I and HEE and we can anticipate increased focus and measurement from these bodies on people metrics in the future.

The plan also refers to an independent strategic review of HR/OD within the NHS to commence immediately. The purpose of the review is to 'seek recommendations to enhance the HR/OD function to support the ambition to make the NHS the best place to work' and will encompass experts from both the NHS and other sectors. The review is due to report by the end of this financial year, with implementation from April 2021. There is a clear steer towards 'professionalism' with the scope of the review with reference to the professional body (CIPD) throughout and I was encouraged to see that MH/LD representation was specifically included in the Steering Group.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 16
Subject:	WRES/WDES Annual report 2019/20	**For Publication: Yes**
Author:	Sam Slaytor, Interim Inclusion & Engagement Team Manager.	**Approved by:** Ann Corbyn, Executive Director, People and OD
Presented by:	Ann Corbyn, Executive Director, People and OD	

Purpose of the report:

The WRES came into effect on 1st April 2015 with organisations required to publish their first dashboard of data by 1st July 2015.

The WDES came into effect on 1st April 2019 with organisations required to first publish their data by 1st August 2019.

This report has been prepared to provide the Board with an overview of findings for the WRES and the WDES across 19/20.

Both standards are designed to measure and improve the experience of Black, Asian, Minority Ethnic (BAME) and disabled staff across the NHS.

The report provides:

- Summary of key findings
- Overview of Trust comparisons (for WRES, compared to 2019 data report)
- HPFT WRES results for 2019/20 broken down by each metric.
- HPFT WDES results for 2019/20 broken down by each metric (or where not possible an explanation as to why)
- General observations re: progress and suggestions for next steps.

The report will need to be complimented by annual WRES and WDES work plans which are required to be published by 30th October 2020.

It is important to note that it is not possible to report any comparison with 2019-20 data from other Trusts, as this will only be made available following all data submissions and is usually published in December.

Therefore it should be understood that the 2019-20 *national* data referenced in this document is one year old.

Action required:

The Board is asked to approve the report so that the Trust can publish our annual compliance as requested by NHSE

To note:

- There has been progress on WRES metrics re: disciplinary and staff appointments
- There has been improvement seen in BAME staff survey responses

Summary and recommendations

The review of WRES data for the year 19/20 shows improvements against a number of the staff survey indicators from 2019. There has also been a positive change relating to the numbers of BAME staff entering the formal disciplinary process, where the disproportionality has significantly reduced.

Additionally, scores have improved for staff being appointed following shortlisting and in relation to BAME staff accessing non-mandatory training.

The review of WDES data for the year 19/20 shows that disabled staff, on the whole, report a poorer experience of the workplace when compared with non-disabled staff (as reported through the staff survey). Furthermore there is a significant gap in data quality with 24% of staff having no data recorded for the disability field on their electronic staff record (in line with the national picture). This is also the case for Trust board members.

However, disciplinary data for WDES shows that disabled staff are not receiving differential experience when compared to non-disabled staff.

Work will be undertaken to put into place some system wide programmes and this will involve the organisations across the ICS (Integrated care system) to ensure more dynamism and connectivity in our region. These programmes of work will improve equity for BAME staff across the ICS. Some of this work has begun and will also include work on the other protected characteristics.

The refreshed Inclusion Strategy, currently being co-developed with our staff and led by the Executive Director of Quality & Safety and the Executive Director of People & OD will set the vision for what the Trust wants to achieve across the Diversity, Equality and Inclusion agenda.

Recommendation:

That the Board agree to the publication of this required annual report.

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

The WRES and WDES are mandated parts of the standard NHS Contract. As such, HPFT will/should be scrutinised in terms of performance by local commissioners.

Non-compliance with the WRES and WDES would create risks for the organisation in terms of reputation, but also more importantly in terms of the wellbeing of the overall workforce.

There is significant evidence to support the need for a diverse and healthy workforce if organisations are to deliver the highest quality of service and support. Additionally there is national and local evidence supporting the case for change showing that BAME and Disabled staff are disproportionately affected by inequality within NHS workplaces.

WRES also forms part of the criteria for CQC inspections under the new inspection regime. This was discussed as part of the Trust most recent inspection during interviews and focus groups with staff. The WDES will not form part of CQC inspections for its first year of implementation.

Both the WRES and WDES require that each Board or corporate leadership must play a full and visible part in signing off the Trust's data and agreeing the associated action plan. They should be clearly seen to own this work.

Summary of Implications for:

There will be a need to look at data capture systems for staff data in relation to the WRES/WDES – highlighted through the initial gathering of data. NHS Digital now collates and auto-generates results for WRES/WDES and HPFT will publish its data for this year's return.

HPFT was required from 5th April 2011 to implement the Public Sector Equality Duty. In addition the WRES is now mandated as part of the standard NHS Contract. As such, HPFT will/should be scrutinised in terms of performance by local commissioners.

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

In terms of service user and carer involvement, this work is focused on staffing however, increasingly; there is a need to connect this work with improved outcomes for care particular in light on the coronavirus pandemic and the NHSI resources address inequalities in NHS provision and outcomes.

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

N/A

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

PODG 03.09.20

NHS Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) Annual Position for the financial year 19/20

1. Background

1.1 The WRES came into effect on 1st April 2015. The standard is designed to improve the representation and experience of Black Asian and Minority Ethnic (BAME) staff at all levels of an organisation – particularly senior management. In the context of the WRES, White staff comprises White British, White Irish and White Other (Ethnicity codes A, B, C) whereas BME staff comprise all other categories excluding 'not stated'.

1.2 The WDES came into effect on 1st April 2019. The standard is designed to improve the representation and experiences of disabled staff across the NHS.

1.3 The WRES results for Hertfordshire Partnership University Foundation NHS Trust (HPFT) are based on 92.9% of HPFT staff. This is the proportion of staff that have ethnicity recorded on their Electronic Staff Record (ESR); overall, 34% of the HPFT workforce is from a BAME background as of 31st March 2020.

1.4 For the 19/20 WDES results for HPFT, we are able to make some comparisons across our workforce from last year's data. However as this is only the second year of data collection, it is premature to look at historical data trends. Overall, at 31/03/20, 4.5% of staff in post had declared a disability and this is a minimal increase from last year (4.1%.) However, 24% of staff have no data recorded in this field on their electronic staff record (ESR). This is a national trend and guidance for WDES states the need to improve workforce data quality; NHS Employers indicated that national declaration level average is 17% of staff.

1.5 Overall, there are nine indicators that make up the NHS WRES and ten indicators that make up the NHS WDES. These are detailed in **Appendix 2** and comprise a mixture of indicators based on workforce data and staff survey data.

1.6 The Trust has always included bank staff in WRES calculations. National guidance allows for this, provided reporting is consistent year on year.

2. Indicators – summary results for HPFT 19/20

2.1 **Tables 1 and 2** below provide an overview of results against workforce indicators. These do not include data against Agenda for Change (AfC) bandings or staff survey results which can be found in the main body of the report.

2.2 **Table 1** – WRES indicators with annual comparison data:

WRES Indicator	Trust score 2020	Trust score 2019	Trust score 2018	Trust score 2017
2 – likelihood of appointment following shortlisting (white staff)	1.22 times greater	1.58 times greater	1.44 times greater	1.42 times greater
3 – likelihood of BME staff entering formal disciplinary process	1.03 times greater	1.89 times greater	2.11 times greater	1.92 times greater
4 – likelihood of access to non-mandatory training / CPD (white staff)	1.12 times greater	1.3 times greater	1.19 times greater	0.93 times greater
9 – BME Board Representation (where ethnicity declared)	12.5%	12.5%	12.5%	20.0%
9 – BME Voting Board	6.7%	7.1%	14.3%	-

Representation (where ethnicity declared)				

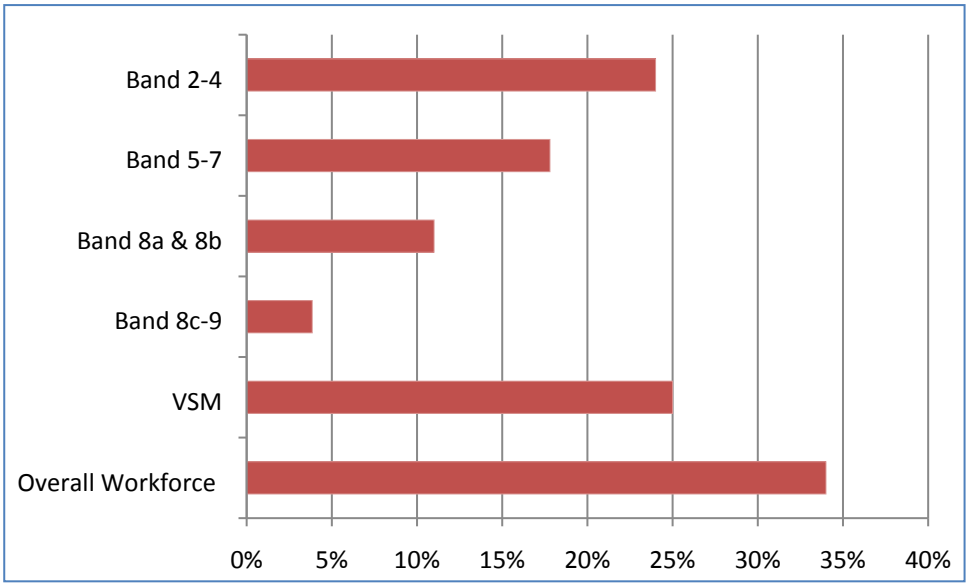
2.3 **Table 2** – WDES indicators

WDES Indicator	Trust score '20	Trust score '19
2 – likelihood of appointment following shortlisting (non-disabled staff)	1.23 times greater	0.99 times greater
3 – likelihood of disabled staff entering the formal capability process	0.00	0.00

3. Workforce Indicators – Workforce Race Equality Standard

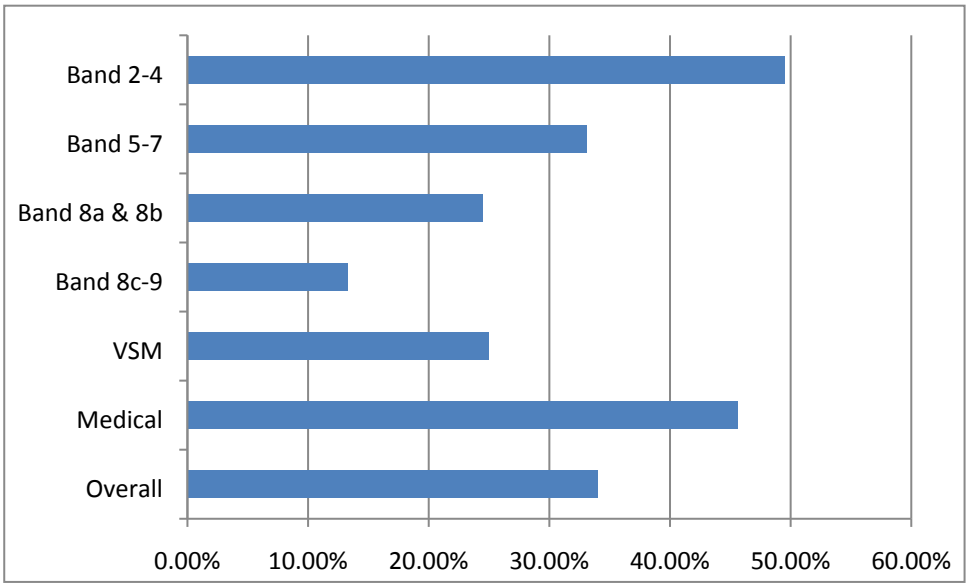
3.1 **WRES indicator 1 -** Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and Very Senior Managers (VSM) (including Executive Board members) compared with the percentage of staff in the overall workforce.

3.1.1 **Graphs 1** (non-clinical) and **2** (clinical) below provide an overview of 2019/20 data against the overall workforce.



***Graph1** – Representation of BAME staff, non-clinical*

Overall Workforce	VSM	Band 8c-9	Band 8a & 8b	Band 5-7	Band 2-4
34%	25%	3.85%	11%	17.80%	24.00%



Graph 2 *– Representation of BAME staff, clinical*

Overall	Medical	VSM	Band 8c-9	Band 8a & 8b	Band 5-7	Band 2-4
34%	46%	25%	13.3%	25%	33.1%	49.5%

3.2 **WRES indicator 2 - Relative likelihood of BME staff or Disabled staff being appointed from shortlisting compared to that of White staff or non-disabled staff being appointed from shortlisting across all posts.**

Relative likelihood of white staff being appointed following shortlisting	1.22 times more likely

Table 3 *– likelihood of appointment following shortlisting*

The figures above show:

- That white staff were 1.22 times more likely to be appointed than BAME staff. The figure has significantly improved when compared with 2019 (1.58 times).

3.3 **WRES indicator 3 - Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.**

3.3.1 This indicator is measured by entry into a formal disciplinary investigation – based on a two year rolling average of cases (1st April 2017 – 31st March 2020)

Year	HPFT WRES result
2020	1.03
2019	1.89
2018	2.11
2017	1.92
2016	1.66

Table 4 – WRES scores for disciplinary data over a five year period

3.3.2 The above data shows that HPFT has made good progress on this indicator yielding the best result for the trust since the WRES began.

3.4 **WRES indicator 4 - Relative likelihood of BME staff accessing non mandatory training and CPD compared to white staff**

The figures represent the likelihood of white staff having access to non-mandatory training and Continuing Professional Development (CPD) when compared with BME staff. Table 2 below provides the results for 2018 alongside the previous year and national averages. A score of more than 1 indicates white staff more likely to have access. A score of less than 1 indicates BME staff more likely to have access.

Year	HPFT WRES result
HPFT 2020	1.12 times greater
HPFT 2019	1.3 times greater
HPFT 2018	1.19 times greater
HPFT 2017	0.93 times greater
HPFT 2016	1.04 times greater

Table 2 – likelihood of BME staff accessing non mandatory training

4. Staff Survey & Board Indicators – Workforce Race Equality Standard

4.1 **WRES indicators 5 – 8 relate to staff survey findings.**

4.1.1 Overall, responses to the 2019 staff survey break down as follows:

- 72.6% (1221) of respondents – White
- 27.4% (458) of respondents – BME

4.1.2 The table below provides overview of the WRES staff survey results:

WRES Metric	HPFT white staff score	HPFT BAME staff score	Compared to 2019
Metric 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	26.4%	35.6%	↑ BAME ↓ White
Metric 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	20.1%	24.8%	↓ BAME ↓ White
Metric 7 - Percentage believing that the Trust provides equal opportunities for career progression or promotion	90.9%	77.9%	↑ BAME ↑ White
Metric 8 - In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager / team leader or other colleagues	5.5%	13.6%	↓ BAME ↓ White

Table 3 – WRES staff survey indicators

4.1.3 The above results show improvement in three of the WRES indicators (ranging from 0.9% to 6% improvement compared to 2019) with a decline in one for BAME staff (2.8%) but an improvement for White staff (0.9%).

4.1.4 We have shown clear improvements for three years on metrics 5-8 and it should be noted that metrics 5-8 are considered more difficult to change as these workforce indicators reflect the culture of the organisation. Cultural change and shift takes 3-4 years and we appear to be bridging the gap at HPFT.

4.1.5 **WRES Indicator 9 –** percentage difference between the organisations' Board membership and its overall workforce disaggregated:

- By voting membership of the Board

- By executive membership of the Board.

4.1.6 For the purposes of this report, the figure listed relates to overall board representation as detailed in **Table 4** below:

	BAME voting board membership
HPFT 2020	6.7%
HPFT 2019	13.3%
HPFT 2018	14.3%
HPFT 2017	20.0%
National Average 2019	8.4%
East of England Average 2019	5.5%
Midlands & East Average 2019	9.5%

Table 4 – WRES board representation

4.1.7 As of 1st April 2019, HPFT had a 34% BAME workforce and 6.7% of voting members on the Board identified as being from a BAME background. When looking at the total Board representation, the percentage difference between HPFT's Board voting membership and its overall workforce is -28.3% compared to -17.4% in the previous year. (Disaggregated data is reported through NHS Digital and the above figures are auto calculated).

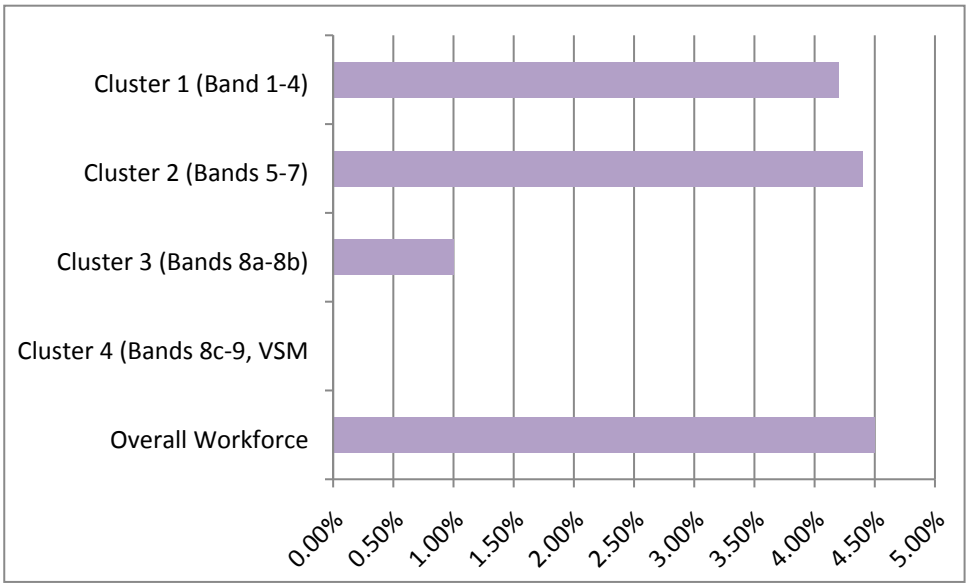
4.1.8 It should be acknowledged that, given the relatively small size of HPFT Board a team change of a single staff member had significantly altered the figures for this indicator. A key purpose of this indicator is to encourage Boards to ensure there are robust plans in place for future recruitment to minimise the opportunity for inequality occurring.

4.1.9 In the past HPFT performed well above all national and regional averages in relation to this indicator; this figure has reduced in the last two years of reporting. It would also be helpful if all members of the Board, where comfortable, would record their ethnicity.

5. Workforce Indicators – Workforce Disability Equality Standard

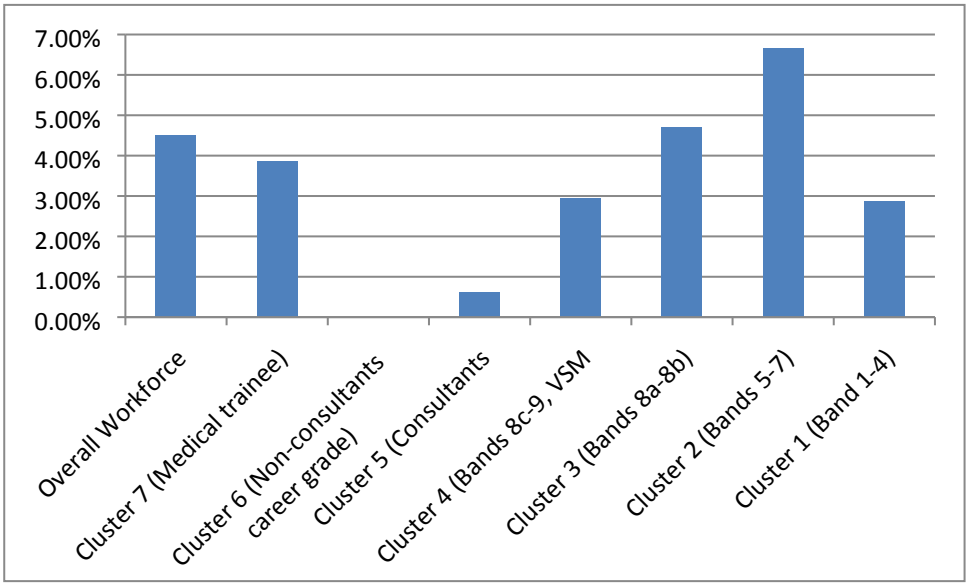
5.1 **WDES indicator 1 - Percentage of staff in AfC pay bands or medical and dental subgroups and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce**.

5.1.1 This metric includes reporting by the seven required clusters detailed in the graphs below for clinical and non-clinical staff.



Graph 3 *– Representation of disabled staff, non-clinical*

Overall Workforce	Cluster 4	Cluster 3	Cluster 2	Cluster 1
4.50%	0%	1%	4.40%	4.20%



Graph 4 *– Representation of disabled staff, clinical*

Overall Workforce	Cluster 7	Cluster 6	Cluster 5	Cluster 4	Cluster 3	Cluster 2	Cluster 1
4.50%	3.85%	0%	0.62%	2.94%	4.69%	6.65%	2.86%

5.2 **WDES indicator 2 - Relative likelihood of Disabled staff being appointed from shortlisting compared to that of non-disabled staff being appointed from shortlisting across all posts.**

5.2.1 During 19/20 the relative likelihood of non-disabled staff being appointed following shortlisting (as compared with disabled staff) was **1.23** times more likely compared to **0.95** times last year. This means applicants identifying a disability were more unlikely to be appointed.

5.2.2 It should also be noted that disability data for this indicator is more robust than for indicator 1 as this data is required from applicants as a part of the recruitment process.

6. Staff Survey and Board Indicators – Workforce Disability Equality Standard

6.1 **WDES indicators 4-9 relate to staff survey findings.**

6.1.1 Overall, responses to the 2019 staff survey break down as follows:

- 75.7% (1345) of respondents – Non-disabled
- 21.2% (377) of respondents – Disabled

6.1.2 **Table 5** provides an overview of the WDES staff survey results

WDES Metric	HPFT Non-disabled staff score	HPFT disabled staff score	Compared to 2019
Metric 4a - Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:			
i. Patients/service users, their relatives or public	27%	**35.6%**	↓Disabled ↑ Non-disabled
ii. Managers	9.9%%	**14.2%%**	↓Disabled ↓ Non-disabled
iii. Other colleagues	13.9%	**20.9%**	↓Disabled ↓ Non-disabled
Metric 4b - Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	59%	**58.3%**	↑Disabled ↑ Non-disabled
Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	87.8%	**84.9%**	↑Disabled ↑ Non-disabled
Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	14.4%	**18.7%**	↓Disabled ↓ Non-disabled
Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	59.9%	**56.5%**	↑Disabled ↑ Non-disabled
Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	N/A	**80.9%**	↑Disabled
Metric 9a - The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	7.4	**7.3**	↑Disabled ↑ Non-disabled
Metric 9b - Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)	Yes through staff networks and consultation.		

***Table 5** – WDES staff survey indicators*

6.1.2 The staff survey results indicate improvements compared to last year ranging from 1% to over 10%. One area that had a decline is disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from service users.

6.2 **WDES indicator 9 – Percentage difference between HPFT's Board voting membership and its overall workforce.** This indicator is identical for both WRES and WDES reporting.

6.2.1 **Table 6** provides an overview of comparative data regarding the percentage of voting Board members when compared with national averages and previous data.

	Disabled voting board membership
HPFT 2020	0%
HPFT 2019	0%
National Average 2019	2.1%
East of England Average 2019	0.3%
Midlands & East Average 2019	0.5%

***Table 6** – comparison of Disabled voting board membership*

6.2.2 As of 1st April 2020, HPFT had a 4.5% disabled workforce and 0% of voting members on the Board identified as having a disability. However it should also be noted that 70% of Board members do not have any data recorded for this field (in line with the wider workforce).

7. WRES programme of work for 20/21

7.1 HPFT is required to publish a WRES action plan along with its data, via HPFT's website, by 31 October 2020. HPFT has seen progress against action plans over the past year.

7.2 Consultation with staff took place during Q1 and the focus of our HPFT' work plan is as follows:

- Cultural awareness programme
- Ambassadors
- Champions programme
- Reverse mentoring programme
- 1st decision panel - continuing and building on the work for metric 3
- Training and support for interview panel members
- Positive action around talent mapping and non-mandatory training (Please refer to appendix 1)

8. WDES programme of work for 20/21

8.1 HPFT is required to publish a WDES action plan along with its data, via HPFT's website, by 31 October 2020. We have seen progress against the action plans over the past year but some pieces of work were impacted by the focus on ensuring services continued during the pandemic.

