Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC

The Colonnades

29 July 2021 10:30 - 29 July 2021 13:30

INDEX

Hertfordshire Partnership University NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 29 July 2021

Time: 10.30am – 13:30pm

A G E N D A					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
1.	**Welcome and Apologies for Absence**	Chair			10:30
2.	**Declarations of Interest**	Chair	**Note**	Attached	
3.	**Shared Experience**				10:30
4.	**Minutes of Meeting held on:** **20 May 2021** **10 June 2021**	Chair	**Approve**	Attached	11:00
5.	**Matters Arising Schedule**	Chair	**Review**	Attached	
6.	**CEO Brief**	Tom Cahill	**Receive**	Attached	11:05
7.	**Chair's Report**	Chair	**Receive**	Verbal	
QUALITY & PATIENT SAFETY					
8.	**Report of the Integrated Governance Committee held on 15 July 2021** **a) Q1 Guardian of Safe Working** **b) Quality Accounts**	Diane Herbert Dr Rakesh Magon Dr Rakesh Magon	**Receive**	Attached	11:15
9.	**Medical Appraisal & Revalidation of Doctors Annual Report**	Dr Rakesh Magon	**Receive**	Attached	11:25
OPERATIONAL AND PERFORMANCE					
10.	**Report of the Finance & Investment Committee held: 21 July 2021** **a) Q1 Performance report**	David Atkinson Paul Ronald	**Receive** **Receive**	Attached Attached	11:30
11.	**Q1 Annual Plan Update**	Karen Taylor	**Receve**	Attached	11:40
12.	**Q1 Finance Report**	Maria Wheeler	**Receive**	Attached	11:50
PEOPLE					
13.	**Q1 People and OD Report**	Janet Lynch	**Receive**	Attached	12:05
14.	**Gender Pay Report**	Janet Lynch	**Receive**	Attached	

	STRATEGY				
15.	**System Developments** **Future demand for Mental Health**	Karen Taylor	**Receive**	Attached	12:15
16.	**East of England Collaborative**	Sandra Brookes	**Receive**	Attached	12:30
	GOVERNANCE AND REGULATORY				
17.	**Report from Audit Committee held on 19 July 2021**	Catherine Dugmore	**Receive**	Attached	12.40
18.	**Trust Risk Register**	Dr Jane Padmore	**Receive**	Attached	12.45
19.	**Board Assurance Framwork**	Helen Edmondson	**Approve**	Attached	
20.	**Fit and Proper Person Compliance**	Janet Lynch	**Receive**	Attached	12.55
21.	**Trust Constitution**	Helen Edmondon	**Approve**	Attached	13:00
22.	**Mental Health Act Manager's Annual Report**	Tim Bryson	**Receive**	Attached	13.05
23.	**Nominations and Remuneration Terms of Reference**	Chair	**Approve**	Attached	13:15
24.	**Any Other Business**	Chair			13:20
	QUESTIONS FROM THE PUBLIC	Chair			13:25
Date and Time of Next Public Meeting: Thursday 30 September 2021					

ACTIONS REQUIRED

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approving it

Note: For the intelligence of the Board without the in-depth discussion as above

For Assurance: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

Chair: Sarah Betteley

Declarations of Interest Register

Board of Directors

July 2021

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
Anne Barnard	Non-Executive Director	Share Portfolio managed by a private client stockbroker Independent member of the Audit & Risk Committee of the Department of Health & Social Care Director and minority shareholder in Qube Information Systems Ltd
Sarah Betteley	Chair	Director DEVA Medical Electronics Ltd
Sandra Brookes	Director, Service Delivery & Service User Experience	Nil Return
Tim Bryson	Non-Executive Director	Director of Tim Bryson Consultancy Services Ltd Chair of Family Psychology Mutual CIC
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	Shareholder in own coaching/leadership business Trustee at London Film School
Kush Kanodia	Associate Non-Executive Director	Chief Disability Officer, Kaleidoscope Group Trustee, Kaleidoscope Foundation Public Advisory Board, Health Data Research UK (HDR UK) Advisory Board, Global Disability Innovation Hub (GDI Hub) Trustee & Director, Center for Access Football in Europe (CAFÉ) Trustee & Director, AbilityNet
Jane Padmore	Director, Quality & Safety	Director of Nursing Forum, National Mental Health and Learning Disability Board Member of NHS Confederation Mental Health Forum
Paul Ronald	Director of Operational Finance	Chair – MIND in Mid-Herts
Karen Taylor	Deputy CEO & Director, Strategy & Integration	Nil Return
Patrick Vernon	Non-Executive Director	Chair of Citizenship Partnership of Healthcare Investigating Branch Sister works for NHS Resolute