8.2 The Trust will continue to work through a project based approach which aims to achieve better disability declaration rates for our staff and achieving improved results against the indicators for Disabled staff via the programmes outlined above in 7.2.

9. Conclusion

9.1 The review of the WRES data for the financial year 19/20 shows improvements in a number of the staff survey indicators from the previous year. There has been a positive change relating to the numbers of BAME staff entering the formal disciplinary process, where the disproportionality has significantly reduced. This was due to introducing 1st and 2nd decision making panels in July 2019, following a piece of triangulated work with the People and OD team, inclusion and engagement team and operational leads. The key to the change of this metric was putting in place a focused programme of changes that would have a positive impact.

9.2 Additionally, scores have improved for staff being appointed following shortlisting and in relation to BAME staff accessing non-mandatory training. We will focus on improving this area as a 20/21 priority (Appendix 1)

9.3 The review of WDES data for the year 19/20 shows that disabled staff, on the whole, report a poorer experience of the workplace when compared with non-disabled staff (as reported through the staff survey). Furthermore there is a significant gap in data quality with 24% of staff having no data recorded for the disability field on their electronic staff record (in line with the national picture). This is also the case for Trust Board members.

9.4 However, disciplinary data for WDES shows that disabled staff are not receiving differential experience when compared to non-disabled staff. We need to continue this good practice.

9.5 Work will be undertaken to put in place system wide programmes and this will involve the organisations across the ICS to ensure more dynamism and connectivity in our region. These programmes of work will improve equity for BAME staff across the ICS. Some of this work has begun and will also include work on the other protected characteristics. This will include a cultural awareness programme and a dashboard so that we can monitor our work across the ICS and support good practice across the organisations.

9.6 The refreshed Inclusion Strategy, currently being co-developed with our staff and led by the Executive Director of Quality & Safety and the Executive Director of People & OD, will set the vision for what the Trust wants to achieve across the Diversity, Equality and Inclusion agenda.

10. Recommendations

10.1 The Board are asked to agree the publication of this required report.

Appendix 1 – WRES/WDES Driver Diagram 2020-21

Aim	Primary Drivers	Secondary Drivers	Areas to target / opportunities
By 2022 we will have eliminated any differential experience for BAME staff (when compared with white staff) and Disabled staff (when compared to non-disabled staff)	Continue to evolve Trust approach to taking disciplinary action		Reviewed our disciplinary process and will implement 1st decision making panel only prior to being formalise to ensure process has been provided in an equitable way.
		Review panels for all disciplinaries	Trust is able to create opportunities for learning and improving from issues rather than issuing blame.
	Representation through tackling inequality, bullying and harassment and discrimination at Work	Introduction of reverse mentoring programme	Mentors recruited from staff across all protected groups as part of a phased programme. Starting with BAME and then Disability.
			Mentees identified from Directors for phase 1 and Senior Leadership Team for phase 2 and will continue downwards. Each mentee will commit to a 6 month programme
		Development of new inclusion programmes	Role of our Ambassadors programme starting with BAME Ambassadors in each SBU working on local plans and projects which is feedback to the Trust Board via our integrated governance structure.
			Delivery of our champions programme who will support our Ambassadors and will act as influencers to tackle workplace inequality and inequity.
		Connecting hearts and minds to change experiences.	Using mechanism to support our just and learning culture through our staff networks and our Schwartz Rounds. Creating safe sharing spaces for our whole workforce.
			Increasing direct dialogue with BAME staff and disabled staff to ensure work develops in the interests of BAME staff through consultation.
	Alter the ways we recruit and retain people	Diverse representation on interview panels	As part of the Ambassadors and champions programmes create a pool of staff from a representative range of protected characteristics is to sit on interview panels across the Trust with specific roles.
			Explore and implement additional training for Panellists (currently VbR training is in place.) are Training will explore how to approach recruitment impartial and directly discussing bias. All panellists must undertake training.

		Talent mapping our people	Identify routes to support our people at the trust through personal development and positive action.
		Positive action around non-mandatory training	Improved the offer and monitoring of non-mandatory training in the trust for BAME and Disabled staff (and other protected groups)
			Review our unconscious bias training and introduce a cultural awareness programme including cultural intelligence and cultural competency across the ICS.

Appendix 2 – WRES Indicators 2019-20

	Workforce indicators For each of these four workforce Indicators, compare the data for white and BME staff
1.	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.
2.	Relative likelihood of staff being appointed from shortlisting across all posts Note: This refers to both external and internal posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for white and BME staff
9.	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board Note: this is an amended version of the previous definition of Indicator 9

National NHS Staff Survey Metrics For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff.	
Metric 4 Staff Survey Q13	**a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) **Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**
Metric 5 Staff Survey Q14	**Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**
Metric 6 Staff Survey Q11	**Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**
Metric 7 Staff Survey Q5	**Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.**
The following NHS Staff Survey Metric only includes the responses of Disabled staff	
Metric 8 Staff Survey Q28b	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**
NHS Staff Survey and the engagement of Disabled staff **For part a)** of the following Metric, compare the staff engagement scores for Disabled, non-disabled staff and the overall trust's score **For part b)** Add evidence to the Trust's WDES Annual Report	
Metric 9	**a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.** **b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)** **Note: For your Trust's response to b)** **If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.

	If no, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.
Board representation Metric For this Metric, compare the difference for Disabled and non-disabled staff.	
Metric 10	**Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:** • By voting membership of the Board. • By Executive membership of the Board.

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 16
Subject:	Public Sector Equality Duty (PSED) compliance and Equality Delivery System 2 (EDS2) Grading update report 2019/20	**For Publication: Yes**
Author:	Sam Slaytor, Interim Inclusion & Engagement Team Manager.	**Approved by: Ann Corbyn, Executive Director People and OD**
Presented by:	Jane Padmore, Executive Director Quality and Safety	

Purpose of the report:

The purpose of this report is to provide assurance of compliance with the Public Sector Equality Duty (PSED) for 19/20

Action required:

The Board is asked to approve the report so it can publish our annual compliance as required by the PSED

Summary and recommendations

- The Trust is required to comply with both the general duties and the specific duties of the PSED and is mandated to publish the results of exercises in relation to the EDS2
- Trust compliance with the general duties is given in the form of a narrative regarding key pieces of project work, as detailed in this report. Following this, data is published on workforce and service users/carers as part of the Trust's compliance with the specific duties
- The EDS2 reporting is given in the form of grades from our previous grading. EDS2 grading is required to be completed by Trust stakeholders (rather than self –assessed) based on evidence supplied
- The Trust is required to publish one or more equality objectives covering a four year period, in the context of the EDS2. The Trust is awaiting National guidance from the Equality and Diversity Council (EDC) on EDS3, so a grading did not take place as EDS3 has not been implemented due the focus on the pandemic
- Our trust Equality Plan outlines all of our targets and strategic objectives until 2022. This is available online at www.hpft.nhs.uk

  It is recommended that this report is approved by the Board so that it can then be published on the Trust website.

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

The programme of work supporting compliance with the PSED and EDS2 links to the following annual plan priorities for 2019/20:

Great Care, Great Outcomes

2. We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy

Great People

4. We will continue to create a more empowered and engaged workforce through developing a culture of collective leadership
5. We will strengthen the capabilities and capacity required to deliver our plans by developing our leadership base

Great Networks and Partnerships

We will be recognised as system leaders having successfully driven and delivered on key system priorities.

Summary of Implications for:

The PSED and EDS2 Annual Report support the Trust in achieving its requirements set within the NHS standard contract in relations to WRES, WDES, AIS and EDS2. It also pays due regard to the Equality Act 2010 and associated Public Sector Equality Duty as well as commissioners targets (Service user Ethnicity data).

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

This paper shows compliance with the PSED and the EDS2 which both contribute to meeting legal responsibilities under the Equality Act 2010. Service user and carer data has been included in the report and will be circulated through our service user and carer councils.

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

N/A

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

PODG 03.09.20

Public Sector Equality Duty (PSED) Compliance and Equality Delivery System 2 (EDS2) Grading update report for the year 2019/20

1. Introduction

1.1 The purpose of this report is to provide assurance of compliance with the Public Sector Equality Duty (PSED) for 2019/20 for Hertfordshire Partnership University NHS Foundation Trust (the Trust), as well as an update on our current NHS Equality Delivery System 2 report.

1.2 The PSED requires the Trust to ensure that all of its functions are carried out in a way that does not disadvantage anyone from a protected group. This forms part of the Trust's overall compliance with the Equality Act 2010.

1.3 The Equality Delivery System 2 Grading (EDS2) is an improvement tool used by NHS providers to focus on one or more areas/functions of compliance annually to track improvements to services and employment. This is to be replaced by EDS3 but the implementation of this was suspended due to Covid-19.

1.4 The Trust is required to comply with both the general duties and the specific duties of the PSED given the size of the organisation. The EDS2 is a mandated part of the NHS standard contract for providers.

1.5 Sections 2 and 3 of this report provide an overview of PSED compliance; section 4 of this report provides an overview of EDS2 compliance.

1.6 A summary of the past year's activities, which have contributed to both PSED and EDS2 compliance, include:

- Monthly Staff inductions with Equality, Diversity and Inclusion (EDI) as a core component
- EDI presentation to staff in Essex - April 2019
- East of England WDES Workshop - April 2019
- Monthly Meetings of our Mental Health and Disabled Staff networks
- Monthly meetings of our BAME staff network
- Monthly Outlook (LGBTQ) Staff Network meetings
- Monthly/every other month meeting of Women's Staff network
- Monthly unconscious bias training for staff
- Disability Summit - April 2019
- Meeting for people with no recourse to public funds and the NHS/Social care - May 2019
- Mental Health Awareness Week – 13-19 May 2019
- Equality & Human Rights Promotion Day - May 2019
- Equality, Diversity and Human Rights week - May 2019
- Schwartz Rounds themed on Race Equality.
- IDAHOBIT Day - May 2019, when we launched our Rainbow badges scheme for staff
- Volunteer & Involvement Induction on various dates throughout the year
- Launch of our Faith & Wellbeing staff network 25th June 2019
- Establishment of disciplinary review panels to ensure just & equitable outcomes - July 2019
- Disability Confident regrading review and submission
- Staff diversity survey - July 2019
- Work with Job Centre Plus in relation to Disability & Employment commenced in July 2019
- Relaunch of Staff Carers Network in August 2019

- Ethnic minority forums and meetings for Strategic Business Units (SBU) Essex and IAPT and East and North from August 2019
- Consultation with staff of our Disabled Staff network to rebrand and launch as Diversability
- Webinar on LBGT Networks with Stonewall In August 2019
- Consultation with Stonewall regarding the Stonewall Work Equality Index (WEI)
- Presentation to Team Leaders - August 2019
- Participation in Herts Pride - August 2019
- A series of Reasonable Adjustments workshops for managers and disabled staff in conjunction with the DWP - August 2019
- Submission of Stonewall WEI in September 2019
- Eastern Region EDS2 Network in Cambridge - October 2019
- Learning disability conference - October 2019
- Herts recovery conference - October 2019
- BHM Event on 18th October 2019
- Big Listen promoting networks - August 2019
- Ethnic minority staff 'Time to Talk' - December 2019
- SBU Equality Meetings - February 2020
- LGBT+ Partnership meetings – May and October 2019, and February 2020 - hosted by HPFT, HCC and Herts Constabulary with 38 partner organisations discussing health and wellbeing including our voluntary sector partners

1.7 Challenges from the past year have included:

- Taking action that has resulted in improvements to the Trust's WRES data and ensuring that the experiences of BAME staff improve in relation to equality and diversity. Changes have been made to disciplinary and recruitment processes to reduce the negative disproportionality impacts on BAME staff. Further work is required in this and we have specific actions within the People and OD plan to continue our focus on this.
- Our performance and operational teams have worked to improve data quality across staff and service user/carer data but further work in required.
- During Q4 and in response to the pandemic, Business Continuity Plans were enacted and as a result some EDI objectives have had to be reprioritised – this work is being revaluated and developed further during the remainder of 2020/21.
- This report also contains a narrative pertaining to our compliance with the general duty and key pieces of project work and demonstrates that whilst we are making progress, there remains lots to do.

1.8 Compliance with the EDS2 is given in the form of last year's partial regrading. The data that is published in respect of our workforce as part of the compliance requirements is detailed in **Appendix 1**

1.9 **Appendix 2** provides an overview of the Trust's requirements in relation to the Public Sector Equality Duty and requirements under the EDS2.

2. PSED - Summary of Key Performance Areas regarding General Duties

The general duty of the PSED requires the Trust, in relation to all protected groups[1], to ensure it is working to:

[1] Age, Disability, Gender identity/reassignment, Pregnancy and maternity (employment only), Race/Ethnicity, Religion/Beliefs, Sex (gender), Sexual orientation, Marriage & Civil Partnership (employment only)

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it
- **Foster good relations** between people who share a protected characteristic and people who do not share it.

2.1 Overview / narrative to eliminate unlawful discrimination

NHS Workforce Race Equality Standard (WRES)
The Trust has continued implementation of their WRES programme focusing on identifying and addressing the inequalities within Trust workplaces.
The WRES data can be found on the public website.[2]
We have also seen enhanced activity locally within services to proactively engage with BAME staff to understand their experiences of working in the Trust in the form of SBU Equality meetings and SBU Ethnic Minority Forums
We have reported progress through our Equality and Information Standards Group (EISG) as part of our Integrated Governance Structure.

NHS Workforce Disability Equality Standard (WDES)
The Trust also has a duty to report on the WDES and this was submitted in July 2019 and our report and action plan is published on our website.
The WDES data can be found on the public website.[3]
Work focused on our Employee Staff Records (ESR) and training with DWP and Jobcentre plus on Employment and Disability and Reasonable Adjustments.
Two of our staff networks Diversability and the Staff Mental Health Network have been instrumental in supporting our work on WDES and engaging at our EISG and our Equality, Diversity and Inclusion Group (EDIG) as part of our Integrated Governance Structure.

2.2Overview/narrative to advancing equality of opportunity

2.2.1 Ambassadors / Champions - For some years we have an established role models programme across the business to support our efforts to become a more inclusive organisation. Our role models acted as champions for equality, working across protected characteristics. As we develop our approach, we are moving to identify equality, diversity and inclusion champions. These sit alongside ambassadors working in each of our Strategic Business Units (SBU). Together they have a role to identify grass root issues and to feed this up the decision making chain so that where necessary changes can be identified and action taken. Our role model programme will be phased out and the ambassadors and champions programme will be the focus for 2020-21.

2.2.2 Stonewall Workplace Equality Index – We have been one of the NHS organisations on the Stonewall Workplace Equality Index (WEI). This year our performance has remained strong. However, due to the number of applicants, we are informed by Stonewall that this has been the most competitive ever. As a result, in the latest index we have dropped from 113 in the previous year to 256 in 2019, despite continuing to perform well. We were due to have a benchmarking meeting with Stonewall which has been postponed due to the pandemic – once we understand more from Stonewall, this will allow us to put in place some key focus areas to further improve our practice. There is no WEI this year and we continue to work with Stonewall and engage our staff in webinars and resources.

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[2] https://www.hpft.nhs.uk/about-us/equality-and-diversity/nhs-workforce-race-equality-standard-wres/

[3] https://www.hpft.nhs.uk/about-us/equality-and-diversity/nhs-workforce-disability-equality-standard-wdes/

2.2.3 Staff Networks – Over the last year we have extended our staff networks so that we now have seven networks – they are: Outlook, the LGBT Staff Network; Black, Asian & Minority Ethnic Staff Network (BAME); Diversability Staff Network; Staff Mental Health Network – aimed primarily at staff with a lived experience of mental health; Women's Staff Network; Staff Carers Network and the Spirituality Staff Network. Our networks work closely together and help to identify issues and to foster good relations within our diverse workforce. The networks have all contributed to identifying issues and areas for improvements.

2.2.4 Launch of Rainbow Lanyards and Rainbow Badges – Our Rainbow Lanyard and Rainbow Badge scheme were launched in 2019. The lanyard signifies that the person is committed to equality, diversity and inclusion for all. The Rainbow Badge signifies a commitment to champion LGBT Equality. Over a third of HPFT Staff have now signed up for the Rainbow lanyards (over 1200). Approximately 300 members of staff have signed up for a rainbow badge. The badges are not suitable for every working situation, particularly in our inpatient settings, and as such the capacity is lower.

2.3Overview/narrative to foster good relations

Our focus over the past year has been to use key events to bring a diverse range of people together to focus on a particular area of quality improvement. This has enabled both celebration of diversity and awareness around inequalities that require attention in order to remove barriers and further promote social inclusion. These have included:

2.3.1 International Women's Day (IWD) Programme 2020 – An exciting programme was planned for IWD 2020 led by our Women's Staff network. Speakers included Dame Janet Paraskeva amongst others. Unfortunately the onset of Covid-19 necessitated a postponement of the event. However, the staff network is looking to identify a suitable opportunity to celebrate the impact of women probably in a virtual form this autumn.

2.3.2 LGBT History Month 2020 – LGBT History Month was held in February 2020 and in conjunction with other stakeholders, a number of activities took place. These included, screen savers celebrating the event running throughout the month, a meeting of our Outlook staff network, a meeting of the Hertfordshire LGBT partnership, LGBT events aimed at young people, publicising poetry on sexual orientation and gender identity and attending Pride Fest 2020 at the University of Hertfordshire.

2.3.3 Carers week – The Trust hosted a conference/events in June and November 2019. For Carers week in June 2019 we covered the following service areas:
- Community Adult Mental Health Services and Older People Service (4 June 2019)
- CATT, ADHT. Mental Health Liaison & Host Families (7 June 2019)
- CAMHS (7 June).

Some service team managers have already taken steps to further this piece of work within their specific services to help implement the carer pathway, address carer identification, support focus on developing staff in carer awareness and Continuous Quality Improvement on the carer plan 2019-21. We are also involved in revamping the carer awareness training programme in liaison with our biggest partner organisation (Carers in Hertfordshire).

A Team Leaders Event in September was planned and delivered with Executive Director of Service Delivery and Service User Experience. It included discussion on matters covering equality and diversity (Equality Act) with support from the trust Equality and Diversity Lead.

Carer Rights Day
The above theme was extended to the whole of the team leaders again during the planning and Delivery of the Carers Rights Day (November 2019).

2.3.4 Race Equality Action Not Words - In October 2019, the Trust hosted its fifth trust wide event attended by 90 staff. We looked at our WRES data and explained the changes we had made to disciplinary panels and the effects we had begun to see in the first three months of implementation. We also focused on white privilege with our keynote speaker Beverley Brathwaite, senior lecturer at the University of Hertfordshire.

Our workshops for the day focused on:

- Continuous Quality Improvement – our approach to to Inclusion and Diversity
- How can we bridge the empathy gap
- Schwarz Rounds- Race: Let's talk about it

We also heard some powerful and emotive personal staff stories from our other speakers.
Our entertainment was provided by Uzambezi Arts.

2.3.5 Hertfordshire Pride – The Trust continued its annual presence at Hertfordshire Pride this year with stalls promoting Trust employment opportunities and the Hertfordshire Wellbeing Service. Our corporate stall spoke to people about careers at HPFT current vacancies and volunteering opportunities. We also spoke with people about ways they could be involved as a service user or carer and the opportunities for young people to be involved in projects. We also spoke to people about their experiences of using HPFT services and listened to some great feedback and also areas that we can improve on to make people's experiences at HPFT better.

This was Herefordshire's 7th annual Pride event and it is important for us at HPFT to be represented at community engagement events. Discrimination is still faced by some people regarding their sexual orientation and their gender identity and we are committed to making sure that people have a good experience at HPFT whether staff, service user or carers were proud to champion equality and provide equity of experience.

Last year's Pride was a wonderful family event and the atmosphere was incredible. It was evident how hard the Herts Pride director and team had been working to ensure that everyone attending felt cared for and had a good time.

3 PSED - Specific Duties

3.3 Overview of requirements

3.3.1 The Trust is required to comply with the specific duties in the following ways:

- Publish information to demonstrate compliance with the general duty
- Publish data on the make-up of the workforce
- Publish data on those affected by Trust policies and procedures
- Publish one or more equality objectives.

3.3.2 *Publish information to demonstrate compliance with the general duty* – this report has been written and published to ensure compliance with this element of the duty.

3.3.3 *Publish data on the make-up of the workforce* – this is provided in **Appendix 1**

3.3.4 *Publish data on those affected by Trust policies and procedures* – this is also provided in **Appendix 1** (service user data).

3.3.5 *Publish one or more equality objectives spanning a four year period* – The Trust's Equality Plan was published in September 2018 detailing strategic objectives for the Trust over the next four years. The plan is available online at https://www.hpft.nhs.uk/about-us/equality-and-diversity/our-equality-plan-2018-2022/. The strategic objectives of the Equality Plan are:

1. People have equity of access
2. People have equity of outcomes
3. People's human rights are promoted
4. People have equally good experiences
5. The impact of the plan is monitored for effectiveness

In addition to the above, the plan includes focused work on improving understanding of intersectionality and the need to remove systemic barriers that can cause inequality.

3.4 Observations against our data

Appendix 1 details data for employment and for service provision by protected group. The following observations have been made from this along with our WRES and WDES data – available at https://www.hpft.nhs.uk/about-us/equality-and-diversity/

3.4.1 There has been overall good progress on our data quality for service users over the past year. We still want to further improve our data quality and will have more focused work on quality improvement for sexual orientation, disability and religion/belief throughout 20/21.

3.4.2 The Trust's Workforce Race Equality Standard (WRES) Data for 19/20 has showed some improvements in relation to workplace culture as reported through the 2019 staff survey for the Trust. Whilst there is improvement, appointments following shortlisting are still an area of focus for the trust and we have co-production work planned in our People and OD Plan. There is a marked reduction in BAME staff entering the formal disciplinary processes. The introduction of 1st and 2nd decision making panels were introduced in July 2019 and this has shown a vast improvement on this year's data. Metric 3 for 2019-20 is 1.03, which is a reduction of 0.85.

3.4.3 There is 36% of the workforce that have not declared their religion and/or belief. This is not currently mirrored across people applying for roles (12.2%). We will continue with our programme of work to encourage staff to amend their staff records aiming to reduce the proportion of data missing for staff records providing us with a better quality of workforce intelligence.

3.4.4 There is 24% of staff who have no data recorded on the disability field of their staff record. We will ensure we have focused work during the year to improve our data quality for Disability this is also part of our WDES work plan.

3.4.5 The year we have seen a shift in applications and have received more from those aged 20-29 (43.6%) but this is not mirrored in our workforce make-up (15.9%) where the age group is underrepresented. We will undertake a deep dive to look at age groups and employment in the Trust.

3.4.6 34% of our employees are from an ethnic minority background (where those who did not state their ethnicity are removed from figures). This is not currently reflected evenly across the workforce which is a key evidence base for the WRES. There are professional groups in which we have underrepresentation of employees from an ethnic minority. The Trust will be coordinating work around talent mapping to drive more equity within the workforce.

4 EDS2 – partial regrading of activity

4.3 The EDS2 requires providers to select one or more EDS2 outcomes to re-assess on an annual basis.

4.4 EDS2 grades should be agreed by the Trust's 'local interests' (stakeholders) through the provision of range of evidence showing the Trust current position.

4.5 The EDS2 has four grading options:

- Red – Under-developed (i.e. no evidence of activity for protected groups)
- Amber – Developing (i.e. evidence of activity (often good) but not for all protected groups)
- Green – Developed (i.e. good evidence of activity for most protected groups)
- Purple – Excelling (i.e. good evidence of activity for all protected groups).

4.6 The last regrade was completed in May 2019 when the Trust chose to re-grade ten outcomes as agreed with the Trust's Equality, Diversity and Inclusion Group (EDIG); due to Covid-19 EDS3 has not yet been ratified by the Equality and Diversity Council (EDC). It was agreed to defer any further regrading until EDS3 is operational. We will then complete a full regrade of all the EDS3 goals.

4.7 **Table 1** shows the results of those EDS2 objectives that were regraded in May last year:

Goal	Outcome	January 2018	May 2019	May 2020
1. Better health outcomes	1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	Not re-graded	Not re-graded	Not re-graded
	1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways *Our FFT data indicates that there has been litthe change emerging from the feedback from our service users and the pandemic has had an impact that is still to be finalised.*			Self Assessment
	1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed. *The pandemic has impacted on the services offered and similarly has affected transition.*			Self Assessment
	1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse. *Our staff survey results indicates that the Trust continues to be top ranked when it comes to a culture of safety and as such this remains*	Not re-graded		Self-Assessment

Goal	Outcome	January 2018	May 2019	May 2020
	green.			
	1.5 Screening, vaccination and other health promotion services reach and benefit all local communities.			Not re-graded
2. Improved patient access and experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds *The impact of Covid 19 has impacted on access to care and despite the best efforts of colleagues access to services has been impacted.*			Self-Assessment
	2.2 People are informed and supported to be as involved as they wish to be in decisions about their care. *Once again engagement with service users has been impacted by the pandemic and as such it has not always been possible keep service users as involved. Our councils were suspended for a time.*			Self-Assessment
	2.3 People report positive experiences of the NHS.			Not re-graded
	2.4 People's complaints about services are handled respectfully and efficiently.			Not re-graded
3. Empowered, engaged and well-supported staff	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.			Not re-graded
	3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations. *Equal pay audits have been completed and indicates that there are no significant gender pay gaps. Ethnicity pay gay should be explored.*			Self-Assessment
	3.3 Training and development opportunities are taken up and positively evaluated by all staff.			Not re-graded
	3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source. *Our staff survey results indicates that there remains significant cause for concern about harassment, bullying and violence in the organisation.*			Self-Assessment
	3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. *There has been a significant move towards more flexible working arrangements and new*			Self-Assessment

Goal	Outcome	January 2018	May 2019	May 2020
	policies and procedures are developing to facilitate this whilst recognising that the core requirement remains to ensure the wellbeing of our service users.			
	3.6 Staff report positive experiences of their membership of the workforce.			Not re-graded
4. Inclusive leadership	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond *The gender diversity of the Board has become enhanced over the last year. Steps have also been taken to enhance the ethnic diversity of the Board. There is clear leadership in emphasising the continuing importance of EDI in all aspects of our work.*			Self-Assessment
	4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed.			Not re-graded
	4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination. *There is not yet the evidence that the commitment at the executive level is being applied consistently at middle management levels.*			Self-Assessment

Table 1: HPFT EDS2 partial re-grading outcome (May 2019)

4.8 EDS2 objectives from 2019-20 position:

- Develop and implement plans to diversify engagement mechanisms such as carer council, service user council and youth council
- Improve the collection of demographic data particularly for sexual orientation and disability for staff and service users
- Identify and develop mechanisms to capture and report demographic data concerning the safety of service users and staff.
- Develop action plan emerging from gender pay gap reporting and put in place arrangements for ethnicity and disability pay gap monitoring and reporting
- Explore the rationale for the significant inequality identified with the workforce race equality standard results and identify solutions
- Identify and develop arrangements to monitor use of informal flexible working arrangements and identify any differential impact by demography.
- Review approach to reasonable adjustments to ensure that there is a consistent approach across the Trust
- Provide training and information on reasonable adjustments for all middle managers.

5 Our Equality Plan

5.3 The trust equality plan is in its second year of a four year plan and our priorities are:

- Human Rights are promoted
- Equally good experience
- Equity of access
- Equity in outcomes

5.4 Evaluation of the impact of our equality plan would suggest we have met our priority areas as part of our PSED as outlined in section 1, 2 and 3 of this report. Section 4 and our EDS2 objectives have been self–assessed due to the pandemic and forthcoming EDS3, so we have only partially met these priorities. We have a programme of work that will focus on service user, staff and carers and this evidence will be complied for our EDS3 grading involving all our stakeholders.

6 Challenges & Opportunities for the coming year

6.1 A key challenge this year will be around improvement in WRES scores for staff appointments and staff experience.

6.2 Launching our reverse mentoring programme to improve the opportunity for senior staff to be mentored by a more junior staff member in relation to improvement equality and inclusion.

6.3 Implementing further changes to pre-disciplinary panels to screen those cases put forward for formal disciplinary to ensure actions are proportionate and build on the improvements from 2019-20.

6.4 The national reporting of the gender pay gap has been suspended due to the coronavirus pandemic; once the reporting requirement is restored we have an opportunity to draw on some trends from our data and set and create a new action plan.

6.5 To build on our rainbow lanyards and NHS rainbow badge schemes. The former focused on improving awareness and commitment from staff to equality, diversity and inclusion. The latter focused on staff and team commitment to creating safe spaces for LGBT people to disclose their sexual orientation and explore their gender identity and receive specialist signposting and information.

6.6 To shape the work on the Trust Equality, Diversity & Inclusion Plan to have a stronger focus on experience and culture change. Also to strengthen our work between all NHS equality standards. It is recognised that improving data quality will help improve our understanding in relation to equitable access to services and employment and we will continue to build on our data quality throughout 2020-21.

6.7 During Covid-19 we have invested more time and resources into the development of staff networks via virtual platforms; during 2020-21 we will expand our virtual spaces for discussion and debate and provide physical spaces for support too when appropriate to do so.

6.8 Reinvest work into our targeted action planning to address the Trust gender pay gap through improving the experiences of women in the workforce, learning from best practice and challenging inequality and inequity.

6.9 We will launch our ambassador and champions programmes to replace our previous role model programme. There will be specific positive action on Race and Disability in the first phase as part of our requirements to report on our Workforce Race Equality Standard (WRES) and Workforce

Disability Equality Standard (WDES). Phase two of the ambassador and champions programmes will focus on intersectionality and integration. The full ambassador and champion programmes will be embedded by March 2021.

6.10 We will undertake a full review of EDS3 and ensure that are stakeholders having the opportunity to grade our performance against the NHS Equality Delivery System.

6.11 All of this work will be driven by the refreshed Inclusion Strategy, currently being co-developed with our staff and led by the Executive Director of Quality & Safety and the Executive Director of People & OD.

7 Conclusion

7.1 This report provides an overview of the Trust's work towards meeting the Public Sector Equality Duty with respect to both the general duties (in the form of narrative) and the specific duties (with respect to the trust equality plan and data in Appendix 1)

7.2 Whilst there is work to be done, the Trust is able to demonstrate improvement and show that it is linking its work into meeting the general duties and identifying areas for improvement.

7.3 The past year has seen a number of successes for the Trust in relation to advancing the Equality, Diversity and Inclusion agenda, including events for Black History Month, launching our rainbow lanyards and rainbow badges schemes and strengthening the Trust's governance structure to relation to equality, diversity and inclusion.

7.4 However there remain some challenges for the Trust, most notably in relation the Workforce Race Equality Standard and improving data quality across both employment and service provision. Targeted work in early 2019 has begun to yield results around some of this in relation to the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) and this will remain a priority over the coming year.

7.5 Throughout 20/21 there are a number of projects planned including the launch of our reverse mentors programme, our ambassador programme and our champions programme. We will continue to push inclusion into the spotlight.

7.6 We will undertake a full EDS3 regrade with our stakeholders to ensure we have the right systems and processes in place and will put in to place an agreed set of Equality objectives.

8 Recommendations

It is recommended that this report is approved so this can be published on the Trust website. This report was previously considered at the People and OD Group in September 2020, prior to submission to the Board.

9 Contact

Any further detail can be obtained from the Trust Equality & Diversity Department within the Inclusion & Engagement Team on hpft.equality@nhs.net

Appendix 1 – Workforce & Service User Data

Data tables for staff and service user equalities data for 2019/20. The % listed in the tables relates the following numbers:

Applicants between 01/04/18 – 31/03/20	7415
Staff in Post at 31/03/19	4325
Leavers between 01/04/18 – 31/03/20	652
Staff with a current Professional Development Plan (PDP)	2349
Service Users as of 31/03/20	49978
Carers as of 31/03/20	2557

AGE

	Employed staff	Leavers	Current PDP
16-20	0.36%	0.4%	0.1%
21-25	6%	9.2%	5.5%
26-30	9.9%	13.6%	10.5%
31-35	9.9%	10.4%	9.6%
36-40	11.6%	11%	11.5%
41-45	12%	9.9%	12.2%
46-50	13.9%	11.1%	14.7%
51-55	13%	10.9%	15%
56-60	11.3%	11.3%	11%
61-65	7.4%	6.6%	6.7%
66-70	3%	3.2%	1.8%
71 & above	1.5%	2%	0.7%

	Applicants	Service Users	Carers
Under 20	0.8%	25.1%	0.47%
20 - 24	24.4%	8.9%	2.4%
25 - 29	19.2%	7.7%	2.9%
30 - 34	12.6%	7.7%	3.2%
35 - 39	11.3%	6.4%	4.9%
40 - 44	8.5%	5.1%	7.2%
45 - 49	9.5%	5.1%	8.3%
50 - 54	6.4%	5.2%	12.8%
55 - 59	4.4%	4.4%	10.8%
60 - 64	2%	3.4%	10.5%
65+	0.28%	21.4%	21.9%
Not stated	0.36%	0.01%	14.3%

GENDER

	Applicants	Employed staff	Leavers	Current PDP	Service users	Carers
Female	77.2	73%	73%	82%	53.8%	66.4%
Male	22.2%	27%	27%	77%	46.1%	31.3%
Did not disclose	0.5%	-	-	-	0.07%	2%
Not recorded	-	-	-	-	0.002%	0.19%

ETHNICITY

	Applicants	Employed staff	Leavers	Current PDP	Service users	Carers
A White - British	47.2%	49.6%	48.1%	81.7%	59.5%	26.9%
B White - Irish	1.3%	2.4%	2.1%	82.9%	1.1%	0.82%
C White - Any other White background	9.6%	6.5%	6.7%	81.6%	3%	1.2%
D Mixed - White & Black Caribbean	0.9%	0.8%	0.7%	88%	0.93%	0.31%
E Mixed - White & Black African	0.9%	0.5%	0.4%	53.8%	0.32%	0%
F Mixed - White & Asian	0.8%	0.7%	0.6%	71.4%	0.49%	0.15%
G Mixed - Any other mixed background	1.4%	0.8%	0.9%	61.5%	1.1%	0.31%
H Asian or Asian British - Indian	7.7%	4.8%	5%	75.2%	0.76%	0.66%
J Asian or Asian British - Pakistani	3.5%	1.3%	1.5%	77.7%	0.62%	0.43%
K Asian or Asian British - Bangladeshi	0.8%	0.4%	0.6%	66.6%	0.24%	0.39%
L Asian or Asian British - Any other Asian background	3.2%	3.8%	2.7%	77.5%	1.1%	0.54%
M Black or Black British - Caribbean	2.3%	2.2%	3%	80.3%	0.46%	0.23%
N Black or Black British - African	13.9%	13.9%	13.3%	83%	0.73%	0.5%
P Black or Black British - Any other Black background	1%	1.8%	2.3%	66.6%	0.81%	0.7%
R Chinese	0.8%	0.5%	0.6%	81.2%	0.14%	0.12%
S Any Other Ethnic Group	2.3%	2.4%	2.4%	83%	0.75%	0.62%
Z Not Stated	2.2%	7.1%	8.4%	76.6%	8.5%	62.9%

SEXUAL ORIENTATION

	Applicants	Employed staff	Leavers	Current PDP	Service users	Carers
Gay or Lesbian	1.5%	1.1%	1.2%	88.5%	0.77%	0.11%
Bisexual	7%	2.2%	2.3%	85.5%	0.75%	0.08%
Heterosexual	85.7%	67.8%	67.6%	81%	42.5%	18.3%
Refused	5.3%	28.%	28.8%	78.5%	2.3%	0.15%
Other	0.2%	0.02%	-	100%	1.1%	0.15%
Not recorded	0.1%	0.02%	-	-	52.4%	81.2%

DISABILITY

	Applicants	Employed staff	Leavers	Current PDP	Service users	Carers
Yes	7.8%	4.5%	4.4%	78.5%	-	-
No	89.9%	71.4%	74%	80.7%	-	-
Not recorded	2.3%	24%	21%	81%	100%	100%

RELIGION & BELIEF

	Applicants	Employed staff	Leavers	Current PDP	Service Users	Carers
Atheism	19.4%	12%	12.4%	83.1%	1.4%	0.86%
Buddhism	1.2%	0.7%	1%	62.5%	0.16%	0.12%
Christianity	38.6%	40.9%	38.9%	81.2%	16.4%	6.8%
Hinduism	8.6%	3.1%	3.5%	79.4%	0.39%	0.5%
Islam	10.1%	3.5%	4.4%	70.6%	1.1%	0.55%
Jainism	-	0.07%	0%	100%	0.004%	-
Judaism	0.7%	0.8%	1.5%	91.6%	0.72%	0.31%
Sikhism	1.5%	0.6%	0.1%	55.6%	0.11%	0.08%
Other	7.5%	7.3%	8.3%	82%	2.6%	0.82%
None	-	-	-	-	8.9%	1.7%
Rather not say	12.2%	30.6%	29.6%	79.6%	1.8%	0.2%
Not recorded	0.1%	-	-	-	66.4%	88.1%

MARRIAGE & CIVIL PARTNERSHIP

	Applicants	Employed staff	Leavers	Current PDP
Civil Partnership	1.5%	1.2%	0.9%	82.3%
Divorced	3.2%	6.7%	6.4%	79.2%
Legally Separated	0.8%	0.9%	1.1%	74.3%
Married	33.1%	50.3%	47%	81.4%
Single	57%	34.8%	39.9%	80.9%
Unknown	3.9%	4.7%	4.1%	74.8%

	Service Users	Carers
Married/Civil Partnership	6.8%	3.1%
Divorced	1.5%	0.4%
Legally Separated	0.77%	0.24%
Single	21.1%	1.8%
Unknown	67.1%	94.3%
Widowed	2.7%	0.2%

Widowed	0.4%	1.1%	0.4%	76.9%

Appendix 2 – Overview of Trust requirements re: Public Sector Equality Duty

In October 2010, the Equality Act 2010 came into effect. Prior to this time there had been over 100 pieces of legislation covering equalities protections and – with them – three associated public duties for race, gender and disability.

The Equality Act 2010 has brought with it a new – legal – public sector equality duty (PSED) requiring public bodies to declare their compliance with the duty on an annual basis. This means that HPFT must show compliance with both the general and specific duties of the PSED. This includes:

For the general duty showing how we have due regard to the need to:

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it
- **Foster good relations** between people who share a protected characteristic and people who do not share it.

Protected characteristics – in the context of the PSED – are defined as:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race – this includes ethnic or national origins, colour or nationality
- Religion or belief – this includes lack of belief
- Sex (gender)
- Sexual orientation

It also applies to marriage and civil partnership in respect of the requirement to have due regard to the need to eliminate discrimination.

For the specific duty HPFT must:

- Publish information to demonstrate compliance with the general duty
- Publish data on the make-up of the workforce
- Publish data on those affected by HPFT policies and procedures
- Publish one or more equality objectives.

This document outlines how HPFT is currently complying with the PSED and working at maintaining a level of excellence in equality & diversity. Much of our evidence of PSED compliance is detailed through Trust Equality Delivery System 2 (EDS2) approached.

The PSED is a legal framework which requires the Trust to be compliant across **ALL** functions in meeting the needs of those with a protected characteristic.

Appendix 3 – Draft Equality Driver Diagram for 2020/21

Aim	Primary Drivers	Secondary Drivers	Areas to target / opportunities
People have equally good experiences, equity in outcomes and access	**Evolving a programme of work that is focused on identifying and removing systemic barriers that can lead to inequity**		Trust is able to promote Just Culture which aims to create opportunities for learning and improving from issues rather than issuing blame.
		Review our experience feedback	Targeted feedback sought from people this means our staff , service users and carers and unpacking the process to understand experience and any feelings of inequity.
			Introducing our stories library focusing on service user, carer and staff stories to support our just and learning culture
			Embedding Inclusion Schwartz rounds as part of our connecting hearts and minds across staff experiences.
		Revised Trust Policies corporate and operation	Provide critical review of processes and engaging our stakeholders in consultation

	Monitoring and recording our data as part of an improvement programme	**Introduction of Equality dashboard**	Equality dashboard that connects our data quality of service user, staff and carers. Connecting our data to the NHSE interim peoples plan and address inequalities in NHS provision and outcomes as outlined by NHSI response to the COVID-19 pandemic guides.
			Increasing direct dialogue with staff to ensure work develops in the interests of our people.
		Working at SBU level to promote and engage staff on the EDI agenda	Working with our SBU leads, ambassadors and champions on local action and reporting.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 17
Subject:	Winter Planning/Covid Surge Planning and Phase III	**For Publication:**
Author:	Fiona McMillan Shields Interim Managing Director E&N SBU	**Approved by:** Sandra Brookes, Director Service Delivery and Service User Experience
Presented by:	Sandra Brookes, Director Service Delivery and Service User Experience	

Purpose of the report:

This plan outlines winter resilience planning for 2020/1. It takes into account the possibility of a second surge in COVID-19 during this period. Throughout this document the term "winter" refers to the period 1st October 2020 to 31st March 2021.

This plan forms part of the assurance required by NHSE/I regarding operational resilience and winter planning across the health and social care systems.

This plan is informed by the current principles outlined in the East of England NHSE/I Winter planning guidance

- To provide a detailed winter assurance process ensuring safe, effective and timely patient care is delivered across urgent and emergency care services during the winter of 2020/2021 by a healthily, resilient and prepared multi agency workforce.
- To ensure a more dynamic and fluid approach to allow for variability due to issues such as COVID 19, flu and severe weather.
- To review the learning from previous years and make certain this is embedded within organisational and system plans, ensuring the sharing of best practice.

Action required:

The Board is asked to receive the report and note the planning underway to ensure the Trust is prepared to response to the winter and a possible second surge.

Summary and recommendations to the Board:

The winter plan incorporating our response to any future Covid surges and winter pressures outlines key actions being implemented to ensure that there we are providing adequate support to staff and service users and maintaining our ability to provide services. A detailed action plan sitting below the plan will be monitored by the Trust Management Group.

Relationship with the Business Plan & Assurance Framework:

The report relates to the following strategic objectives:

- Deliver safe and effective services.
- Service users, carers, referrers and commissioners will have a positive experience of our services.

as One

Our Values
Welcoming Kind Positive Respectful Professional

Summary of Implications for:

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

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

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

Introduction

This year's Trust Winter Plan has been formulated within the context of a continuing increase in demand for services against a backdrop on the Covid-19 Pandemic.

The purpose of the Trust's Winter Plan is to ensure that finance, activity and workforce plans are triangulated and developed to support the delivery of safe, effective care and services throughout the period of winter, building on the lessons learnt from last winter and from the Trust's response to Covid-19 and that controls are in place to address the risks facing the Trust at this time.

In formulating our plan, we are mindful that in addition to continuing high levels of demand, our preparations need to take into account of the following related issues;

- Sustaining trajectories to meet the National targets outlined within the Trust's Phase 3 Planning Submission
- Contingencies in the event of a serious influenza outbreak or a resurgence of Covid-19 either nationally or locally
- Continuing financial challenges and the complexity of reimbursement within this financial year
- The continued spectre of EU Exit and potential impact of a "no deal" on our supply chains across the health economy

This winter planning report relates to, and should be read in the context of the following Trust level work programmes / papers;

- Trust's Pandemic Flu plan
- Trust's Business Continuity Planning
- Trust's response to the NHS People Plan
- Updated financial plans

The Trust's Winter Plan covers:

A. Support for our staff
   1. Keeping people at work
   2. Flu plan

B. Support for service users and carers

C. Service provision and system working
   1. Capacity and demand planning
   2. Business continuity plans
   3. Services and schemes that aim to support the management of demand over winter

D. Covid-19 surge plan

E. Adverse weather planning
F. Trust response to EU Exit
G. Phase III Planning

A. Support for our staff

1. Keeping staff at work

A range of measures have been introduced to maximise staff capacity and flexibility to respond to surges in demand and these include the actions we have taken to return staff to safe working within hubs and offices. We will continue to review the use of trust buildings in line with Infection control guidance whilst maximising capacity and providing information to staff regarding their safety.

Remote working for staff has been mobilised with the majority of trust staff having the capability to work remotely if required which means that even when staff may have to self-isolate, they may still be enabled to undertake meaningful work. All staff have been provided with the equipment required to work remotely. The impact of working from home will be reviewed on a regular basis and initiatives to ensure staff wellbeing is supported will continue to be developed.

We are maximising staffing capacity through winter including the implementation of the staff influenza vaccination programme and through proactively planning and managing staff annual leave.

Additional actions in place for inpatient settings include daily safer staffing calls and reporting supporting team leads and Matrons to proactively manage the shift cover and ensuring safe levels of care available on the wards.

A key measure to keeping staff in work is the rigour of enhanced infection and prevention controls introduced as a result of Covid-19. Ensuring PPE is available, providing additional uniforms and reviewing practice in every clinical and non-clinical setting is designed to keep staff safe and prevent the spread of infection. A business case is in development regarding the introduction of a mobile changing facility for the Kingfisher Court site.

Teams have been actively reviewing their vacancies and ensuring that they are actively recruiting. This has been supported by the return of corporate functions. More than 50 newly qualified nurses will be starting within the Trust this autumn which will significantly impact on both vacancy rates and the need for Bank and Agency staff to cover the wards.

Redeployment was a key feature of the initial Covid-19 incident response and a new redeployment register has been developed on Spike to improve allocation of people and match skills better. In order to support the ongoing provision of services throughout any further Covid surge, redeployment will be focused on corporate and bank staff.

In addition the Organisational Development team will continue to review ways to support staff wellbeing and ensure easy access to support. The communications department will provide ongoing communication to staff in various forms learning from the last 6-months and feedback from staff, regarding the most successful approaches for example the live Q&A sessions.

2. Flu Campaign

The national media campaign on flu vaccination starts imminently and there is an expectation that the vaccination programme will start at the end of September.
The Team has reviewed the campaign against the NHSE Healthcare worker flu vaccination best practice management checklist and is green on all eighteen indicators.

Over 100 flu clinics are booked through October and November, delivered by nearly 70 peer vaccinators and colleagues from Occupational Health. This year peer vaccinators will also be offering informal opportunities for staff to have their vaccinations with a particular focus on inpatient areas and out of hours.

We have implemented an online booking system to facilitate safe numbers in buildings. Over 600 staff booked their appointment within an hour of the system launching.

We have worked with our BAME network to ensure we meet the needs of our BAME staff with one of our service line operational leads actively championing this with our network.

The trust continues to make improvements to our business intelligence systems to ensure we have accurate live data and allow us to identify any teams who are outliers in staff having their flu vaccinations.

The Trust has helped Public Health England, to develop resources to encourage people with a learning disability to have a flu vaccination including an easy read flu leaflet, poster and a guide on what to expect at your flu vaccination appointment especially during Covid-19.

B. Support for service uses and carers

Each Strategic Business Unit and all corporate teams have reviewed their current business continuity plans, BIAs and arrangements following Covid-19. Whilst specific winter schemes have been highlighted above, **all services** have undertaken reviews to maximize capacity and minimise risks to delivery.

Actions taken by all of our teams to strengthen the support offered to our service users include:

- All service users on the community caseloads continue to be regularly reviewed and are RAG rated according to their risk; this includes risk in relation to Covid. This enables the teams to focus on their resources in the right places.
- Guidance has been produced for all teams to be clear on the interventions that wherever possible are carried out face to face.
- Managing safe access to hubs optimising use of clinical space following the introduction and regular review of the Covid Building Risk Assessments.
- The review of all Trust policies and undertaken a Covid impact assessment
- Continued development of the digital strategy to support service user access and experience.
- Continued waiting list and caseload management oversight.
- Improved communication regarding accessing services
- Continuation of the 24/7 helpline

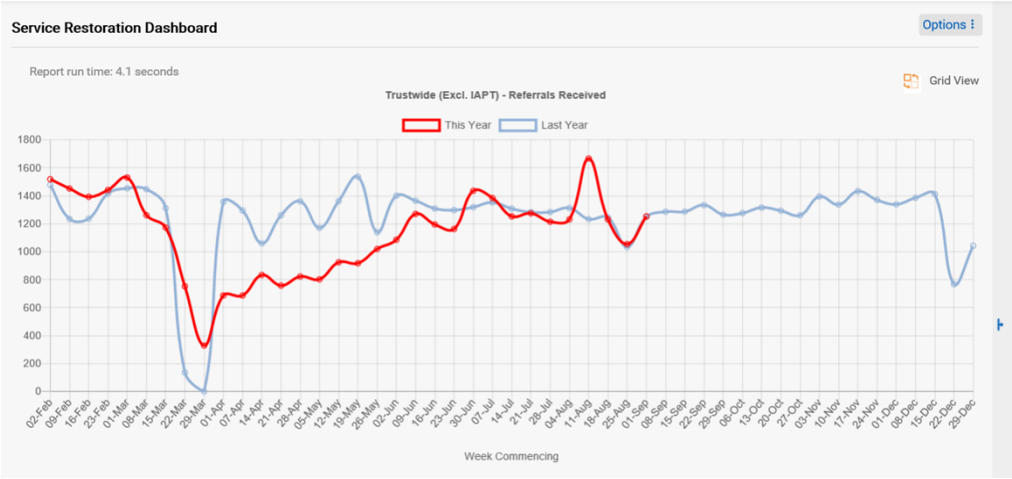
The Clinical and professional advisory group (CPAC) that was stood up during Covid continues to meet to advice staff and services on the introduction of guidance and best practice to support optimum service delivery.