		Centre for Ageing Better Every Generation Media and Foundation Vice Chair of Bernie Grant Trust Board member of 38 Degrees Sole shareholder and founder of social enterprise Campaign on reforms of NHS Associate for Good Governance Institute
Jon Walmsley	Non-Executive Director	Independent Board Member of Ravensbourne University, London | Would recuse from any relevant discussions. Trustee on Board of homelessness charity: 'Accumulate' (1170009) | Would recuse from any relevant discussions
Maria Wheeler	Director, Finance, Performance & Improvement	Nil Return
Asif Zia	Director, Quality & Medical Leadership	Nil Return

Minutes of the PUBLIC Board of Directors Meeting
Thursday 20 May 2021
VIRTUAL

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Sarah Betteley | SBe	Chair
Tim Bryson | TBr	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
Catherine Dugmore | CD	Non-Executive Director
David Atkinson | DA	Non-Executive Director
Patrick Vernon | PV	Non-Executive Director
Jon Walmsley | JW	Non-Executive Director
Kush Kanodia | KK	Associate Non-Executive Director
DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Paul Ronald | PR	Director of Operational Finance
Dr Jane Padmore | JPad	Director, Quality and Safety
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Dr Asif Zia | AZ	Director, Quality & Medical Leadership
Keith Loveman | KL	Director Finance
IN ATTENDANCE	
Kathryn Wickham	PA to Chair & Company Secretary (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Barry Canterford | BC	Lead Governor & Engagement Champion (until agenda item 10 only)
Louise Thomas | LT	Deputy Director People & Organisational Development
Jacky Vincent | JV	Deputy Director of Nursing, Quality & Safety & DIPC
Maria Wheeler | MW	Deputy Director Finance
Mark Graver | MG	Deputy Director Communications
Katie Dyton | KD	Interim Experience Lead (Agenda Item 3 only)
Finn Morgan | FM	Carer Story (Agenda Item 3 only)
APOLOGIES	
Ann Corbyn | AC	Director of People & Organisational Development
Karen Taylor | KT	Deputy CEO & Director, Strategy and Integration

Item	Subject	Action
044/21	**Welcome and Apologies for Absence** SBe welcomed all to the meeting. Apologies for absence were received from Ann Corbyn and Karen Taylor. SBe recorded that this was would be KL last Public Board meeting before his retirement.	
045/21	**Declarations of Interest** The Declarations of Interest Register was noted. JW advised that he had sent through an updated Declaration of Interest form since the Board papers were published. These were recorded as: • Independent Board Member of Ravensbourne University London • Trustee of homelessness charity Accumulate (UK Charity number	

	1170009) **NOTED**	
046/21	**Story to the Board** Finn Morgan shared the story of his son's treatment from diagnosis to his stay in Dove Ward in the summer of 2020.	
047/21	**Minutes of the Meeting held on:** **29 April 2021** The minutes were reviewed with one amendment to item 030/21 Covid 19 Update. Paragraph 6 should read ***3rd wave***: We were planning for a ~~4th~~ 3rd wave towards the end of summer, coupled with a predicted increase in flu due to the lack of immunity through social distancing. The remainder of the minutes were approved as an accurate account of the meeting. **APPROVE** **The Board APPROVED the minutes**	
048/21	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated. **Well Led Review** HE updated reporting that following the Board receiving the final report of the Well Led Review some adjustments had been made to the timescales for actions. This paper formally reported the reviewed and revised timescales with HE asking the Board for their support. The Board noted the timescales and provided their support.	
049/21	**CEO Brief** TC presented the CEO Brief to the Board which was taken as read. Headline messages of note to the Board were: TC reported that it was 'good news' as lockdown for Covid started to ease and key milestone dates of 17 May and 21 June arrived. Close monitoring of the situation continued as Variants of Concern emerged. TC noted the importance of remaining vigilant and ensuring the use of good IPC. As a Trust we had stepped down a number of our processes however remained in Major Incident. We currently had zero cases on our inpatient wards. There was real progress being achieved with regards to the roll out of the vaccine and Trust wise we had 85% of staff vaccinated and 85% of LD service users vaccinated. Significant work had taken place in terms of legislation for the ICS. Sir Simon Stevens had announced he would be stepping down as Chief Executive of NHS England in July 2021. Further development in the ICS meant the Chair and CEO would need to be re-appointed. The change to boundaries	