C. Service provision and system working

1. Capacity and demand planning

In terms of bed provision the default operational assumption is that the peak of open bed capacity [achieved through the winter of 2019/20] will be at least maintained through 2020/21. In addition Elizabeth Court (24 bed) refurbished as the Covid ward remains available to support bed capacity if required.

Teams have been working hard to recover services to pre-Covid-19 levels of activity and we now see referrals coming through SPA at pre-Covid-19 baseline levels. As in graph below.



SPA referral activity

Modelling performance helps each service to develop credible plans to release capacity to manage the peaks or surges in demand expected this winter through managing reductions in length of stay, making improvements to prevent delayed transfers of care (DTOCs), and to develop admission avoidance programmes in order to maintain the flow of activity through services through programmes of continuous quality improvement, led by the SBUs and services.
Activity levels are monitored on a weekly basis. In business as usual these are monitored via the performance reporting mechanisms and in relation to the management of the incident, escalations are via the command structure.

Each of the service lines is able to track activity against a trajectory based on last year's data and intelligence following the last few months. This is being re-modelled based on information being gathered in relation to potential mental health surges and will be constantly reviewed to support services in planning and managing resources. It is anticipated that seasonal variation troughs and peaks are likely to continue but with the impact of Covid overlaying this.

There are some pinch points/services that are critical to the management of our response and service delivery over this winter including access to AMHPs, the Bed Management Service, the A&E Diversion Hubs, and Crisis services. These are being targeted for increased support and the models of delivery and staffing are being actively reviewed to enhance effective working.

2. **Business continuity plans**

The Trust's Major Incident and Business Continuity Plan that outlines the Trust responsibilities during a major incident includes a core set of principles, which support and assist consistent decision making in incident situations.

Business continuity and impact assessments are undertaken for every service line and were refreshed both at the beginning of the Covid pandemic earlier in the year and again within the past month to reflect any changes and learning from the Covid-19 incident.

Our teams recognise the need to manage and prioritise Tier 1 services (24/7 / Crisis) and are working to ensure these services continue to be fully staffed, in a good positon to cope with any surge. Community services have recovered well but are anticipating the current increase in activity that we see, to go on for much longer than the duration of the Covid incident.

Learning from the Covid-19 incident is critical to managing our plans this winter and services acknowledge and fully recognise that it will not be possible to stop or temporarily close front line services in the event of a further surge. Rather, the focus of all our teams and services is 'how might they further adapt and develop in order to keep services open and operating effectively'.

The Trust has restored and recovered service provision throughout the summer and the strategic business units have been actively making changes to manage their services differently including through the way service users are contacted and seen and how staff are operating and working in a much more agile way.

In addition there has been particular focus on the services where following review of our Covid response where in some cases; IAPT, ECT and EMDASS we scaled back or were unable to provide services. As part of the provision going forwards for these services the following has been agreed:

Learning Disability Services- improved, integrated working with the local authority means that the team uses a system approach to ensuring that the most vulnerable service users are identified and supported. Closer working with general hospitals, including Trust staff with honorary contracts allows for greater flexibility in the ability to support vulnerable individuals should they be admitted to the general hospital or care homes. Clinicians are improving links with GPs to ensure closer monitoring of service user's physical health and further developing their own skills/skill mix to support.

IAPT - The team are continuing in the development of the IAPT digital strategy to support service users through identified best practice such as signposting to written self-help guidance on the IAPT service website. The service is promoting the availability of self-directed unsupported online digital interventions (including delivery via YouTube) The teams are proactive in training staff in the use of the new innovations in response to new presentations as a result of Covid and are building on their learning from the incident phase as they anticipate a prolonged period of presentations with post-Covid psychological distress. All IAPT staff are able to work remotely and work continues to support/ maintain staff wellbeing.

ECT – access to anaesthetists, equipment and suitable premises was a challenge during the Covid-19 Incident phase. In the case of West Herts Hospital being unable to continue to support at the level now agreed to meet both the urgent, routine and maintenance cases, the teams are proactively reviewing all cases to prioritise and risk assess urgent cases; this will ensure that anyone who is receiving maintenance treatment is being seen and assessed regularly, to prevent deterioration.

EMDASS –the team have implemented a recovery plan which is in line with the trajectory to manage the backlog created by not accepting referrals during the Covid period. A review of the model has focused on ways to work more efficiently using remote consultation that brings the consultant into the service user's home during the nurse led memory home-visit assessments. This way of working increases the capacity of the team and frees up appointments. The team is also working with primary care on developing a model, that means fewer referrals for the more straightforward diagnostic cases and less pre-diagnostic testing which is difficult to access when acute services are under pressure. These new ways of working, will provide a more effective approach to maintaining and supporting service users.

The following are some of the actions are in place across trust services to ensure resilience over winter 2020/21:

- Incident command response to COVID-19 remains in place and will be flexible in response to local and national circumstances being able to step up as required.
- SBU daily leadership /oversight operational, bed management and safer staffing meetings – these routine business as usual approaches give assurance that there is strong operational and clinical oversight for teams and services
- Cross SBU Operational leadership – this has been a welcome unintended outcome of the incident – teams are reporting greater levels of across trust understanding and effective working as a result of managing the incident together and having to work together for collective solutions
- Support for and engagement with the wider health and social care systems through the formal Strategic Resilience Groups and through Mutual Aid arrangements

3. Services and schemes that aim to support the management of demand over winter

There is no routine to access 'Winter monies' per se for any mental health or learning disabilities trust this year, however there is Commissioner support to improve discharge and system flow and support for a number of schemes that were put in place to support the provision of care during winter 2019, some of which were extended until 30th September 2020 as part of managing the COVID 19 pandemic risk.

The following schemes have been put forward to support resilience over winter 2020/21 and are being considered by the CCGs as part of the system-wide winter plans:

- **Mental health D2A -** Additional resource to the HPFT Bed Management Team as an assessor for D2A and to provide additional short term capacity to support earlier discharge for 30 service users during the Winter period

- **Mental health floating support in community** - A block contract for short term care packages and crisis care - to reduce LOS by 5 days for service users identified as waiting for community care package

- **Additional bed capacity for MH -** Funding for 6 beds during the winter period (Oct 20 – March 21)

- **MH A&E Diversion Centre** – Evaluation of the model to support the continuation of these services throughout winter and enhance the model to increase use of the centre and provide additional physical health care e.g. Registered General Nurse to avoid admission the Emergency Department.

- **24/7 MH Help and Advice Line -** to support the growth in people experiencing mental distress or seeking support with their mental health. Note the Trust will continue to fund this at risk as a requirement to provide.

D. Covid-19 surge plan

1. Learning from the Covid Incident

Learning has emphasised the importance of strong visible clinical leadership and presence within services to support MDT timely decision making and also to promote staff confidence in delivering effective and safe care.

Other aspects that have worked well include more joined up working between teams and between SBUs, staff responsiveness and flexibility, not only around their own working conditions but also around the rapid deployment of changes to the delivery and shape of clinical services, such as digital developments. Many staff reflected positively on the development opportunities the incident afforded for staff through redeployment and through engaging in incident command processes.

Learning that will support teams to strengthen delivery under adverse conditions include making improvements to communication to service users and the wider health and care system and how we can keep communication with staff updated in a timely way, especially for frontline staff who found it hard to keep up with or access messages. Further themes we are addressing include how we are creating capacity to cover 7 day working.

2. Covid-Surge Planning Assumptions

The current planning assumptions include that COVID 19 will continue to circulate within the population for the next 1-2 years and possibly longer. This is supported both nationally and regionally. The NHS is being asked to put in place robust contingency plans to prepare for the possibility of a ‘second peak’ in COVID-19 infections this year and to ensure that sufficient capacity is in place over the winter period to manage a very high level of demand for both COVID and non-COVID activity.

A range of national guidance has been published (and continues to be published) setting out expectations on NHS and Care providers to ensure the delivery of ‘COVID Secure’ services and to support a restoration of normal levels of activity, whilst being able to respond to increases in demand as a result of winter or a resurgence in COVID-19.

Implementation of guidance can have significant capacity and productivity implications for the delivery of services; for example, the requirement for cleaning

rooms and equipment between service users and providing clinical space large enough to accommodate group work and interventions with a number of people.

There are workforce constraints in relation to sickness, self-isolation, shielding and vulnerable staff, representing a challenge in delivering pre-COVID activity levels. Personal Protective Equipment (PPE) supplies and testing capacity may represent a risk in response to the revised Infection Prevention and Control (IPC) guidance and to support the delivery of the Flu Vaccination Programme.

3. Current Covid update within the Trust

National and local

Nationally the 'R' rate has continued to rise and within the west of Hertfordshire and Norfolk there have been local outbreaks reported. Surveillance and intelligence from public health is indicating a rise in the number of community acquired transmissions of Covid. Locally and nationally we are aware of a significant rise in activity through 111 and 119 services driven by a rise in the demand for testing and in increased numbers of young people with Covid. School closure is an increasing issue that will impact on staff and over recent weeks we are seeing an increase in schools being closed or year groups being isolated.

Incident Command

The incident command structure remains responsive to the current situation and has recently been stepped up in response to the National and Local picture and the impact on services and the workforce. Tactical Command oversees any outstanding Covid-19 actions and ensures non-incident or outbreak related activity is handed back to business as usual. National sit reps have been increased again to daily, including the weekends.

Oversight and reporting remains in place through the command structure should there be a suspected or actual outbreak of Covid-19. A senior nurse on call rota, specifically for the management of the incidence of infection, is in place to support the on call system and has effectively called Outbreak Control Team meetings when the need has arisen.

Service user

The number of Covid-19 related deaths is 90, of which 13 were reportable. There have been no additional Covid-19 related deaths since 12th August 2020.

At the time of writing there is one positive case of Covid on Forest House Adolescent Unit. This young person has been an inpatient a number of weeks, therefore it is a hospital acquired infection. A root cause analysis is underway with the acute hospital as she had returned from an acute hospital just before she had a high temperature.

There have been a significant number of service user and staff with Covid-like symptoms who have been isolated and tested, all, in recent weeks, apart from the young person mentioned above, have come back with a negative result.

Workforce

Whilst staff absence levels have remained low throughout the summer in September have started to see the impact of more staff needing to self-isolate either due to a family member or themselves needing to self-isolate. Of those who are not working, most are self-isolating, are on a phased return or are in discussions to consider alternative duties.

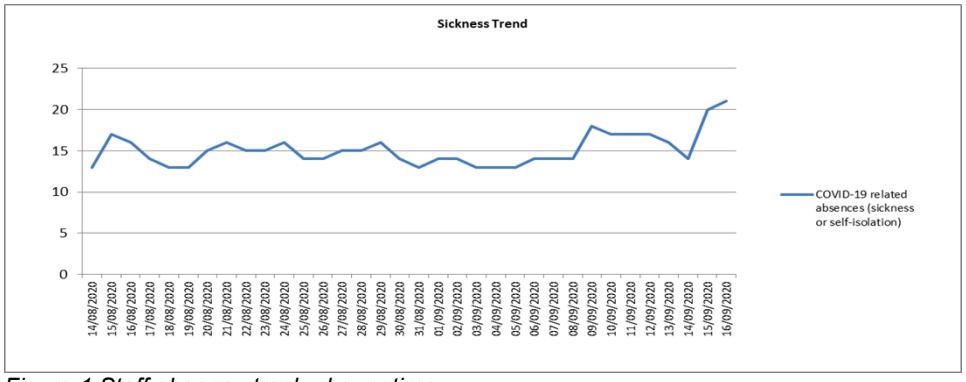


Figure 1 Staff absence tracked over time

Annual leave is being monitored and planned for the remainder of the year as is travel overseas, with the command structure ensuring the latest quarantine and overseas travel restrictions are managed and available through the HIVE.

Covid Risk Register

The Covid risk register continues to be reviewed weekly through the command structure. Additional risks has been identified and mitigations put in place relating to

- Covid surge with the risk of an increase in numbers nationally and locally.
- Information for staff is not clear and is conflicting.
- Access to testing for staff and their families.

E. Adverse Weather Planning

The adverse weather policy briefly explains what requirements are needed when invoking the cold weather planning. This can be found the cold weather planning section of the adverse weather policy.

This will identify the key aspects of cold weather planning and ensure the organisation prepares and stands up the necessary requirements in conjunction to this and acknowledges any key areas which are likely to be a main cause for concern.

To enact the winter plan arrangements this will require staff to familiarise themselves with the national cold weather plan 'The cold weather plan for England – Protecting health and reducing harm from cold weather' which can be found the emergency planning section of the hive.

This planning should acknowledge the winter period and identify key areas which need focus and provide guidance on how best to respond to the cold weather.

F. Trust response to EU Exit

Trust arrangements for EU Exit will need to be reinstated during the winter and this will monitored closely. Reporting requirements are now being reintroduced.

G. Phase III Planning

The Trust submitted an updated plan on 1 September as part of the Herts & West Essex ICS system return made to NHSE/I. This built on our previous submissions made that have been reviewed by the Trust Board with the main themes/assumptions being:

- The Trust has restored services and is largely at usual levels of demand and service provision in line with seasonal trends
- In a number of services contact levels remain high due to the significant shift made towards virtual contact with service users during the pandemic and ongoing Infection prevention and control procedures in place, although face-to-face contact is available and used reflecting individual service users need.

- Services will continue to increase activity levels in line with Long Term Plan and this will see the Trust deliver the LTP ambitions by the end of March 2020. This includes increasing access to IAPT services, increasing the number of young people accessing services, increasing dementia diagnosis, increasing the number of service users accessing employment support (IPS), increasing the number of women accessing support through the perinatal service, achieving the Level 3 Early Intervention Psychosis standards, and putting in place enhanced all age crisis services to support our service users when they are most unwell.

- Given the significant drop in referral volumes and subsequent activity during April – June in the early stages of the pandemic, our plan shows that overall the volume of service users seen will be less than originally targeted this year as part of the Long Term Plan, however by the end of the year the 'run rate' of activity will be at the required LTP level. This is reflected in three services – Perinatal, IPS and IAPT, and we are continuing to review this position with the operational teams.

- Community transformation is a key area of delivery for the Trust during the remainder of 2020/21 – with the focus remaining on supporting those people with severe enduring mental illness to receive joined up care through an integrated primary and community mental health service.

- Reducing Out of Area placements is a key area of focus nationally, and in line with our original target for 2020/21 we have committed to eliminating all out of area placements by the end of the year for young people and adults accessing acute care. Specialist beds that form part of a broader network of care are excluded from this – for example Eating Disorder beds, where the most appropriate care may be best provided through an alternative provider.

- It is important to highlight that given the increase in acuity and complex presentations we are seeing into the Trust, we have seen placements outside the Trust increase and this will be a challenge for us to reduce. This also has financial implications for the Trust which have been included in our financial plans (see below).

A final return is due and will be made on the 21 September. The planning assumptions above are not likely to change significantly to the return made on 1 September subject to the financial allocation we receive supporting those planned activities. At the time of writing this report the financial allocation has been received by the Herts and West Essex Integrated Care System, and the allocation for mental health and learning disabilities and for HPFT is part of this and under review.

As previously reported to the Trust Board our current financial plan allows for reimbursement of COVID related costs (mainly related to staffing levels, PPE and Infection Prevention and Control activities). The financial plan also supports the running the 24/7 helpline and access hubs in place in Hertfordshire, together with provision to fund additional specialist beds reflecting demand levels anticipated for the remainder of the year. National transformation funding is required to deliver our plans and this is assumed to be forthcoming within our plan for crisis, community and IPS services. Funding related to Mental Health Investment Standards (EIP, perinatal, IAPT and Eating Disorders) is also required to support delivery of the plans for the remainder of the year. As noted above, the financial allocation has now been received by the Integrated Care System, and the financial allocation for HPFT is contained within this. We are currently working to review and understand the allocation and what this may mean for the remainder of the year and impact on our plans.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 18
Subject:	Safety Suite Capital Investment	**For Publication:** No
Author:	Paul Ronald Director of Operational Finance Jane Padmore Director of Quality and Safety (Chief Nurse)	**Approved by:** Paul Ronald Director of Operational Finance
Presented by:	Paul Ronald Director of Operational Finance	

Purpose of the report:

To:-
Request approval for the proposed investment in the provision of four new safety suites to be built over the remainder of this year and the first quarter of next year.

Action required:

To:-
Review the attached business case which sets out the case for change, how the investment supports the Annual Plan and the robust process for the successful management of the delivery of the project.

Summary:

Introduction

The Trust's Good to Great Strategy has at its centre 'Great Care, Great Outcomes' with safety of our service users and staff as a strategic objective. This business case is for a programme of capital investment as set out in our Strategic Investment Programme to create four Safety suites linked to existing mental health and learning disability wards/ units operated by the trust. Investment is required to improve our environments which are used to support service users when they are often at their most vulnerable and at risk. This will also address the focus of the Care Quality Commission (CQC) on safety, restrictive practice and the facilities available to best care for service users and reflections from their visits to our existing facilities.

The investment in a significant increase in the capacity and quality of our safety suite provision has been identified as a key priority within the Annual Plan and the Quality Strategy. An early version of the business case was discussed and presented previously to the Finance and Investment Committee. This early proposal has been updated significantly to reflect the needs of this critical facility to ensure it provides the safe and therapeutic environment that is essential for the most vulnerable individuals within our care.

The room designs have been extended and there is now a separation of the living and sleeping

areas as well as access to outside space. This affords greater flexibility to facilitate greater freedom and dignity whilst supporting basic human rights. Additionally this offers better facilities to support reintegration as risk is managed in a responsive, proportional and least restrictive manner.

This offers benefits to both staff members and patients as these changes offer greater opportunity to enhance relationships, whilst formulating proactive active approaches to limit the need for higher levels of restriction at the earliest opportunity. Where this is not possible, this allows for reduced stimulus in a more dignified environment whilst offering protection for all concerned at times of high challenge, whilst offering privacy and dignity.

The most recent and final change was to extend and improve the fire safety features of the four suites taking the learning from the recent events such as Grenfell. These changes offer a higher standard of protection compared to the UK wide standard of seclusion facilities, offering a future proof design, if response rates by Fire Services change as an outcome of a major incident. The detailed designs have been shared with CQC who were very positive on the proposal.

This has increased the costs from the early design iterations but this is strongly supported in order to ensure that the facilities do fully provide what is viewed as the essential features to provide the individual with the full range of support needed to maintain their safety, support their recovery and return into the ward facility.

The previous proposal considered six new safety suites, given the increase in specification, and the related impact on costs, this proposal is to proceed with the four priority facilities. The design work for the other two potential suites in Astley Court and Beech Ward has been completed and can be progressed quickly in a future phase. Neither is considered a priority at this time. A robust ongoing review of these facilities is maintained to ensure basic privacy and dignity is preserved, in keeping with procedural safeguards and trust standards.

The business case is set out in the attached Executive Summary and the full document is included for reference.

Recommendation

The Board is recommended to approve the business case for the preferred option (option three) being the creation of four Safety suites through a combination of extensions and refurbishment at an expected total cost of £8.3m (with a further £0.3m as a risk sum). The cost of this investment will be made from existing cash resources

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

The capital works described are in line with the current Estates Strategy

Summary of Implications for:

1 Finance - The financial plans are in line with the Trusts capital plan
2 IT

3 Staffing
4 NHS Constitution
5 Carbon Footprint
6 Legal

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

The new facilities will be designed in accordance with NHS and Government guidelines to support access to and around the buildings

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

The new facilities will be designed in compliance with NHS standards

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

Executive Summary

Introduction

The Trust's Good to Great Strategy has at its centre 'Great Care, Great Outcomes' with safety of our service users and staff as a strategic objective. This business case is for a programme of capital investment as set out in our Strategic Investment Programme to create four Safety suites linked to existing mental health and learning disability wards/ units operated by the trust. Investment is required to improve our environments which are used to support service users when they are often at their most vulnerable and at risk. This will also address the focus of the Care Quality Commission (CQC) on safety, restrictive practice and the facilities available to best care for service users and reflections from visits to our existing facilities. The business case considers options to meet our strategic objectives and the priorities of our Annual Plan, responding to the comments of the CQC by proposing as a first phase a preferred option comprising Investing £8.3m to create four Safety suites through a mix of extensions and refurbishment to four prioritised mental health and learning disability wards/ units.

The current phase of four prioritised projects is costed within the current capital plan across 2020 - 2021. The following wards/ units are in scope for the programme; Dove Ward; 4 Bowlers Green; Warren Court; and Broadland Clinic.

The business case is supported by local commissioners and is a key element of the trust's strategy for improving its estate.

The business case has been prepared in line with the guidance from NHS Improvement (NHSI) and the total cost of the investment is within the approval limits of the Foundation Trust. It is structured in accordance with the standard five case model:-

- Strategic Case
- Economic Case
- Commercial Case
- Financial Case
- Management Case

Strategic Case

The strategic case demonstrates that the proposed investment in creating Safety suites fits with national and local healthcare priorities. It sets out the case for change and investment objectives for the programme. The case sets out the current way service users who require Seclusion, have their needs met, before discussing the local and national strategic context and the trust's response.

In particular the strategic case confirms that the investment set out will:

- meet the Mental Health Act Code of Practice in providing purpose built seclusion facilities with no other function,
- meet CQC guidance (2018) on the physical environment expected for safety facilities which underpins CQC assessments
- address CQC 'must do' comments relating to the MHA Code of Practice and the seclusion environment, following their 2018 inspection

- meet Royal College guidance on adult inpatient service standards (Sept. 2019)

The proposed development of Safety suites is entirely consistent with the trust's strategy because:

- It will support our people by providing fit for purpose facilities in which to care for service users when they are most vulnerable;
- It enables care to be delivered in a way facilitates the least restrictive practice.
- It enables service users to be cared for in high quality environments when they are at their most vulnerable.
- It demonstrates that the organisation listens to the concerns service users and partners such as the CQC;
- It will improve service user experience by providing care that is safer;
- It is consistent with the Royal College of Psychiatrist accreditation for inpatient services.

The investment is also consistent with the core aim of the trust's estate strategy i.e. to ensure environments are improved; and are fit for purpose for service users and staff.

Economic Case

The economic case tests the relative value for money of shortlisted options and identifies the preferred option.

A separate option appraisal was undertaken for each of the four priority sites. All four projects had the following three high-level base options:

- Option one - do nothing;
- Option two - creating dedicated long-term Safety suites from within the current footprint of each in scope ward/ unit;
- Option three - creating dedicated long-term Safety suites through a combination of new build extensions and where possible, conversion of existing ward/ unit non-bedroom space. Variants on the extension/ conversion option were prepared for a number of the projects.

The preferred option has been identified "in the round" by considering the results of both the benefits appraisal and the financial appraisal.

Based on the appraisal method the clear preferred option is option three, the creation of Safety suites through a combination of extensions and refurbishment.

In summary over the 45 year life applied to the assets created, which is based upon the average building lives, then **Option 3 would cost an undiscounted sum of £7,783k which is equal to a net present cost (discounted at 3.5%) of £4,564k.**

Commercial Case

The following two-step procurement approach was employed:

- Step one - to procure design services up to RIBA stage 3 using the NHS Shared Business Service (SBS) framework via direct call-off;
- Step two - to procure design and construction services for RIBA stages 4-7 via the ProCure 22 (P22) framework.

The proposed scheme complies with standards and guidance as set out with The Design Component matrix. The design is consistent with statutory and mandatory standards, national guidance and best practice including the applicable Health Technical Memoranda (HTM) and Health Building Notices (HBNs) for the intended patient groups and activities. The trust's infection control, clinical and estates teams have worked together to ensure that the design is accordance with HBN 00-09 guidance.

Key commercial reasons for using P22 are:

- Cost certainty - a Guaranteed Maximum Price (GMP) is agreed and risks are allocated to the party best able to manage each risk
- Value for money - P22 costs are benchmarked by the Department of Health (DH)
- Programme - the pre-selection of the Principal Supply Chain Partner (PSCP) avoids the need for further OJEU tendering
- Control of design and quality - the trust is able to maintain control of the design through partnering with the PSCP
- Early contractor involvement - P22 enables early involvement of the contractor's supply chain

Financial Case

The financial case considers the affordability of the programme to the trust and the impact on the wider health and care system. The financial appraisal has been undertaken in line with HM Treasury Guidance and NHSI guidance - Capital regime, investment and property business case approval guidance for NHS providers. The financial case differs from the economic case in a number of important aspects:

- It only considers the preferred option;
- The focus of the financial case is affordability;
- Depreciation and interest on public dividend capital (PDC) is included;
- VAT is included.
-

The financial case demonstrates that the programme will result in an average annual revenue cost of £245k (depreciation and PDC charge) over the first 5 years which the trust will meet through additional efficiencies across its portfolio of services. This is based upon the average building lives as the suites are seen as an integral part of the overall facility. This assumption will be confirmed with external audit. Any reduction in the asset life assessment will increase the revenue charge in the earlier years (but not the total project investment) but will see an overall reduction in the revenue charge over the full period due to reduced PDC.

The programme will result in:

- An increase in existing asset values;
- A reduction in cash balances equal to the capital investment.

There is no impact on the wider Hertfordshire health and social care economy because we are assuming no commissioner financial support for the programme.

Management Case

The programme will be delivered by a programme team consisting of:

- Relevant estates professionals:
- Clinical leads (the clinical leads involved will vary as the programme progresses through each project to take account of the different service delivery units impacted;
- A finance lead;
- Health and safety, and infection control specialists as required.

Specialist advisers will be commissioned as needed.

The realisation of benefits linked to this investment will be managed through the project team working closely with each wards and service. Benefits realisation will focus on delivering the following key benefits:

- Facilities meet CQC and royal college requirements;
- Facilities meet statutory requirements
- Providing a high quality therapeutic and healing environment that affords service users their privacy and dignity;
- Supporting the delivery of high quality, safe, and effective treatment tailored to individuals' specific needs;
- Safety facilities that are able to meet expected future demands for seclusion;
- Value for money

A risk register for the programme is being established to identify, assess and control risks to delivery.

An Equalities Impact Assessment will be completed for each project.

Conclusion

This business case demonstrates a compelling case for HPFT to invest capital funding to create Safety suites in four of the trust's existing wards/ units. The recommended investment will resolve matters raised by the CQC and supports Royal College of Psychiatrist accreditation for inpatient services. The investment recommended would be made through a programme rather than individual project basis delivering the preferred option of using a combination of new build extensions and conversion of existing space within wards/ units to create Safety suites. The new build/ conversion option was selected following a detailed project level evaluation of all options available to the trust – as such the preferred option represents the best value for money for HPFT. The business case is now being submitted by the SRO for approval by the Trust Board to approve the full investment of £8.3m represented by the preferred option.

Recommendation

The Board is recommended to approve the business case for the preferred option (option three) is the creation of four Safety suites through a combination of extensions and refurbishment at an expected cost of £8.3m using existing cash reserves. A further £0.3m is requested to be set aside as a risk sum.

Hertfordshire Partnership
University NHS Foundation Trust

NHS

Business Case for a Programme of Investment in Safety Suites

September 2020

1.1 Introduction

The Trust's Good to Great Strategy has at its centre 'Great Care, Great Outcomes' with safety of our service users and staff as a strategic objective. This business case is for a programme of capital investment as set out in our Strategic Investment Programme to create four Safety suites linked to existing mental health and learning disability wards/ units operated by the trust. Investment is required to improve our environments which are used to support service users when they are often at their most vulnerable and at risk. This will also address the focus of the Care Quality Commission (CQC) on safety, restrictive practice and the facilities available to best care for service users and reflections from visits to our existing facilities. The business case considers options to meet our strategic objectives and the priorities of our Annual Plan, responding to the comments of the CQC by proposing as a first phase a preferred option comprising Investing £8.3m to create four Safety suites through a mix of extensions and refurbishment to four prioritised mental health and learning disability wards/ units.

Each Safety suite is forecast to cost circa £1.5m with additional project management costs meaning the expected full cost is estimated at a maximum of £8.3m for the full investment, (with a further £0.3m as a risk sum). In order to bring certainty to the overall investment cost and to remove the risk of the cost exceeding the total of £8.3m, a guaranteed maximum price figure is being developed for the next construction phase of the project. The current estimate is a total guaranteed maximum price (GMP) of £6.1m with Kier, which with the additional costs expected will ensure the total cost is within the overall sum. The current project planning also facilitates a second phase of development for suites being provided at Astley Court and Beech Ward at a future date.

The current phase of four projects is costed within the current capital plan with an initial allocation of £6.4m within 20/21, £0.7m within the outline capital plan for 21/22, and £1.2m incurred in prior years. The prioritisation of the four suites is to maintain spend within the overall capital and revenue affordability envelope whilst ensuring the quality of build, design and facilities. At this point there are very limited instances of the use of seclusion in either of these two units although this may change with the implementation of the New Care Models.

The business case is supported by local commissioners and is a key element of the trust's strategy for improving its estate.

The following wards/ units are in scope for the programme; Dove Ward; 4 Bowlers Green; Warren Court; and Broadland Clinic.

The business case has been prepared in line with the guidance from NHS Improvement (NHSI) and the total cost of the investment is within the approval limits of the Foundation Trust.

This business case is supported by the trust's Modernising Our Estate Board and is now being presented to the Board for approval.

1.2 The strategic case

The strategic case demonstrates that the proposed investment in creating Safety suites fits with national and local healthcare priorities. It sets out the case for change and investment objectives for the programme. The case sets out the requirements for restrictive practice, the current practice for service users who require more restrictive practice before discussing the local and national strategic context and the trust's response.

Restrictive practice includes restraint, seclusion, long term segregation and rapid tranquilisation and the aim is to use the least restrictive practice with any individual that is responsive to their needs. The proposed safety suites offer an environment where seclusion and long term segregation can be practiced safely whilst promoting the reduction of restrictions and complying with regulations and the law. They will provide service users with as positive experience as possible whilst they are at their most vulnerable.

Seclusion is defined in the Mental Health Act Code of Practice, as "*the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others*".

The code of practice also states that, "*seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward*" and then goes on to set out the following factors to be taken into account in the design of rooms or areas where seclusion is to be carried out:

- The room should allow for communication with the patient when the patient is in the room and the door is locked, e.g. via an intercom;
- Rooms should include limited furnishings which should include a bed, pillow, mattress and blanket or covering;
- There should be no apparent safety hazards;
- Rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside);
- Rooms should have externally controlled lighting, including a main light and subdued lighting for night time;
- Rooms should have robust door(s) which open outwards;
- Rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature;
- Rooms should not have blind spots and alternate viewing panels should be available where required;
- A clock should always be visible to the patient from within the room, and;
- Rooms should have access to toilet and washing facilities.

It is important to note that seclusion is an intervention and not a room. Currently, seclusion can happen in either a seclusion room or, in other rooms, where a seclusion room is already occupied or a ward does not have a seclusion room.

Long Term Segregation (LTS) is defined by The Mental Health Act (MHA) as "a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from

the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis". The criteria for instigating such a regime should be that it has "been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patients were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time".

Facilities in which LTS takes place should:

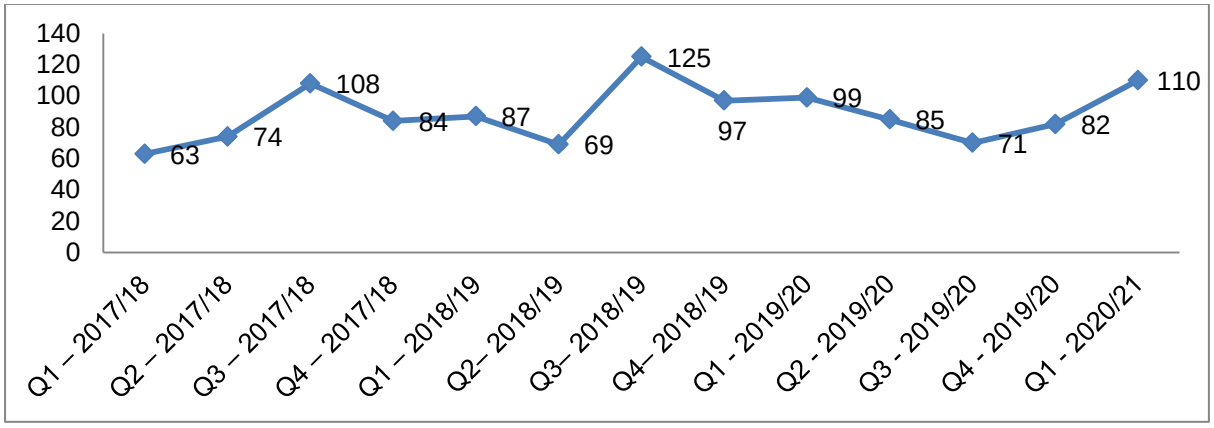
1. Have access to a secure outdoor space, a bathroom, a bedroom and a lounge area.

2. Enable therapeutic activities to be provided and that service user to have access to staff and are not isolated from human contact for long periods.

3. Enable the service user to have appropriate health care including; screening programmes, physical and mental health, dental and optical care.

The number of seclusions that have been initiated across the trust between April 2017 to June 2020 (figure 1), per quarter, varies from 63 to 125 across all Trust in patient units. The number per ward does not give a useful number of episodes alone and should not be considered in isolation, and reducing the length of time people spend in these environments is an important factor that has been translated into a priority in objective one of the annual plan,

Figure 1: Number of seclusions since Quarter 1, 2017/18 to Quarter 1, 2020/21



At any one time the Trust has between one and three people, on average, in Long Term Seclusion.

The Trust currently has seclusion rooms on:

- Beech Ward
- Broadlands Clinic
- 4 Bowlers Green
- Oak Ward
- Warren Court

The Oak Ward Seclusion room is being considered in the refurbishment of Oak Ward. The four wards proposed in this paper where prioritised through consultation with services and

considering the current state of the environment, the frequency of use, feedback from CQC during mental health act visits and core services inspections and the projected changes in service user presentation due to the New Care Models work.

Dove Ward has an extra care area for seclusion which was designated whilst this business case was developed. Although fit for purpose and compliant with the legislation, this room is not of a standard that the Trust would want for the service users.

There is currently an area for LTS in SRS, which has been adapted for a specific individual. Apart from that the Trust does not have any specifically designated LTS areas. This has proved challenging and has meant that seclusion rooms have had to be decommissioned to ensure LTS could be in place safely.

The specifications of the Safety suites have been developed to be compliant with the CQC brief guide (2018) to the physical environment expected for Safety facilities and the Mental Health Act Code of Practice and Royal College of Psychiatrists guidance on adult inpatient service standards (September 2019).

Consideration was also given to the concerns raised by CQC in January 2018. They required that that "*the trust must ensure adherence to the Mental Health Act code of practice in regards to recording of seclusion practices and the seclusion environment."* The CQC also recommended that, *"the trust should decommission seclusion rooms as soon as the environment becomes unsuitable to ensure that all of the seclusion rooms meet the Mental Health Act Code of Practice."* Whilst immediate action was taken to ensure compliance, the safety suites ensure compliance is maintained and safeguarded for the future and addresses the further concern that they were not assured the wards had sufficient seclusion facilities to manage the behaviour of the patients.

The Royal College of Psychiatrists guidance on adult inpatient service standards (September 2019), in addition to setting similar standards for the environment also sets a standard for a "de-escalation space" and states that there should be "*The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.*" The safety suites have taken this into consideration in their development.

National policy reflects CQC and Royal College guidance with the proviso that service users should always be accommodated and treated in the least restrictive environment possible given their individual needs and the risk posed to themselves and others. A growing body of research evidence demonstrates the effects of healthcare building design and the environment more widely, on the wellbeing of patients and staff. Two literature reviews (one by University of the West of England and Avon and Wiltshire Partnership NHS Trust and the second by the London South Bank University's Medical Architecture Research Unit in association with ProCure 21+ partners, found evidence that art, design and environmental enhancements can have a positive impact on safety, health and wellbeing of patients and staff, including physiological, psychological, clinical and behavioural effects. The trust's detailed plans for the development of Safety suites have taken account of this evidence for the impact of design upon ill-health and recovery.

The trust's five-year strategy for 2016 to 2021, "Good to Great" set out how the trust would improve on its "Good" CQC rating achieved in 2015 and led to its recognition as an "outstanding" organisation in 2019. In achieving the vision of *Great Care and Great Outcomes* the trust focused on:

- Great people;

- Great networks and partnerships;
- Great organisation;
-]Great care and great outcomes.

The proposed development of Safety suites is entirely consistent with the trust's strategy because:

- It will support our people by providing fit for purpose facilities in which to care for service users when they are most vulnerable;
- It enables care to be delivered in a way facilitates the least restrictive practice.
- It enables service users to be cared for in high quality environments when they are at their most vulnerable.
- It demonstrates that the organisation listens to the concerns service users and partners such as the CQC;
- It will improve service user experience by providing care that is safer;
- It is consistent with the Royal College of Psychiatrist accreditation for inpatient services.

The investment is also consistent with the core aim of the trust's estate strategy i.e. to ensure environments are improved; and are fit for purpose for service users and staff.

The case for change is addressed by this proposed investment in developing Safety facilities. The sections below set out the specific investment objectives linked to the project and the benefits that the investment is expected to deliver.

The investment objectives are:

- **Objective one** – to deliver a standard best-in-class Safety specification on all sites;
- **Objective two** – to reduce the frequency of service users being secluded in non-designated Safety facilities;
- **Objective three** – to reduce the frequency of service users being transferred off their ward to access Safety facilities.

The desired benefits associated with the investment have been identified and the links between these benefits and the investment objectives are shown in the table below. The benefits appraisal criteria that are set out in are related back to these investment objectives and they aim to summarise the desired benefits shown below.

Table 1: Linking benefits to objectives

Objectives	Benefits
Objective one – to deliver a standard best-in-class Safety specification on all sites	• Meets CQC requirements, including addressing previous CQC concerns • Improved ward layout • Provides an improved quality, therapeutic and healing environment • Offers privacy and dignity for service users • Enables care to be tailored to individual

Objectives	Benefits
	needs • Provides an environment that promotes high quality, safe and clinically effective treatment • Improves service user and family satisfaction • Improves staff satisfaction • Improves staff safety • Meets Equality Act requirements for accessibility
Objective two – to reduce the frequency of service users being secluded in non-designated Safety facilities	• Seclusion provided in appropriate facilities • Improves service user and family satisfaction • Improves staff satisfaction
Objective three – to reduce the frequency of service users being transferred off their ward to access Safety facilities	• Service users requiring seclusion are secluded on their "host" ward • Reduction in need for staff escorts

The key constraints linked to this investment are the availability of capital funding from within the trust.

The proposals for the creation of dedicated Safety suites are the Trust's response to the case for change described above. The next section (the economic case) describes the alternate to options to deliver Safety suites and the trust's appraisal of each option before identifying the preference.

1.3 The economic case

The economic case tests the relative value for money of shortlisted options and identifies the preferred option.

A separate option appraisal was undertaken for each of the four projects. All four projects had the following three high-level base options:

- Option one - doing nothing;
- Option two - creating dedicated long-term Safety suites from within the current footprint of each in scope ward/ unit;
- Option three - creating dedicated long-term Safety suites through a combination of new build extensions and where possible, conversion of existing ward/ unit non-bedroom space. Variants on the extension/ conversion option were prepared for a number of the projects.

The table below describes each high-level option in more detail.

Table 1: Business case options

Option	Description
Option 1 - Do nothing	• No Safety suites created • Service users requiring long-term seclusion continue to be secluded in in appropriate facilities or transferred to existing Safety facilities • Existing levels of risk to service users and staff, continue • Failure to meet RCP standards and CQC guidelines
Option 2 - Current ward footprint	• Purpose built Safety suites developed within existing ward/unit footprints for four wards/ units (no extensions) • Number of beds on each ward/ unit reduced to enable creation of Safety suites leading to increase in the number of out of area placements • Reduction in risk • Safety suites meet CQC and RCP standards
Option 3 – Extensions & conversion	• Safety suites created which are linked to four individual units • Suites will be created through a mix of extensions to existing units and conversion/ adaptation of existing space • Reduction in risk • Safety suites meet CQC and RCP standards

Each project options appraisal was against benefits criteria designed with reference to the objectives of the project.

Table 2: Benefits criteria

Criterion	Explanation
Technical compliance	The extent to which CQC, MH Act and Royal College standards and guidelines are met. This criterion links to objectives one and two, and the constraint requiring a response to CQC. Considerations include: • Enables Trust to resolve CQC actions from 2018 visit • Assists trust to gain Royal College of Psychiatrist accreditation for inpatient mental health services • Meets MH Act Code of Practice recommendations • Future proofed re potential changes to requirements • Improved inpatient ward layout
Fit for purpose accommodation	The extent to which the option delivers accommodation which is “fit for purpose” from the perspective of service users and staff including the extent to which it facilitates the delivery of modern care pathways. This criterion also links

Criterion	Explanation
	to objectives one and two. Considerations include: • Improved staff recruitment and retention • Improved staff satisfaction scores • Improvements in patient and family feedback e.g. Friends & Families test • Supports likely future changes to models of care • Improved Patient-Led Assessments of the Care Environment (PLACE) scores • Reduction in backlog maintenance • Improved estate six facet survey results
Acceptability	The extent to which the option is acceptable to stakeholders: • Service users • Family and friends of service users • Trust staff • Commissioners This criterion is linked to all three objectives.
Deliverability	The extent to which the option is deliverable. Considerations include: • Project complexity • Disruption • Resulting impact on capacity

A full write up of all four option appraisals with each option presented in the form of pros and cons, and summarised against the four criteria above was completed.

The table below provides a summary of how the three high-level options perform against the criteria – the detail varies to a limited extent at individual project level.

Table 3: Summary of appraisal

	Option 1 - Do nothing	Option 2 – Current ward footprint	Option 3 – Extensions & conversion
Technical compliance	• Not compliant	• New suites would be partially compliant for seclusion	• Suites would be fully compliant with HBNs and other standards for LTS and seclusion
Fit for purpose accommodation	• Seclusion continues to be undertaken in not fit for purpose rooms	• Depending on existing ward layout, some but not all suites would be fit for purpose – adherence to standards compromised, but better than do nothing option	• Suites are fit for purpose • Meets all relevant standards
Acceptability	• Unacceptable to stakeholders including CQC and Royal College of Psychiatrists as well as service users, staff and commissioners	• Loss of an average of two bedrooms per ward leading to an average of two service users per ward, being placed out of area • Less acceptable to stakeholders	• This is the preferred option according to stakeholders • Fits with CQC requirements • Meets Royal College standards
Deliverability	• N/A	• Construction works would take place within the building footprint, deliverability would be easily achieved. However, ward operations would be disturbed for whole period of construction	• Some disruption to clinical services during the last period of construction

The evaluation of the options demonstrated that from a non-financial perspective the preference was option three, the creation of Safety suites through a combination of adding extensions to existing wards/ units and refurbishing existing non-bedroom areas.

A full economic appraisal of costs has not been carried out on all of the shortlisted options because the trust does not have fully costed capital estimates for Option 2. However, it is clear that under Option 2 an average of two bedrooms per ward would be lost to areas refurbished to become Safety suites which would therefore result in two service users per ward i.e. 8 in total needing to be placed in out of area facilities at the trust's expense. Using a conservative £500

per occupied bed day, this would lead to an annual out of area cost of £1.5m in addition to the initial capital investment.

Under Option 3 the trust would make an initial investment of £8.3m across four projects. The £1.5m cost per project would cover the capital works required plus the one-off cost of additional nursing staff needed to manage risk whilst works were ongoing within a functioning ward environment. The investment would lead to an increase in facilities costs (cleaning, utilities etc.) estimated at circa £20k per annum for all four suites.

In summary over the 45 year life applied to the assets created, **Option 3 would cost an undiscounted sum of £7,783k which is equal to a net present cost (discounted at 3.5%) of £4,564k.**

The 45 year life estimate used in the evaluation is based upon the building life estimates provided by the District Valuer in the regular building valuations. This is consistent with the safety suites being considered as an integral part of the inpatient facility.

The preferred option has been identified “in the round” by considering the results of both the benefits appraisal and the financial appraisal.

Based on the combination of appraisal methods shown above, the clear preferred option is option three, the creation of Safety suites through a combination of extensions and refurbishment.

The rest of this business case focuses only on the preferred option.

The preferred option will result in compliance with CQC Safety room guidance. The option will also reduce the likely frequency of incidents where service users are secluded in non-designated Safety rooms which have been raised as a concern as a result of CQC inspections. Safety suites will allow for clear observation and will not provide the service user with items that could potentially cause harm. The development of Safety suites should also result in a reduced frequency of incidents that result in trust staff calling upon the police to assist and are consistent with the trusts aspiration to operate in a less restrictive manner. Service users will be treated in safe, modern facilities and will be afforded the maximum dignity possible. Risk to other service users and members of staff on the ward will be minimised.

At an individual project level the preferred option will deliver the following:

- Dove Ward – extension of existing Dove ward isolation areas. The extension will include two seclusions rooms with en-suite areas and an observation room and will be constructed to the standard set out in the component evaluation matrix/ design standard. The existing isolation facilities will be refurbished;
- 4 Bowlers Green low secure unit – extension to be added to the north wing to create one seclusion room and en-suite area. The seclusion room to be served by a shared observation room, shared lobby and air locks. The extension is to be constructed to the design standard;
- Warren Court - the existing service room is to be demolished and the building structure is to be altered to accommodate an extension. The extension will provide two seclusion rooms with en-suite areas and an external compound. In addition, the extension will have: an observation room, an air lock, a de-escalation room and a shared lobby. All rooms to be constructed to the design standard;
- Broadland Clinic – a combination of an extension and refurbishment. The extension will provide two seclusion rooms with en-suite and external compounds, to be constructed to

the design standard. The refurbished area will provide a de-escalation room, toilet and shared observation, all refurbished as per the design standard;

Key points within the design are:

- The outside area must be securely fenced to a height of three metres and conform to BS358 and be contained entirely with a roof to negate the possibility of objects being thrown into the area;
- The suite must have very robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside) The window(s) must be able to withhold and stand up to a sustained and extremely forceful assault from a physically strong and immensely determined individual whose sole intent is to reduce the effectiveness of the window(s) provision of secure and safe containment or to use its component parts as a weapon or tool with which to do further damage;
- The suite must have robust door(s) which open outwards. The door(s) must be able to withhold and stand up to a sustained and extremely forceful assault from a physically strong and immensely determined individual whose sole intent is to reduce the effectiveness of the door(s) provision of secure and safe containment or to use its component parts as a weapon or tool with which to do further damage. The door should have a minimum opening leaf of 1000mm. Consideration should be given to the following dimensions as a minimum for a steel door size 2100mm high x 1000mm wide x 50mm although larger dimension may be required and advise should be sought from other experts in the field as to the most up to date dimension recommended;
- The walls and any coverings must be able to withhold and stand up to a sustained and extremely forceful assault from a physically strong individual whose sole intent is to reduce the effectiveness of the walls provision of secure and safe containment or to use its component parts as a weapon or tool with which to do further damage. The walls also need to be constructed in such a way that they can support the heavy-duty doors, metal plates can be added to the door surround to assist in this endeavour;
- The suite must have externally controlled heating and air conditioning, which enables those observing the patient to monitor the room temperature;
- The suite must not have observation blind spots and alternate viewing window panels should be available where required;
- The suite clock must always be visible to the patient from within the room;
- The suite must have access to toilet, shower and hand basin washing facilities;
- The suite should have externally controlled lighting, including a main light and subdued lighting for night time. All lights should be ceiling mounted, flush, unbreakable (anti-vandal covers), with a main light – with light dimmers, a night light, and an over bed light;
- If possible, the suite should have speaker system built into the ceiling that could be connected to IT equipment, for music, sound for DVD which would be operated external to the suite;
- The entire suite must be ligature point free;
- The suite must have ceiling mounted personal alarm sensor detectors situated within in;
- The suite must have full CCTV coverage including infrared night time viewing capability. Cameras must be wall and ceiling junction mounted;

- The suite will require convex viewing mirrors (unbreakable) placed at the junction of the walls and ceiling to eliminate any blind potential viewing difficulties;
- The suite will require heat/smoke detectors located throughout which should be ceiling mounted, flush and protected;
- All components of the suite must be constructed in such a manner that they cannot be dismantled and are extremely resistant to vandalise without the use of tools or substantial pieces of equipment for that purpose;
- All screws used in the suite must be completely anti-tamper;
- The suite must be constructed of material and designed so that it can be easily and quickly cleaned;
- The suite ceiling height should be a minimum height of 3m and not able to be touched by an individual of 6.6 foot height when standing on the suites bed or other furnishings.

1.4 The commercial case

The following two-step procurement approach was employed:

- Step one - to procure design services up to RIBA stage 3 using the NHS Shared Business Service (SBS) framework via direct call-off;
- Step two - to procure design and construction services for RIBA stages 4-7 via the ProCure 22 (P22) framework.

The proposed scheme complies with standards and guidance as set out with The Design Component matrix. The scheme's architects, Medical Architecture have more than 25 years' experience in designing mental health facilities and have designed and evaluated more than 100 projects in the UK.

The design is consistent with statutory and mandatory standards, national guidance and best practice including the applicable Health Technical Memoranda (HTM) and Health Building Notices (HBNs) for the intended patient groups and activities.

The trust's infection control, clinical and estates teams have worked together to ensure that the design is accordance with HBN 00-09 guidance.

Each project is individually, below the limit above which a Building Research Establishment Environmental Assessment Method (BREEAM) assessment is required. However, we would expect to achieve good energy targets with each of these projects.

The use of P22 means that programme risks have been allocated to the party best able to manage each risk as illustrated below.

Table 4: Risk Transfer

Risk Category	Potential allocation		
	Trust	Construction partner	Shared
Design risk	✓ (refurbishment)	✓ (new build & infrastructure)	
Construction and development risk	✓ (refurbishment)	✓ (new build &	

Risk Category	Potential allocation		
	Trust	Construction partner	Shared
		infrastructure)	
Transition and implementation risk			✓
Availability and performance risk	✓		✓
Operating risk	✓		
Variability of revenue risks	✓		
Control risks	✓		
Residual value risks	✓		
Financing risks	✓		
Legislative risks	✓	✓	✓
Other project risks	✓	✓	✓

Other key reasons for using P22 are:

- Cost certainty - Once the Guaranteed Maximum Price (GMP) is agreed, any increases in cost are borne by the contractor, provided no changes are made by the trust;
- Value for money - P22 costs are benchmarked by the Department of Health (DH) to ensure value for money. Mark ups are pre-set and this protects the Trust from potential economic fluctuations during the contract period;
- Programme - the pre-selection of the Principal Supply Chain Partner (PSCP) avoids the need for further OJEU tendering for the programme of works thereby reducing programme duration;
- Control of design and quality - the trust is able to maintain control of the design through partnering with the PSCP and collaborative development of the final design at GMP stage. Access to design innovation through the P22 framework (repeatable rooms, shared design information) enables the trust to achieve aspirations in terms of design quality and functionality. Consistency in approach can be achieved through the novation of the existing team i.e. MA;
- Early contractor involvement - P22 enables early involvement of the contractor's supply chain in the development of the full business case and design process. This contributes to the scheme by providing access to buildability advice, improving construction planning, and reassurance for the trust on cost, time and quality. The supply chain also develops a far better understanding of the scheme and the client.

The trust is planning to improve Safety, de-escalation, Section 136 and long-term segregation facilities across a number of locations. The range of statutory requirements governing the physical and operational setting is very broad. The points below highlight the main areas of conformance and those aspects that require approval.

The Mental Health Act 1983 sets out the operational requirements for Safety and long-term segregation. The physical setting must support these requirements specifically in respect of safety and observation. This is set out in Mental Health Act (MHA) Code of Practice 2015. The CQC adopts this code and requires the design of Safety rooms to have a range of features as described above. The new or improved facilities must support conformance with the Mental Health Act.

The Equality Act became law in 2010. It replaced previous legislation (such as the Race Relations Act 1976 and the Disability Discrimination Act 1995) and ensures consistency in what employers and employees need to do to make their workplaces a fair environment and comply with the law. The new or improved facilities must support conformance with the Equality Act. The trust will conduct an Equalities Impact Assessment for each project.

Building regulations are minimum standards for design, construction and alterations to virtually every building. The Building Regulations 2010 cover the construction and extension of buildings and these regulations are supported by "Approved Documents" which set out detailed practical guidance on compliance with the regulations. The new or improved facilities must gain approval under the building regulations.

Town and country planning in the United Kingdom is the part of English land law which concerns land use planning. Its goal is to ensure sustainable economic development and a better environment. The main legislation is the Town and Country Planning Act 1990, for England and Wales. A long list of other unconsolidated Acts and Regulations also affect UK planning. The proposed new or improved facilities must gain approval under the Town Planning regulations where they exceed the limits of permitted development.

1.5 The financial case

The financial case considers the affordability of the programme to the trust and the impact on the wider health and care system. The financial appraisal has been undertaken in line with HM Treasury Guidance set out in the Green Book and the more recent NHSI publication, Capital regime, investment and property business case approval guidance for NHS providers.

The financial case differs from the economic case in a number of important aspects:

- It only considers the preferred option unlike the economic appraisal which considered all short-listed options;
- The focus of the financial case is affordability as measured by the impact on the Trust's income and expenditure (I&E) account, balance sheet and cashflow, as opposed to net present values;
- Depreciation and public dividend capital (PDC) charge is included;
- VAT is included.

There is no impact on the number of service users the trust will be able to admit and treat under the preferred option. The option to create Safety suites from within existing ward footprints would result in an average of two bedrooms per ward/ unit being lost, in turn resulting in a loss of income to HPFT or additional out of area placements costs equivalent to 8 patients (two lost bedrooms x four wards).

The capital and project cost of the full programme is £8.3m inclusive of all fees and VAT based on a capital cost of circa £1.5m per Safety suite. The full amount includes an allowance for additional nursing staff that will be required to ensure service user safety during the period of works on each ward/ unit.

This business case covers four projects which entail internal modifications to existing wards/ units and part new building to provide facilities which would meet CQC standards. Feasibility studies for each project identified a consistent and optimal arrangement for the new and upgraded accommodation. The costs are based upon the individual designs and are fully costed. In projects of this type and scale there are construction risks associated with the detail of each project and a cost contingency is included to cater for this uncertainty.

The impact upon the trust's income and expenditure account is the combined cost of:

- Capital charges (depreciation based on a 45 year life, reflecting the mix of new build and conversion/ adaptation and 3.5% PDC charge);
- Some additional facilities management costs per Safety suite;
- A one-off need for additional ward-based staffing for an average of six weeks per project (costed at the agency rate for a Band 2 for a 12 hour shift each day);
- A small number of one-off project costs which would not be capitalised.

Except for the one-off need for an extra Band 2 during the construction phase, no impact of staff costs has been assumed because service users would continue to be observed on a one-to-one or even two-to-one basis as at present (modest savings could be made if the investment leads to a reduction in sickness absence). Included is an estimate for anticipated savings from reduced maintenance associated with damage to ward environments caused by patients being secluded in inappropriate areas. The table below summarises the combined revenue cost of the four projects for years 1-5.

	Yr 1 £'000	Yr 2 £'000	Yr 3 £'000	Yr 4 £'000	Yr 5 £'000
Facilities Costs	£20	£20	£20	£20	£20
Savings	(£75)	(£75)	(£75)	(£75)	(£75)
Subtotal EBITDA	**(£55)**	**(£55)**	**(£55)**	**(£55)**	**(£55)**
Depreciation	£129	£129	£129	£129	£129
PDC @ 3.5%	£99	£196	£192	£187	£183
Total revenue costs	**£173**	**£270**	**£265**	**£261**	**£256**

The tables demonstrate that the programme will result in an annual cost pressure of £153k in year 1, £270k in year 2, with an average revenue cost over the first 5 years of £245k a year. The increase in PDC in year 2 relates to the calculation imposed and in year 1 only half the cost is incurred. The Trust will meet these budgeted revenue costs through additional efficiencies across its portfolio of services. A full profile of the costs is included in appendix 1.

The programme will result in the following changes to the trust's balance sheet:

- An increase in existing asset values (being the wards/ units) equal to the capital sum invested adjusted for any revaluation agreed with the District Valuer (no revaluations have been assumed at this stage);

- A reduction in cash balances equal to the capital investment.

There is no impact on the wider Hertfordshire health and social care economy because we are assuming no commissioner financial support for the programme.

The proposed investment will lead to an increase in cost through depreciation which will require to be met from future revenue streams.

1.6 The management case

The programme will be delivered by a programme team consisting of:

- Relevant estates professionals:

- Clinical leads (the clinical leads involved will vary as the programme progresses through each project to take account of the different service delivery units impacted;
- A finance lead;
- Health and safety, and infection control specialists as required.

Specialist advisers will be commissioned as needed.

The nominated members of the project team are professionals who have experience in working on NHS projects and specifically successfully delivering Capital projects for HPFT.

The programme team is accountable for delivery. The team will report into the Modernising Our Estate group which in turn reports to the trust's Finance and Investment Committee.

The key milestones in delivering the preferred option are set out below with a detailed programme plan supporting this.

Table 5: Programme milestones

Activity	Date
HPUFT approval of typical details and roll out of stage 2-3 design on all sites	05/02/19
HPUFT tendering start for PSCP – 10.07.2019	10/07/19
Start of P22 phase with PSCP appointment	20/0819
Dove Ward – start of construction	18/10/20
Dove Ward – facility commissioned	29/05/21
4 Bowlers Green - start of construction	18/10/20
4 Bowlers Green – facility commissioned	29/04/21
Warren Court – start of construction	18/10/20
Warren Court – facility commissioned	29/04/21
Broadland Clinic – start of construction	18/10/20
Broadland Clinic – facility commissioned	29/04/21

The realisation of benefits linked to this investment will be managed through the project team working closely with each wards and service. Benefits realisation will focus on delivering the following key benefits:

- Facilities meet CQC and royal college requirements;
- Facilities meet statutory requirements including health and safety, fire, disability, legionella, asbestos, reduced carbon emission and energy consumption, and increased sustainability;
- Providing a high quality therapeutic and healing environment that affords service users their privacy and dignity;
- Supporting the delivery of high quality, safe, and effective treatment tailored to individuals' specific needs;

- Safety facilities that are able to meet expected future demands for seclusion;
- Value for money - P22 costs are benchmarked by the Department of Health (DH) to ensure value for money. Mark ups are pre-set and this protects the Trust from potential economic fluctuations during the contract period;
- Early contractor involvement - P22 enables early involvement of the contractor's supply chain in the development of the full business case and design process. This contributes to the scheme by providing access to buildability advice, improving construction planning, and reassurance for the trust on cost, time and quality. The supply chain also develops a far better understanding of the scheme and HPFT requirements.

A risk register for the programme is established to identify, assess and control risks to delivery. Its purpose is to support better decision making through understanding the risks inherent in a programme of this size and their likely impact. Effective risk management helps the achievement of wider aims such as:

- Effective change management;
- Efficient use of resources;
- Better project management;
- Minimising waste and fraud;
- Supporting innovation.

The Trust will use the RAID (risks, assumptions, issues and dependencies) management process to manage risks. RAID has a simple step by step process of:

- Raising a risk, assumption, issue or dependency item;
- Registering the item in the RAID register with a description of the item and the impact;
- Assessing the probability of the item occurring, the severity if it were to occur and the proximity i.e. likely timescale of occurrence;
- Assigning actions including actions relating to dependencies;
- Implementing actions;
- Monitoring and reporting RAID.

The table below presents the risks to delivery that have been identified to date – each apply at individual project level

Table 6: Programme risks

Area	Risk	Closed / Open
Design	Design does not meet clinical needs	Closed - Plans signed off
	Satisfactory planning permission cannot be obtained for existing facilities requiring resubmission	Closed - On four sites
	Implementation of the project fails to adhere to the terms of planning permission requiring retrospective approval	Open - Till built and signed off
Build	Construction works are not completed on time	Open - Close programme monitoring by Trust and threat of LADs penalty
	The costs associated with the construction works exceed anticipated spend	Open - Till completion mitigated through risk register inclusion

Area	Risk	Closed / Open
	Disruption to provision of therapeutic and academic services through need for multiple decants	Mitigated - By clinical leads and service agreement for works
	Unable to source additional staff needed for the eight week period, per build, requiring additional ward-based staff to ensure service user safety	Mitigated – Early staff appointments to be managed by clinical leads

An Equalities Impact Assessment will be completed for each project. We do not anticipate any negative impact as a result of the programme.

Regular communications will be provided to update colleagues on the progress of the programme. Service leads and staff have been involved in the programme to date and will continue to be involved as each individual project is taken forward. Service users will be consulted as appropriate as each project progresses.

In line with best practice of investment programme sponsors evaluating and learning from projects which cost over of £1m, we will develop a post-project evaluation process to understand what went well and what could have gone better in delivering the new facilities, in order to improve the management of future projects.

To ensure the value of the review process is maximised, the review will follow best practice including:

- Starting the planning for the post-project evaluation as an integral part of the project now;
- Securing commitment to post-project evaluation from senior trust clinicians and managers, and a trust director to champion the post-project evaluation;
- Involving all key stakeholders in planning and undertaking the post-project review;
- Developing relevant criteria and indicators to assess project outcomes from the outset of the project – see the benefits realisation section above;
- Putting in place project management mechanisms to enable monitoring and measurement of progress – see project management section above;
- Fostering a learning environment to ensure lessons are heeded.

1.7 Conclusion

This business case demonstrates a compelling case for HPFT to invest capital funding to create Safety suites in four of the trust's existing wards/ units. The recommended investment will resolve matters raised by the CQC and supports Royal College of Psychiatrist accreditation for inpatient services. The investment recommended would be made through a programme rather than individual project basis delivering the preferred option of using a combination of new build extensions and conversion of existing space within wards/ units to create Safety suites. The new build/ conversion option was selected following a detailed project level evaluation of all options available to the trust – as such the preferred option represents the best value for money for HPFT. The business case is now being submitted by the SRO for approval by the Trust Board to approve the full investment of £8.3m represented by the preferred option with a further £0.3m set aside as a risk sum for identified risks.

The business case is supported by local commissioners and is a key element of the trust's strategy for improving its estate.

Appendix 1 Financial Cost

GMP Cost £'000	8,279	Estimated Impairment		30%		Net Capitalised Cost £'000			5,795
Year	Cost/ NBV b/f £'000	Depreciation £'000	NBV c/f	PDC impact £'000	Facilities Costs £'000	Savings £'000	Revenue Total £'000	DCF @ 3.5%	Discounted R Cashflow £'000
1	5,795	129	5,667	99	20	(75)	173	1.00	173
2	5,667	129	5,538	196	20	(75)	270	0.97	261
3	5,538	129	5,409	192	20	(75)	265	0.93	248
4	5,409	129	5,280	187	20	(75)	261	0.90	235
5	5,280	129	5,151	183	20	(75)	256	0.87	223
6	5,151	129	5,023	178	20	(75)	252	0.84	212
7	5,023	129	4,894	174	20	(75)	247	0.81	201
8	4,894	129	4,765	169	20	(75)	243	0.79	191
9	4,765	129	4,636	165	20	(75)	238	0.76	181
10	4,636	129	4,507	160	20	(75)	234	0.73	172
11	4,507	129	4,379	156	20	(75)	229	0.71	163
12	4,379	129	4,250	151	20	(75)	225	0.68	154
13	4,250	129	4,121	146	20	(75)	220	0.66	146
14	4,121	129	3,992	142	20	(75)	216	0.64	138
15	3,992	129	3,864	137	20	(75)	211	0.62	131
16	3,864	129	3,735	133	20	(75)	207	0.60	123
17	3,735	129	3,606	128	20	(75)	202	0.58	117
18	3,606	129	3,477	124	20	(75)	198	0.56	110
19	3,477	129	3,348	119	20	(75)	193	0.54	104
20	3,348	129	3,220	115	20	(75)	189	0.52	98
21	3,220	129	3,091	110	20	(75)	184	0.50	93
22	3,091	129	2,962	106	20	(75)	180	0.49	87
23	2,962	129	2,833	101	20	(75)	175	0.47	82
24	2,833	129	2,704	97	20	(75)	171	0.45	77
25	2,704	129	2,576	92	20	(75)	166	0.44	73
26	2,576	129	2,447	88	20	(75)	162	0.42	68
27	2,447	129	2,318	83	20	(75)	157	0.41	64
28	2,318	129	2,189	79	20	(75)	153	0.40	60
29	2,189	129	2,061	74	20	(75)	148	0.38	57
30	2,061	129	1,932	70	20	(75)	144	0.37	53
31	1,932	129	1,803	65	20	(75)	139	0.36	50
32	1,803	129	1,674	61	20	(75)	135	0.34	46
33	1,674	129	1,545	56	20	(75)	130	0.33	43
34	1,545	129	1,417	52	20	(75)	126	0.32	40
35	1,417	129	1,288	47	20	(75)	121	0.31	38
36	1,288	129	1,159	43	20	(75)	117	0.30	35
37	1,159	129	1,030	38	20	(75)	112	0.29	32
38	1,030	129	901	34	20	(75)	108	0.28	30
39	901	129	773	29	20	(75)	103	0.27	28
40	773	129	644	25	20	(75)	99	0.26	26
41	644	129	515	20	20	(75)	94	0.25	24
42	515	129	386	16	20	(75)	90	0.24	22
43	386	129	258	11	20	(75)	85	0.24	20
44	258	129	129	7	20	(75)	81	0.23	18
45	129	129	0	2	20	(75)	76	0.22	17
		5,795		**4,462**	**900**	**(3,375)**	**7,783**		**4,564**

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 19
Subject:	Revised Board Assurance Framework	**For Publication: Yes**
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To provide assurance that the Trust's principle risks have been identified and are being appropriately managed.

Action required:

The Board is asked to review the new principle risks in the revised draft Board Assurance Framework (BAF) noting that these have been approved by the Audit Committee. Also to note that further work will be undertaken to update the BAF and this will be reported to IGC in November 2020.

Summary and recommendations to the Board:

Summary

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and also enable the board to gain assurance about the effectiveness of these controls. The Lead Director for each risk is responsible for assessing the risks assigned to them and providing assurance on the effectiveness of risk controls.

The BAF has been reviewed and amended. The significant amendments relate to the principle risks; these have been rewritten to reflect the Trust's position and the context of the wider environment, including operating in world where there is Covid-19.

RSM as our internal audit function have undertaken a review of the proposed new principle risks and have confirmed that they 'fit' with the strategic objectives and resonant with the risks they are aware of for HPFT.

At its meeting on 15 September 2020 the Audit Committee reviewed and approved the re-written principle risks subject to one amendment.

Recommendations

The Board is asked to review and approve the rewritten principle risks detailed in appendix 1 and included in the draft BAF attached.

The Board are asked to receive the draft BAF, (Appendix 2) noting that further work will be

undertaken to finalise the controls, assurance and to update the relevant meeting dates. The final review will also include feedback from RSM's recent report on BAFs that was received by the September Audit Committee.

Next Steps

- Head of Corporate Affairs and Company Secretary, with relevant SRO to finalise the controls and assurances in place for each of the agreed risks.
- Head of Corporate Affairs and Company Secretary ensure BAF reflects feedback provided by RSM and recent BAF report.
- IGC to receive updated BAF at its November meeting
- Trust Board to receive updated and final BAF at its meeting at the end of November 2020.

Recommendation:

1. For Board to approve revised principle risks as detailed in the draft BAF, see appendix 1.
2. For Board to note next steps.

Relationship with the Business Plan & Assurance Framework:

The BAF identifies the risks associated with the strategic objectives as set out in the Annual Plan.

Summary of Financial, IT, Staffing and Legal Implications:

None outlined in the summary report.

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

None.

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

Evidence of robust governance review process for the NHSI/CQC Well Led Standard.

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

Executive Team 9 September 2020. Audit Committee 15 September 2020

Appendix 1

Strategic Objective	New Principle Risks
Strategic Objective 1. We will provide safe services, so that people feel safe and are protected from avoidable harm	1. Risk that do not provide safe standards of care, meaning service users to not feel safe and are not protected from avoidable harm or deaths through suicide. 2. Risk that do not deliver restrictive practice in line with best practice, therefore impacting on patient safety and experience 3. Failure to implement Infection Prevention and Control policies and behaviours. 4. Failure to comply with the legislative framework for the care and treatment of individuals with mental health problems will impact on quality of care and could lead to regulatory sanctions. 5. Failure to provide safe working environment for staff, adversely impacting on staff wellbeing.
Strategic Objective 2 We will deliver a great experience of our services, so that those who need to receive out support feel positively about our experience.	1. Service Users unable to access the right services in a timely way, meaning a poor experience and or outcomes for service users. 2. Failure to engage effectively with service users and carers will impact on Trust's ability to transform services to best meet their needs 3. Failure to invest to improve the standard of Trust's environments will impact on patient experience and quality of care.
Strategic Objective 3 We will improve the health of our service users through the delivery of effective evidence based practice	1. Do not provide appropriate assessment and treatment of physical conditions which will impact on service user wellbeing and outcomes. 2. Do not provide appropriate psychological intervention and treatment, leading to poorer outcomes. 3. Do not use latest research or evidence to inform clinical practice which means we don't deliver the optimum outcomes for service users.

Strategic Objective	New Principle Risks
Strategic Objective 4 We will attract, retain and develop people with the right skills and values to deliver consistently great care and treatment	1. Unable 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. 2. Failure to develop a sustainable, adaptive and resilient workforce model that will impact on Trust's ability to deliver safe and effective care. 3. Failure to provide an inclusive and diverse workforce with equality of opportunity and experience 4. Failure to improve the employment experience for all our staff, including health and wellbeing support (incorporating psychological safety) which will mean staff do not feel valued or enabled to reach their potential 5. Unable to provide appropriate learning, development and training opportunities to enable staff to be skilled to the right levels, both clinically and managerially 6. Fail to deliver the promises within the NHS People Plan ('we are the NHS') resulting in increased regretted attrition
Strategic Objective 5 We will improve, innovate and transform our services to provide the most effective, productive and high quality care	1. Failure to deliver a sustainable financial position and longer term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements. 2. Staff do not have access to accurate and timely information to assist clinical and non-clinical decision making and planning, will impact on ability of Trust to innovate and transform. 3. Failure to implement and embed digital technology will impact on service user and carer experience and our ability to transform services and support staff to respond to changing needs. 4. Do not enable or encourage people to continuously improve care provided.
Strategic Objective 6 We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners.	1. Failure to develop and sustain partnerships with other organisations which will improve access to joined up services and outcomes. 2. Fail to develop relationships with Primary Care Networks which means primary mental health services are fragmented and disjointed for service users 3. Fail to deliver integrated mental health services for older people which detrimentally impacts on their recovery and

	wellbeing 4. Fail to develop and deliver integrated services for CYP across partners, increasing earlier intervention and treatment options for young people 5. Fail to work with the third sector and other organisations such as the police to improve the crisis response and services available for adults when they are at their most unwell.
Strategic Objective 7 We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	1. Fail to develop the Hertfordshire MH and LD ICP, which may mean voice of service users not represented and has adverse impact on resources available and care provided in the future 2. Changing external landscape regionally and nationally leads to a shift of influence and resources away from MH and LD, the service users and communities served by HPFT. 3. Fail to develop relationships with the geographical ICPs to ensure the needs of those with LD and/or SMI, service users and communities served by HPFT are appropriately addressed 4. Fail to develop the required relationships with the developing ICS to ensure there is not a shift of influence /resources away from MH & LD

Board Assurance Framework (BAF)

September2020

Reviewed by:

- Integrated Governance Committee
- Board Assurance Committee: Covid19
- Audit Committee
- TB

as one

Our values

Welcoming Kind Positive Respectful Professional

Introduction

This Board Assurance Framework brings together the principal risks potentially threatening the Trust's Strategic Objectives and outlines specific control measures that the Trust has put in place to manage the identified risks and the independent assurances relied upon by the Board to demonstrate that these are operating effectively.

Explanation of Assurance types and levels

Assurance Type - The identified source of assurance that the Trusts receives can be broken down into a three line model (1st, 2nd and 3rd line assurances)**. The assurance type column RAG rating records the highest level available for each control**

1st Line	2nd Line	3rd Line
Assurance from the service that performs the day to day activity E.g. Reports from the department that performs the day to day activity, Departmental Meetings, Departmental Performance Information	Assurance provided from within the Trust - Internal assurance E.g. Management Dashboards, Monthly monitoring	Assurance provided from outside the Trust - Independent assurance E.g. Internal Audit, External Audit, Peer Review, External Inspection, Independent Benchmarking

Assurance Level - For each source of assurance that is identified you can rate what it tells you about the effectiveness of the controls

High	Medium	Low
One or more of the listed assurance sources identify that effective controls are in place and the TB are satisfied that appropriate assurances are available Substantial assurance provided over the effectiveness of controls	One or more of the listed assurance sources identify that effective controls are in place but assurances are uncertain and/or possibly insufficient Some assurances in place, or substantial assurance in place, but controls are still maturing so effectiveness cannot be fully assessed at this time.	The listed assurance sources identify that effective controls may not be in place and/or appropriate assurances are not available to the Board Assurance indicates poor effectiveness of controls.

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	1.1 Risk that do not provide safe standards of care, meaning service users to not feel safe and are not protected from avoidable harm or deaths through suicide.	Briefing of all Serious and potential serious Incidents Moderate Harm Panel	Executive Committee Board CCGs QRMs Safety committee reporting into QRMC	Moderate harm panel/ datix notes Internal review of incidents during Covid19	Serious Incident Briefing Report. Weekly to exec and Board Exec and Board reports and minutes of meetings	CCG SI reviews Independent Authors from selected SI investigations CQC Whistleblowing	High	Weekly SI report to Exec and monthly report to TB Weekly moderate harm panel Exec Team April 2020 TB 23.4.20	**Action** Review of Management of Incidents. Implementation of recommendations Quarter Two 2020/21	Director of Quality and Safety [IGC]
	1.1 Risk that do not provide safe standards of care, meaning service users to not feel safe and are not protected from avoidable harm or deaths through suicide.	Mortality Governance processes (including LEDER	IGC TB Brd Ass Sub-Cttee Covid		Mortality Governance Reporting Quarterly Integrated Safety Report	Externally Reporting	High	IGC 20.11.19 19.8.20 TB 5.12.19 25.06.20 Brd Ass Cttee 11.06.20		
	1.1 Risk that do not provide safe standards of care, meaning service users to not feel safe and are not protected from avoidable harm or deaths through suicide.	Quality Report Processes (including Annual Report)	Executive Committee IGC Brd Ass Sub-Cttee Covid TB Commissioner's Eternal Audit	Service reports on Quality priorities Covid 19 Update reports Clinical and Professional Advisory Committee	SBU, ICG and Board reports on Quality priorities and Quality Account	Quality Account 19/20 (published) Annual Report 19/20 (externally audited) External audit advisory report	High	Brd Ass Cttee 09.07.20 EIGC 6.4.20 Audit Committee 13.02.20 30.04.20 19.06.20 TB 19.06.20 30.07.20	**Action** Development of Quality framework to triangulate information from visits.	
	1.1 Risk that do not provide safe standards of care, meaning service users to not feel safe and are not protected from avoidable harm or deaths through suicide.	CQUIN Processes	TMG Executive Committee IGC Brd Ass Sub-Cttee Covid TB CCG QRM	Trust Management Group update reports Service and SBU reports on CQUIN	CQUIN Reports – Part of quarterly Performance Report	CCG CQUIN reports as part of the Quality report	High	IGC 15.1.20 TB 30.1.20 30.7.20 Brd Ass Cttee 09.07.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
1. We will provide safe services, so that people feel safe and are protected from avoidable harm		Training Recruitment process Professional standards adhered to Clinical Outcomes	Executive Committee IGC TB QRM	Quarterly Safe Staffing Levels report CCG Contract reporting (quarterly) Supervision Appraisals			High	IGC 20.11.19 06.04.20 19.08.20 QRM TB 27.02.20 23.04.20		
	1.2 Risk that do not deliver restrictive practice in line with best practice, therefore impacting on patient safety and experience	Freedom to Speak Up Practice and Processes	Integrated Governance Committee Brd Ass Sub-Cttee Covid Quality and Risk Management Committee CCG QRM	Service audits Service feedback from FSUG	Freedom to Speak up – 6 monthly review & Annual Report	CQC MHA Inspections Freedom to speak up Guardian Concerns raised with the Trust via the CQC (CQC Concerns) Duty of Candour Audit	High	IGC 18.11.19 15.01.20 Brd Ass Cttee 11.06.20 CCG QRM September 2019 TB 25.06.20	**Action** Review of Management of Incidents. Implementation of recommendations **Action** Board level self assessment Quarter three 2020/21.	
	1.2 Risk that do not deliver restrictive practice in line with best practice, therefore impacting on patient safety and experience	Making Our Services: MOSStogether Strategy	QRMC Executive Committee IGC TB CCG QRM	Peer review (SBU to SBU) of seclusion practice.	Quarterly & Annual Integrated Safety Reports MOSS Together strategy Use of Force Act and Restrictive Practice Committee Clinical and Professional Advisory Committee	Independent reviews of Respect Seclusion) Assurance visits from CQC & CQC, MHA team. Ongoing involvement in Restrictive Practice Peer Review Collaborative.	High	IGC 20.11.19 19.8.20 TB 5.12.19 25.06.20 Brd Ass Cttee 11.06.20 Ongoing. unannounced & announced visits		
	1.3 Failure to implement Infection Prevention and Control policies and behaviours.	Infection Prevention and Control Board Assurance Framework	Infection Prevention & Control Committee Brd Ass Sub-Cttee Covid IGC	Reports to IGC IPC audits	Annual Infection Prevention & Control Report Reports on emerging issues	CQC external review of IPC	Medium	Brd Ass Cttee 14.05.20 11.06.20 IGC 20.11.1922.05.19 TB 06.06.19 TB 27.02.20, 26.03.20 23.04.20 25.06.20 30.07.20	**Action** Implement actions to support IPC BAF	DIPC [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	1.4 Failure to comply with the legislative framework for the care and treatment of individuals with mental health problems, will impact on quality of care and could lead to regulatory sanctions.	Mental Health Act & DoLs Act Guidance is updated and followed.	CCG QRM IGC TB QRMC Safeguarding Strategic Committee	MHA Quarterly Newsletter (themes & actions)	HPFT Quality Visits & CCG Quality Visit reports. CCG Adult and children's safeguarding reviews Deprivation of Liberty using MHA & DoLS Quarterly Report Mental Health Legislation Quarterly Update from MH Legislation Quality and Policy Group (attended by CCGs) Mental Health Act Managers Annual Report 2018/19	Assurance visits from CQC and CQC MHA team – Provider Action Statements Herts-wide assurance group	High	TB quarterly Executive Team QRMC Safeguarding Strategy Group 20.05.19 QRMC 10.05.19 IGC 22.05.19 QRMC 10.05.19 TB 5.9.19 Quarterly		Director of Quality and Safety [IGC]
	1.4 Failure to comply with the legislative framework for the care and treatment of individuals with mental health problems, will impact on quality of care and could lead to regulatory sanctions.	Major Incident Policy	Executive Committee IGC TB	Service Business Continuity plans Core standards compliance Implementation of Business Continuity Plan during Covid 19	Emergency preparedness, Resilience and Response Annual Report 2019 reported to TB Table top exercises	Emergency Planning and Business Continuity EPRR Core Standards compliance – CCG & NHSE approval Quarterly meetings and reports from Herts wide Local Resilience Partnership	High	Compliance Report to TB 7.11.19 IGC 15.1.20 Implementation: EIGC 6.4.20 TB: 26.3.20 23.4.20	**Action** Action plan to ensure Trust meets one partial compliance area of self-assessment	Director of Service Delivery and Experience [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	1.4	Safeguarding processes and monitoring	Safeguarding Strategic Committee		Safeguarding Reports (Annual and quarterly)	Section 11 safeguarding assessment Annual CCG safeguarding assurance assessment Adults and Childrens Quality Assurance Visit	High	31.10.19		Director of Quality and Safety [IGC]
	1.5 Failure to provide safe working environment for staff, adversely impacting on staff wellbeing.	Safe Care Standards processes and policies	CCG QRM		Quality Assurance Visit Programme Quarterly & Annual Integrated Safety Reports	Integrated Health and Care Commissioning Team (IHCCT) Volvina annual audit programme (ligatures)	High	CCG QRM 18.06.19 22.10.19 12.12.19 11.2.20		
			Health Safety and Security Committee Audit Committee		Health, Safety and Security Report (Annual / Quarterly Report) Health & Safety Annual Report	Health & Safety Executive Inspection Report May 2019 & Action Plan Internal Audit Report – H&S Service User Contact		HSE Inspection Report to IGC 17.07.19 & TB 04.07.19 & 05.09.19 Feb 2019 TB 05.09.19	**Action** Health & Safety Audit with HCT underway.	
			Quality and Risk Management Committee		Quarterly Safety Reports Policy Compliance Report CQC Action Plan	CQC Insight Reports		01.08.19 EIGC 6.4.20		
			IGC	Clinical and Professional Advisory Committee	Reporting Quarterly Integrated Safety Report	Internal Audit Reports - CQC Action Plan		Audit Committee April, July and Sept 2019 IGC 22.05.19 17.07.19 18.9.19 3.12.20 EIGC 6.4.20		
		Quality Strategy	QRMC IGC Board	Service and SBU objectives related to the Quality Objectives as	HSCC QRMC IGC Quality Improvement	CCG performance reports related to Quality Objectives	High	IGC 22.05.19 TB 06.05.19	**Action** Quality strategy being roll out. Leads identified for four domains and reporting back to IGC.	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
				defined in the Strategy Covid19 Risk Register	reports Quality Strategy launched			18.9.19 Implementation: EIGC 6.4.20 TB: 26.3.20 23.4.20		
		Quality Measures including Quality Strategy	IGC TB CCG QRM		Trust performance KPI report on Workforce Quality Strategy review & approval Quarterly Claims Reports Briefing & Annual Claim Report	POM UK Accreditation Quarterly CCG Quality Review Meeting/Reports	High	IGC 22.05.19 TB 06.06.19 18.06.19 22.10.19 12.12.19 11.2.20 Exec 4.3.20	**Action** Quarter one 20/21 roll out of Quality Strategy	
2. We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	**2.1** Service Users unable to access the right services in a timely way, meaning a poor experience and or outcomes for service users.	Performance Monitoring Processes - Implementation of Accurate Clinical Information Strategy - SPIKE	Service Line Leads & Modern Matrons Executive Committee TMG TB SBU Core Management PRM Contract review meetings Internal & External Audit FIC	Spike Performance Reports Service Experience team reports Complaints seen in real-time Datix and local reporting of incidents SBU performance reporting and local PRM service line reporting structures Agreed service changes to meet Covid 19 pandemic	Trust Performance KPI report – Access Times. Re-admission rates. SBU Quarterly Performance Reviews Live Data Performance Dashboards Performance Audit Performance against Annual Plan Internal & External Audit SPIKE live data Spike data quality reports QIAs of service changes to respond to Covid19	Internal Audit Data accuracy and data quality report to Audit Committee Dec 18 Quality Account 19/20 externally published Audited Annual Report 2109/20		FIC 09.07.19, 17.9.19 17.1.20 TB 09.05.19 TB 05.09.19 TB 7.11.19 TB 27.2.20 IGC 22.05.19 TB 23.06.19 Audit Committee 23.05.19 TB 23.05.19 AGM 17.07.2019 EIGC: 6.4.20 TB 23.4.20		Director of Service Delivery and Customer Experience / Director of Finance [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	2.1 Service Users unable to access the right services in a timely way, meaning a poor experience and or outcomes for service users.	Quality Impact Assessments	QRM – reports to Commissioners IGC Brd Ass Sub-Cttee Covid	Datix Complaints in real-time Experience reports Friends and Family results Having Your Say	Individual Quality Impact Assessments External Commissioner scrutiny Quality Impact Assessment reports to IGC		High	QRM IGC 22.05.19 18.9.19		
	2.2 Failure to engage effectively with service users and carers will impact on Trust's ability to transform services to best meet their needs	Service User Feedback	QRMC Executive Committee IGC Brd Ass Sub-Cttee Covid TB	Complaints in real-time Experience reports Friends and Family results Having Your Say	Complaints & Service User Experience Annual Report 2018/19 Peer listening reports and feedback Friends and Family Test data Feeling Safe data	Community Mental Health Annual Survey Commissioner reviews by carers in Herts and View Point	High	Com Survey TB 30.1.20 27.2.20 Exec 26.2.20 TB 06.06.19 IGC 18.09.19 20.11.19 30.1.20	**Action** Community Survey action plan and task and finish Group	
	2.2 Failure to engage effectively with service users and carers will impact on Trust's ability to transform services to best meet their needs	Outcomes Framework for Carers Pathway Development	QRMC TMG	Reporting via Experience Team Feedback from the Council of Carers	Carer Pathway report	CQC inspection CCG reports	High	May 2019		
	2.2 Failure to engage effectively with service users and carers will impact on Trust's ability to transform services to best meet their needs	Recruitment & Involvement of Expert by Experience Policy	QRMC IGC	Involvement and Experience Group 6 monthly report to QRMC	Service User Council/Carer Council – 6 monthly report		High	IGC Sept, Nov 2018		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	2.3 Failure to invest to improve the standard of Trust's environments will impact on patient experience and quality of care.	Capital Plan	FIC TB	Quarterly reports to FIC and TB			High	Exec FIC 18.08.20 TB		
3. We will improve the health of our service users through the delivery of effective evidence based practice	3.1 Do not provide appropriate assessment and treatment of physical conditions which will impact on service user wellbeing and outcomes.	Physical Health Strategy CQUIN IAPT Adult Community FEP Dedicated consultant for physical health	TMG TB Physical Health Committee IGC QRM QRMC	Audit of care plans and records Structured Judgement reviews Clinical and Professional Advisory Committee Covid19 Risk Register	CQUIN achieved and agreed with commissioners quarterly SBU Physical Health Leads Annual Physical Health Strategy Report Mortality Harm Panel	CQC inspection CCG reports on CQUIN STP Ethics Committee	Medium	Bi-monthly CQUIN reports to IGC 20.03.19 22.05.19 17.07.19 18.9.19 IGC 17.07.19 EIGC 6.4.20 TB: 26.3.20 23.4.20	**Action** Implemented training to identify physical health needs, including recording and monitoring. Implement new guidance to identify and manage physical health needs of services users as a result of Covid19	Director of Quality and Medical Leadership / Director of Quality and Safety [IGC]
	3.2 Do not provide appropriate psychological intervention and treatment, leading to poorer outcomes.	Psychology Strategy Performance Monitoring	TMG QRMC Exec				Medium			
	3.3 Do not use latest research or evidence to inform clinical practice which means we don't deliver the optimum outcomes for service users.	Annual Programme of Clinical Audit (Practice Audit and Clinical Effectiveness) inc NICE Guidance Policy	Executive Committee QRMC IGC Audit Committee TB CCG QRM Brd Assurance Committee	Individual Clinical Audits Audit of Care Plans & records	Annual Audit Programme Practice Audit Clinical Effectiveness Progress Reports (PACE) PACE Annual Report	NICE Progress Reports Internal Audit Report Jan 20	High	Annual Audit Programme to IGC 22.05.19 IGC 17.7.19 AC 13.2.20 IGC 22.05.19	**Action** First wave of peer review by Royal College of Psychiatrists. Quarter Two 2020/21	
	3.3 Do not use latest research or evidence to inform clinical practice which	Medicines Management	QRMC Executive Committee IGC TB	Service level feedback Datix reports	DTC Annual Report 6 monthly committee update	CCG Quality report	High	QRMC IGC 17.07.19	**Action** Implementation of Medicines Management Strategy	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	means we don't deliver the optimum outcomes for service users.				Pharmacy & Medicines Optimisation Annual Report Medicines Management Strategy	Internal Audit Report – Medicines Mgt.		IGC 17.07.19 Audit Committee 13.09.18 March 2020		
4. We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment	4.1 Unable 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.	People and OD performance metrics Safe Staffing levels People and OD strategy – implementation programme	TMG Executive Committee PODG TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB	Internal Audits	Medium	PODG IGC TB	**Action** Implement actions to ensure improved employment experience	Director of People and OD [IGC]
	4.1 Unable 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.	Organisational Development Strategy	Executive Committee PODG IGC TB	Supervision Appraisal	People and OD Reports Pulse Survey Good to Great Road Shows Big Listen and Local Listen.	CQC inspection Internal audits	High	IGC TB Deep Dive Audit Committee 3.12.19	**Action** Good to great workshops in 2020	
	4.1 Unable 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.	Appraisal / PDP Reward and Recognition Processes	TMG SBU Core management SLL's Executive Committee PODG Workforce Board IGC TB	Performance by team/service reported monthly from Discovery system	Quarterly PODG reports to IGC Monthly Inspire and annual awards Staff awards Long Service Recognition Awards	External award nominations and awards	High	PODG IGC TB		
	4.1 Unable 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.	Organisational Development Strategy	Executive Committee PODG IGC TB	Supervision Appraisal	People and OD Reports Pulse Survey Good to Great Road Shows Big Listen and Local Listen.	CQC inspection Internal audits	High	Workforce Quarterly Report -TB 5.9.19 Deep Dive Audit Committee 3.12.19	**Action** Good to great workshops in 2020	
	4.2 Failure to develop a sustainable, adaptive and resilient	Revalidation and appraisal of medical staff	IGC TB		Annual Report on Revalidation and Appraisal of Doctors	Internal Audit – Doctor Revalidation	High	IGC		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	workforce model that will impact on Trust's ability to deliver safe and effective care.							TB		
	4.3 Failure to provide an inclusive and diverse workforce with equality of opportunity and experience	People's Plan Implementation Plan	Executive Committee PODG IGC TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB Pulse Survey	Internal Audits	Medium	TB 27.2.20 (National Staff Survey)	**Action** Implement reverse mentoring for senior leadership team Action plan to support Inclusion strategy	
	4.3 Failure to provide an inclusive and diverse workforce with equality of opportunity and experience	External Systems for Staff Feedback	Executive Committee PODG IGC TB	FSUG report	PULSE quarterly report	National Staff Survey	High	Staff survey 04.19 and 5.11.19 TB 27.2.20 Pulse & National Staff Survey 30.1.20		
	4.3Failure to provide an inclusive and diverse workforce with equality of opportunity and experience	People and OD performance metrics, including Gender Pay Analysis, WRES and WDES and Clinical Excellence Awards Inclusion Strategy	Executive Committee PODG IGC TB		CEA awards	WRES and WDES Gender Pay Analysis	Medium	WODG and PODG IGC Exec TB	**Action** Implement reverse mentoring for senior leadership team Action plan to support Inclusion strategy	
	4.4 Failure to improve employment experience for all our staff, including health and wellbeing support which will mean staff do not feel valued or enabled to reach their potential	Appraisal / PDP Reward and Recognition Processes	TMG SBU Core management SLL's Executive Committee PODG Workforce Board IGC TB	Performance by team/service reported monthly from Discovery system	PODG reports to IGC Monthly Inspire and annual awards Staff awards Long Service Recognition Awards		High	WODG and PODG IGC TB Audit Committee 13.2.20		
	4.4 Failure to improve employment experience for all our staff, including health and wellbeing support which will mean staff do not feel valued or enabled to reach their potential	Workforce Health and Wellbeing Strategy Action Plan New Occupational Health provider	Executive Committee PODG IGC TB	Service and SBU objectives related to Strategy Wellbeing offer for staff during Covid 19 Well being bulletins	People and OD Report 24/7 staff helpline Interactive Q&A sessions for staff	CQC inspection Well Led Review	High	WODG and PODG IGC TB 26.3.20 and 23.4.20 Twice weekly bulletins		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
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	4.4 Failure to improve employment experience for all our staff, including health and wellbeing support which will mean staff do not feel valued or enabled to reach their potential	External Systems for Staff Feedback	TMG Executive Committee WODG IGC TB	OD activity plan for year 2, bullying and harassment	Equality review meetings with commissioners (annually)	National Staff Survey 2018 Report on Key Findings and action plan in place	High	Staff Survey TB 27.2.20 Exec Jan and Feb 2020		
	4.4 Failure to improve employment experience for all our staff, including health and wellbeing support which will mean staff do not feel valued or enabled to reach their potential	People and OD strategy – implementation programme	TMG Executive Committee PODG TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB	Internal Audits CQC visit	High			
	4.4 Failure to improve employment experience for all our staff, including health and wellbeing support which will mean staff do not feel valued or enabled to reach their potential	Staff Feedback systems		Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum Q&A Interactive Sessions	Pulse Survey Report– Part of the Workforce & Organisational Development Report		High	WODG & PODG TB April and May 2020		
	4.5 Unable to provide appropriate learning, development and training opportunities to enable staff to be skilled to the right levels, both clinically and managerially	Discovery Learning Management System (easier access to e-learning and training compliance)	PODG IGC FIC	Training Compliance to PODG Training Compliance to IGC		Internal Audits	High	IGC 15.1.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	4.5 Unable to provide appropriate learning, development and training opportunities to enable staff to be skilled to the right levels, both clinically and managerially	Organisational Development Plan Continuous Quality Improvement Implementation	Executive Committee PODG IGC TB FIC	Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum Team Leaders Development Programme Exec. Committee Update	People and OD Reports	Internal Audit	High	WODG and PODG IGC TB FIC 16.1.20	**Action** Continued roll out of Great Teams.	
	4.5 Unable to provide appropriate learning, development and training opportunities to enable staff to be skilled to the right levels, both clinically and managerially	Clinical leadership within teams – clinical & management leadership aligned in teams including nurse leadership & modern matrons.	Trust Management Group Senior Leadership Team Senior Leadership Forum	SPIKE Audits Supervision Appraisal	Guardian of safe working report QRMC PACE report IGC Quality report Audits	Focus Group feedback to CQC	High	IGC 18.3.20 TB 27.2.20		
	4.5 Unable to provide appropriate learning, development and training opportunities to enable staff to be skilled to the right levels, both clinically and managerially	Mandatory Training Programme Statutory & Essential Training Policy	IGC Executive Committee TMG SBU Core management SLL's	Performance by team/service reported monthly from Discovery system	Quarterly Workforce and Organisational Development KPI Report (to services monthly) Bi-annual statutory & mandatory training report Quarterly report to WODG & TB Statutory & Essential Training Policy Ratification	Internal Audits	High	WODG and PODG IGC TB		
	4.6 Fail to deliver the promises within the NHS People Plan ('we are the NHS') resulting in increased regretted attrition	People and OD strategy – implementation programme	TMG Executive Committee PODG TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB	Internal Audits CQC visit	Medium		**Action** Implement action plan to support strategy	
	4.6 Fail to deliver the promises within the NHS People Plan ('we are the NHS') resulting in	Staff Feedback systems		Team meetings Local Listens Good to Great Roadshows	Pulse Survey Report– Part of the Workforce & Organisational Development		High	PODG TB		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
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	increased regretted attrition			Big Listen Senior Leaders Forum Q&A Interactive Sessions	Report			April and May 2020		
	4.6 Fail to deliver the promises within the NHS People Plan ('we are the NHS') resulting in increased regretted attrition	External Systems for Staff Feedback	TMG Executive Committee WODG IGC TB	OD activity plan for year 2, bullying and harassment	Equality review meetings with commissioners (annually)	National Staff Survey 2018 Report on Key Findings and action plan in place	High	Staff Survey TB 27.2.20 Exec Jan and Feb 2020		
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care	**5.1** Failure to deliver a sustainable financial position and longer term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements.	Annual Operational & Financial Plan Strategic Investment Programme NHSI Control Total NHSI Agency Cap	Executive Committee TB FIC Trust Management Group Modernising our Estate Board Executive Committee FIC Audit Committee	Monthly 'flash' reports from finance dept Weekly monitoring of key financial indicators Departmental Budget Reports (monthly) Bi-monthly FIC reports. Board Finance Reports	Financial summary report monitoring performance against plan including the NHSI Use of Resources Risk Rating and the Agency Cap Progress report on Delivery of Strategic Investment Programme	CQC reports Internal Audit Reports – CRES Planning & Delivery Internal Audits External Audit	High	FIC : 19.11.19 17.1.20 Deep Dive CRES 19.11.19 TB 7.11.19 5.12.19 30.1.20 27.2.20 26.3.20 23.4.20		Director of Operational Finance [FIC and Audit]
	5.1 Failure to deliver a sustainable financial position and longer term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements		TB Audit Committee			Annual Governance Statement Annual Financial Statements & Audit Report Head of Internal Audit Opinion External Audit	High	Audit committee 30.4.20 TB AGM		
	5.1 Failure to deliver a sustainable financial position and longer term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements	Productivity Monitoring Processes	Executive Committee FIC IGC IM&T Programme Board TB	Monthly 'flash' reports from finance dept Weekly monitoring of key financial indicators ICT Service Improvement Update	Financial summary report Annual Accounts Finance Reports CRES Programme Assurance Board Trust Performance KPI report	Internal and External Audit Benchmarking	High	FIC deep dive 19.11.19 Exec team monthly flash reports Audit Committee	**Action** Implement use of Model Hospital Delivering Value programme	Director of Operational Finance [FIC & TB]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	5.1 Failure to deliver a sustainable financial position and longer term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements	Trust Contracts with Commissioners	TB FIC		Contract Update Reports	5 Year contract signed with commissioners	High	FIC 17.3.20 TB		
	5.1 Failure to deliver a sustainable financial position and longer term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements	Cash Releasing Efficiency Programme Delivering Value Programme	Executive Committee FIC TB Trust Management Group	Delivering Value Group Monthly updates to TMG	Part of Financial Summary Report Updates to CRES Assurance Board		High	FIC : 19.11.19 17.1.20 Deep Dive CRES 19.11.19 TB 7.11.19 5.12.19 30.1.20 27.2.20		
	5.2 Staff do not have access to accurate and timely information to assist clinical and non-clinical decision making and planning, will impact on ability of Trust to innovate and transform.	Monitor, validate and audit data quality against standards	TMG IM&T Strategy Board IM&T Programme Board MSC Executive Committee	Progress reports against project plan Accurate Information Group		Internal Audit Data accuracy and data quality report to Audit Committee	High	April 2020 IGC Brd Ass Cttee Audit Committee	**Action** Data Quality Maturity Index dashboard has been developed and added to BI reporting at team level. Implement findings from 20/21 internal audit programme	Deputy CEO [FIC & TB]
	5.2 Staff do not have access to accurate and timely information to assist clinical and non-clinical decision making and planning, will impact on ability of Trust to innovate and transform.	Performance Monitoring Processes	Executive Committee IGC FIC TB	Weekly and Monthly 'flash' performance KPIs	Quality Dashboard Performance Review Process Operational Services Report Quarterly Performance Report Trust Performance KPI report	CCG Quality reports CQC inspection	High	Exec FIC: 17.9.19 19.11.19 16.1.20 TB 7.11.19 5.12.19 27.2.20		
	5.3 Failure to implement and embed digital technology will impact on service user and carer experience and our ability to transform services and support staff to respond to changing needs.	Opportunities for staff to develop ideas and implement through and innovation fund. Implementation of Digital Strategy	IM&T Programme Board Executive Committee IGC TB	Service level reports	Pulse Survey Report– Part of the Workforce & Organisational Development Report PARIS/BI Development Group – progress reports IM&T Strategy External review	Benchmarking with like organisations	High	Exec 29.4.20 IGC 18.9.19 20.11.19 17.1.20 TB 7.11.19 5.12.19 30.1.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
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	5.4 Do not enable or encourage people to continuously improve care provided	Continuous Quality Improvement	Executive Committee PODG IGC FIC TB	Improvement & Innovation Fund Updates Transformation Update	CQI Update Reports		High	Exec IGC FIC 16.1.20		Director Quality and Safety [IGC]
6. We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	6.1 Failure to develop and sustain partnerships with other organisations which will improve access to joined up services and outcomes.	Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans in year as necessary	CCG QRM Strategy Group Exec FIC TB	Stakeholder bulletins		Bi-monthly Joint Delivery Boards (Hertfordshire) Feedback from Clinical Commissioning Group Minutes (Reviews)	High	At least monthly		Director of Strategy and Integration [FIC or IGC]
	6.1 Failure to develop and sustain partnerships with other organisations which will improve access to joined up services and outcomes.	Stakeholder Map and plans	Exec Committee	Intelligence sharing via EC	Exec Buddies for ICPs	Feedback from Commissioners	Medium		**Action** Stakeholder plans to be updated given changing external landscape	
	6.2 Fail to develop relationships with Primary Care Networks which means primary mental health services are fragmented and disjointed for service users	Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans in year as necessary	CCG QRM Exec TB	Stakeholder bulletins	Aligned NEDs and EDs to emerging system infrastructure	Bi-monthly Joint Delivery Boards (Hertfordshire) Feedback from Clinical Commissioning Group Minutes (Reviews)	High	At least monthly		
	6.3 Fail to deliver integrated mental health services for older people which detrimentally impacts on their recovery and wellbeing	Integrated Care projects and plans (e.g. primary mental health, LTC, older peoples, frailty)	Executive Committee FIC TB	Complaints seen in real-time Performance data via SPIKE GP feedback Contract hotline via CCG Integrated care Systems Board Workshop Service Changes in response to Covid19	ICS Participation Project reports Aligned NEDs and EDs to emerging system infrastructure	ICS Updates to Trust Board	High	TB 7.11.19 5.12.19 30.1.20 27.2.20 System meetings March – May 2020	**Action** Ensure appropriate representation at system meetings	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	6.4 Fail to develop and deliver integrated services for CYP across partners, which would provide earlier intervention and suitable treatment options for young people	CAMHs transformation CYP Emotional Wellbeing work stream MH & LD ICP	TMG Exec TB	PRM SBU reporting	Executive reports Monthly TMG reports	ICP reporting ICS reporting OSM with NHSI/E Scrutiny	Medium		**Action** Continued active involvement in system wide work for Children and Young People Delivery of relevant MH & LD ICP work stream	
	6.5 Fail to work with the third sector and other organisations such as the police which would lead to poor crisis response and services being available when they are at their most unwell.	Crisis concordant MH &LD ICP work stream Transformation programme	TMG Exec FIC TB	PRM Transformation programme	TB reports	Scrutiny	Medium		**Action** Continued active involvement in system wide work for Children and Young People Delivery of relevant MH & LD ICP work stream	
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	7.1 Fail to develop the Hertfordshire MH and LD ICP, which may mean voice of service users not represented and has adverse impact on resources available and care provided in the future	MH & LD ICP Partnership Board ICP Development Group New Co Chair of MH & LD ICP	Exec Strategy Group FIC TB		Exec monthly updates Board updates	ICS CEO Board ICS Partnership Board E&N and West Partnership Boards	High			Director of Strategy and Integration [FIC]
	7.2 Changing external landscape regionally and nationally leads to a shift of influence and resources away from MH and LD, the services users and communities served by HPFT	Visibility and leadership by HPFT across the ICPs ICP Leadership of MH and LD streams ICP Partnership Board ICP Transition Group Locality Board membership across Herts	Executive Committee FIC Trust Strategy Group TB	Clinical staff involved in system meetings Executive Committee Minutes	Updates to TB Update to Strategy Group Board workshop to agree approach to emerging system architecture	Local Delivery Partnership Boards ICP local delivery group ICP Transition Groups for East & North Herts and West Herts	High	Weekly to Executive Committee TB 7.11.19 5.12.19 30.1.20 27.2.20 Strategy Group	**Action**	
	7.3 Fail to develop relationships with the geographical ICPs to ensure the needs of those with LD and/or SMI, services	Relationships with all Key Stakeholders to drive and deliver key priorities	Executive Committee Strategy Group	Update to Strategy Group	Weekly reports Stakeholder map and plan Aligned NEDs and EDs to emerging		Medium	Weekly to Executive Committee Strategy Group, October,	**Action** Stakeholder plans to be updated given changing external landscape end Q1 Develop relationships with emerging PCNs	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
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	users and communities served by HPFT are appropriately addressed				system infrastructure			January 2020		
	7.4 Fail to develop the required relationships with the developing ICS to ensure there is not a shift of influence /resources away from MH & LD	Annual Plan Emerging system strategy for MH and LD New Care Model Collaborative (leadership role for CAMHS)	Executive FIC TB Executive Committee FIC Trust Strategy Group TB	Partnership Advisory Board for ICS MH and LD	Annual plan Quarterly reports CCG Commissioning Intentions. Aligned NEDs and EDs to emerging system infrastructure New Care Model Collaborative Directors Group	ICS CEO Board New Care Model Collaborative CEO Group	High	Exec FIC TB: 7.11.19		

Board of Directors PUBLIC

Meeting Date:	24 September 2020	**Agenda Item:** 20
Subject:	Development Review of Leadership & Governance Using the Well-Led Framework	**For Publication:** No
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Helen Edmondson, Head of Corporate Affairs and Company Secretary
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To update the Board with regard to the process underway to deliver the developmental review of leadership and governance using the Well-Led framework in accordance with the requirements of the NHS Foundation Trust Code of Governance.

Action required:

To:-

- Note the work underway to complete the external Well-Led Review.
- Approve proposal that the self-assessment report is circulated to all Board members with an executive summary and supported by the a short virtual workshop with all Board and the workshop reflections would be feedback back to Deloitte and would form part of their approach to conducting the external review.
- Note the proposed timeline of final report to Board at end of November 2020

Summary and recommendations to the Board:

Background

In 5 September 2019 it was agreed to start the process of planning for undertaking a developmental review of the leadership and governance using the Well-Led framework in accordance with the requirements of the NHS Foundation Trust Code of Governance. The Board agreed to undertake a process whereby the organisation commissioned to undertake the independent part of the process provides input into the design of the self-assessment part of the process.

A specification for the services to be commissioned was agreed and the process to directly awarding the contract under the SBS framework was made with advice from the procurement team. The outcome of this was that Deloitte was approved as the Trust partner at the January 2020 Board meeting.

Update

The review was started in January 2020, with the aim of reporting the final report to the Board in April 2020. Due to the Covid-19 pandemic and in line with national guidance the external review process was paused in March 2020. Following the decision to cease interim corporate governance arrangements it has been agreed to re-start the Well Led review process.

There are two stages to the review:

a) Self-assessment
b) External review.

Before the process was paused the self-assessment was completed by Board members and has recently been collated into a report by Deloitte. It is proposed that the report is circulated to all Board members with an executive summary of the key issues identified to date. This would then be supported by the a short virtual workshop with Board members the reflections from which would be feedback back to Deloitte and would form part of their approach to conducting the external review.

The external review includes a number of activities, such as surveys of Governors, Board members and staff. There are also interviews with Board members, senior managers and external stakeholder. Deloitte will hold focus groups with staff and Governors as well as observe Board and Committee meetings. This is all complimented by a thorough review of a wide range of documents covering all aspects of leadership of the organisation.

Prior to the pausing of the process Deloitte had completed the Governors focus group and survey, the feedback from these will be included in the final report.

Summary

The external Well-Led review has been restarted and is due to present its final report to the Board at the end of November 2020. It is an important external source of information and assurance with regard to the requirement of Well Led domains.

The Trust is aware that recently CQC announced its ambition to what they call a more "streamlined and less burdensome" approach to trust inspections from September 2020. Which they aim to achieve by relying on more offsite monitoring and keeping onsite activity to a minimum. The Trust are committed to ensure the outcome of the external Well-Led review supports the new CQC approach.

Recommendation

It is recommended that the Board:

- Note the work underway to complete the external Well-Led Review.
- Approve proposal that the self-assessment report is circulated to all Board members with an executive summary and supported by the a short virtual workshop with all Board and the workshop reflections would be feedback back to Deloitte and would form part of their approach to conducting the external review.
- Note the proposed timeline of final report to Board at end of November 2020

Relationship with the Business Plan & Assurance Framework:

Reviews provide a tool to facilitate continuous improvement to develop and improve capacity and capability in the organisation. This in turn enables Boards to demonstrate that their organisations are providing high quality, sustainable care.

Summary of Financial, IT, Staffing and Legal Implications:

There will be a financial implication in relation to the cost of the independent review.

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

Governors have a key role in the Well Led Key Line of Enquiry No. 7: "Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?" The independent reviews usually include interviews and focus groups with Governors and other key stakeholders.

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

The independent review provides assurance for the CQC Well Led standard.

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

Hertfordshire Partnership University NHS Foundation Trust

Trust Public Board of Directors

Meeting Date:	24 September 2020	**Agenda Item:** 21
Subject:	Mental Health and Learning Disability Integrated Care Partnership (MHLD ICP)	**For Publication: Yes**
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Purpose of the report:

To provide an update to the Trust Board on key activities undertaken by the Hertfordshire Mental Health and Learning Disability Integrated Care Partnership and upcoming milestones.

Action required:

To note the progress detailed in the report

Summary and recommendations to the Board:

This report has summarised the significant activity that has taken place across the Hertfordshire Mental Health & Learning Disability Integrated Care Partnership during July – August. The main focus across the ICP has been the restoration and transformation of services in the context of COVID19, together with planning ahead to meet other local and national requirements. Across the system we have seen increasing activity and demand across all services, and increasing complexity, alongside changes in need and risk that have been brought about by the societal changes following COVID are providing new challenges for our organisations, systems and communities. Staff wellbeing and tackling health and social inequalities are priorities in the restoration period and the longer term development of services and systems of support. The MHLD ICP will be undertaking an Inequalities self-assessment that will be presented at the October Board.

The ICP is developing at pace, and with the contribution of all partners the Terms of Reference for the Partnership have now been developed and approved by the ICP partnership Board, an initial governance structure has been approved, and the co-production approach also agreed, together with a high level programme plan. This is split into three distinct areas of focus:

- ICP Development
- Priority Transformation areas
- COVID

The Trust Board is asked to note the update provided and the key areas of focus for the MHLD ICP over the next 6 months.

Mental Health & Learning Disability Integrated Care Partnership
Update Report
September 2020

1. Covid-19 Pandemic

1.1. Organisations continue to work on both their individual priorities and as a wider system to evaluate, restore and reconfigure services, whilst planning for winter pressures and a potential COVID second peak. All organisations are seeing a return towards pre-COVID demand levels and activity is being increased across a wide range of services.

1.2. This however, is at the same time as we are experiencing an increase in crisis and urgent presentations and responding to people with more complex health and social needs. A co-ordinated system-wide response is needed to meet the impact of the societal changes brought about by COVID, including increased homelessness, unemployment, financial difficulty, mental health issues and incidents of domestic abuse. This will be an ongoing focus for the MH & LD ICP.

1.3. Our staff across the system are also adjusting to changes in their personal and professional lives, some having been directly impacted by COVID who are now experiencing trauma and bereavement. We recognise as a system that supporting staff wellbeing and ensuring that we take action to protect those most at risk, including our BAME colleagues, is a key priority going forward. Tackling inequality, discrimination and ensuring we develop more inclusive services and systems of support going forward sits at the heart of our organisation's and system recovery.

2. Phase Three Restoration

2.1. A letter was received from Simon Stevens on the 31st July which detailed the expectations for the NHS in terms of restoration and running of services for the remainder of the year.

2.2. There is a requirement for systems to develop plans for the remainder of the year which focus delivery of the Long Term Plan commitments. A draft plan was submitted on 1st September and final plans will be submitted on 21st September. There is a significant focus on tackling inequalities and we are working as a system with people that use services, their families and communities to develop plans and make decisions on the reshaping of our services to ensure that there is increase recognition of the needs of people with protected characteristics and are generally more inclusive.

3. Update on Transformation Areas

3.1. Significant work has been taking place across the system in the priority transformation areas as detailed below. Particular achievements include:-

- Hertfordshire Children's Services have been successful in the Community Regional Keyworker pilot bid and will now progress this in partnership with HPFT.

- Referrals to the Enhanced Primary Care Mental Health Service, which went live on 1st July 2020, are now increasing steadily, with referral from GP's, GP Plus and HPFT.
- GP Health Checks for people with Learning Disabilities will now recommence with a revised process to ensure these are delivered in a COVID secure way.
- Evaluations are in progress for both the A&E Diversion Units and Single Point of Access (SPA) 24/7 services, both of which were set up in response to COVID. The findings are due in September and will inform the longer term development of these services.
- The first phase of the Autism review has now been completed and shared and a new service model to address the identified gaps is being co-produced.
- Plans have now been implemented to recover and improve dementia diagnosis by developing a primary care diagnosis offer utilising technology to improve access and reduce isolation.

3.2. Children's and Young People's Mental Health and Wellbeing

The bid for the Community Regional Key working pilots was successful and Children's Social Care will be working with HPFT CAMHS to move this forward.

There has been good partnership working across the system and full compliance with Care, Education and Treatment Reviews (CETR) has been achieved with the Transforming Care inpatient trajectory also being achieved at the beginning or August.

Work across the system to reduce the need for inpatient admissions across the system will continue and there are plans for HPFT to join the Dynamic Support Register (DSR)

3.3. Enhanced Primary Care Mental Health (EPCMH)

The EPCMH Service went live on 1st July with the aim of bridging the gap between existing GP and secondary care services, through providing multi-disciplinary structured support to people experiencing mild to moderate mental health issues to stay connected in their communities.

As anticipated, the numbers of referrals were low initially but have now increased and the service is now accepting referrals via the GP+ service, directly from GPs and from HPFT, following SPA triage, initial assessment or step down from secondary care. As the service develops, the option for self-referral will also be implemented. The next phase of mobilisation will be the expansion of the service offer to include the 18-25 cohort and older adults.

3.4. Learning Disability

A revised process has been agreed for GP Learning Disability health checks to be delivered in a COVID secure way and has been shared with GPs so that they can restart health checks. An initial review of Learning Disability deaths during the Covid period has been undertaken. This showed a continuation of many of the themes that had been noted pre Covid such as poor quality general healthcare interventions and the risk of diagnostic overshadowing. A plan has been developed to ensure all outstanding Learning Disability Death Reviews (LeDeR)) are completed by the end of December in line with NHS England timescales, utilising reviewers from across the health and social care system.

3.5. Crisis for People with Severe Mental Illness

The A&E diversion hubs continue to operate across the two sites (Watford and Lister Hospitals) and an all-age 24/7 Helpline and First Response services are also in place. An evaluation is in progress, involving all system partners to inform the longer term direction of these services. The final evaluation is due in September 2020.

3.6. Autism

The first phase of the adult autism review has been completed and shared with HPFT, both CCGs and Adult Social Care. This identified a significant waiting list for diagnosis (with some people waiting more than two years) and a lack of support for people pre and post diagnosis. A new service model is being developed in co-production with experts by experience, carers and other stakeholders with the aim of presenting this model to partners in September.

3.7. Dementia

The draft Dementia strategy for Hertfordshire is currently being discussed with the CCG's and HCC. This has been developed by the Dementia Coproduction Board. The board opted to delay full public consultation on developing a 5 year strategy, in favour of quickly developing a practical plan to support people with Dementia and carers in the Covid-19 situation through 20-21.

Day services and respite services are now re-established, offering support to carers. The work to recover and improve dementia diagnosis by rolling out a primary care diagnosis offer has commenced alongside making technology available to reduce isolation and facilitate access to services. Public messaging to encourage people to seek diagnosis and explaining what services/options are available is in place following a decrease in referral throughout the COVID period.

3.8. *Substance Misuse*

A Deep Dive into substance misuse has been undertaken and was presented to the Partnership Board in August. This included all aspects of service provision for substance misuse and for dual diagnosis within Hertfordshire, including HCC Public Health and Adult Social Care, voluntary sector provision, Change Grow Live and HPFT.

4. Governance

4.1. ICP Board Terms of Reference

Following feedback from the ICP Board in July the Terms of Reference have been amended and were approved. The key changes were:-

- A statement of commitment to working in partnership with people with lived experience and other stakeholders.
- To establish the co-production development group to promote co-production across the ICP.
- The role of the Board in monitoring progress against the ambitions and key milestones within the Long Term Plans, Transforming Care and the Mental Health Investment Standards.
- The addition of the Director of System Transformation & Integration, Hertfordshire & West Essex Integrated Care as Co-Chair.

4.2. Governance Structure

Changes have been made to the Governance Structure in response to feedback at the July ICP Board. The main changes being:-

- The addition of the Co-production Development Group
- The Stakeholder Assembly has been positioned as a reference group
- The existing Co-production forums have been positioned as reference groups for the relevant priority transformation areas.

4.3 ICP Directors Development Group

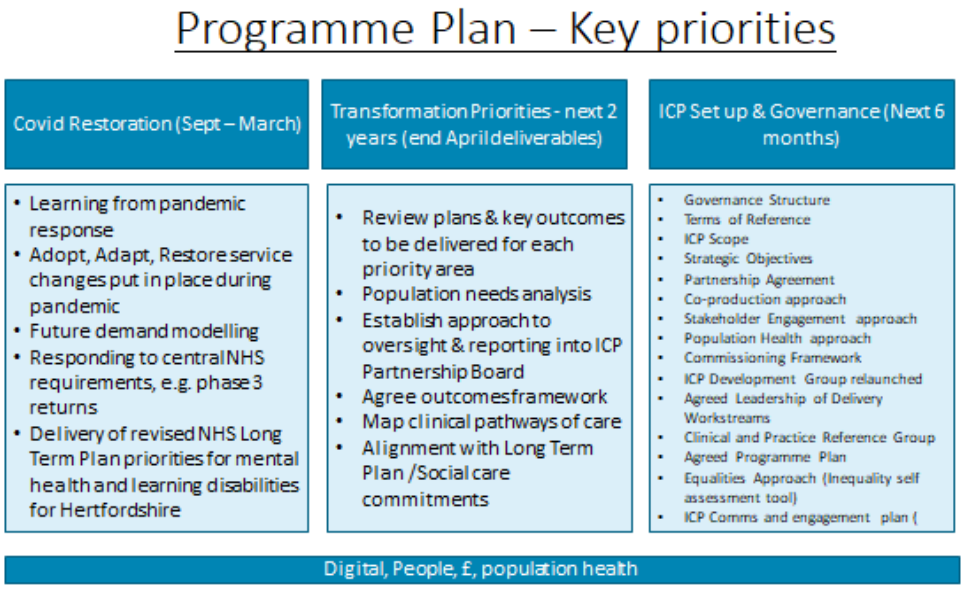
An ICP Directors Development Group has been established to support development of the ICP itself, following a similar structure to those in East & North Herts ICP and West Herts ICP.

5. Programme Plan

An outline plan has now been developed that outlines the key elements of the programme. This is framed around three key areas of:

- COVID restoration
- Priority Transformation
- ICP Set UP and Governance

A high level overview is presented below.



6. Co-production

Following feedback changes have been made to the ICP approach to co-production. This was discussed at the August ICP partnership Board with the key changes agreed as follows:-

- A statement of commitment to co-production within the Terms of Reference
- The establishment of the Co-production working group to promote co-production across the ICP.
- The proposal that the existing co-production groups act as reference groups for the priority transformation areas.
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7. Inequalities Self-Assessment

Work is continuing completing the Inequalities self-assessment and findings will be presented at the October Board, along with a proposed approach to tacking inequalities.

8. **Conclusion**

This report has summarised the significant activity that has taken place across the Hertfordshire Mental Health and Learning Disability ICP during July and August. We continue to develop as an ICP in the context of restoring and transforming our services, planning ahead for future challenges and meeting other local and national requirements.

These steps are moving us further towards delivering our vision to ***"Support people living with a mental illness and/or a learning disability in Hertfordshire to live longer, happier and healthier lives"***