Action	within the ICS was also an issue with more information expected in June/July. The Oversight Framework would be explored at the Board Away day being held on the 8 June 2021. The MH & LD Integrated Care Partnership was now known as a Collaborative. A significant meeting was being held on the evening of the 20 May with Jane Halpin. Niche had been commissioned to undertake demand modelling with the report almost done. This would be shared at a future Board. The West Essex IAPT contract ended on the 1 July 2021 with us continuing to support staff as they transferred. TC noted the Board would recall that at its meeting in March it had approved the Trust's Annual Plan and Financial Plan for 2021/22. Following publication of the NHS Planning Guidance we were able to confirm that both Trust plans were in line with the published guidance and therefore they would not require any significant amendments. Operationally it continued to be busy with real pressure being seen. TC acknowledged the fantastic work of the Trust staff. Out of Area Placements were seeing an improving picture, however there was significant pressure on children's services with us currently having 7 young people needing beds were not currently able to be provided locally or nationally. The East of England (EOE) Provider Collaborative had made good progress and would be ready to 'go live' on 1 July 2021. A formal report would be presented to a Public Board before July.	
Action	TC noted the CQC Provider Collaborative Review of CAMHS stating they would have dual focus. TC also commented on the good news for the additional CAMHS investment. Following a robust recruitment process TC was delighted set out the recommendation from Remuneration Committee to appoint Maria Wheeler as Executive Director of Finance, Performance and Improvement. The Board approved the recommendation from Remuneration Committee. It was noted that Maria would take up post on the 1 July 2021. Final interviews for the Director of Quality & Safety (Chief Nurse) were to be held on the 26 May 2021. **RECEIVED AND APPROVED** **The Board RECEIVED the CEO Update** **The Board APPROVED the recommendation from Remuneration Committee**	
050/21	**Chairs Brief** SBe provided the Board with a verbal update on her recent activity since the last Board meeting. SBe had undertaken 3 site visits to Single Point of Access Team (SPA), The Marlowes and Colne House. The visits had been useful, very interesting and	

	insightful. SBe had attended the BAME Staff network meeting and a Medical Staffing Committee meeting (MSC) SBe attended the ICP Chairs meeting and noted the good progress SBe had chaired the Hertfordshire Chairs quarterly call SBe had attended an EoE workshop chaired by Ann Radmore which had provided updates on key issues. This had been followed by a workshop on anti-racism SBe continued to attend the weekly Mental Health Chairs conference calls SBe updated the Board with regard to annual Fit and Proper Person compliance. She reported that we had recently completed the annual requirements of Fit & Proper Person declaration and no issues were recorded. **RECEIVED** **The Board RECEIVED the Chairs verbal Briefing**	
	QUALITY & PATIENT SAFETY	
051/21 **Action**	**Report of the Integrated Governance Committee held on 13 May 2021** DH presented the report which was taken as read and provided a short summary with the below key highlights: DH reflected on the past year and commented on all that the Committee had achieved over and above Covid. There were no matters for escalation to the Board. The Committee had held a Deep Dive on Workforce Planning where assurance had been received. This would be re-looked at the Committee's next meeting. The Committee had discussed the Staff Survey and the positive results whilst acknowledging the focus for further work around bullying and harassment. Tina Kavanagh had provided an update to the Mental Health Legislation with the Committee considering the data around disproportionate detentions for the BAME community with an action to look at the pathway. DH invited questions. SBe referenced section 5.1 of the report paragraph 2 asking for the below narrative to be reworded stating that an increase in deaths was not a key highlight. *Key highlights: increase in deaths, overall, mainly due to deaths of people with Covid-19 but a reduction in deaths thought to be through suicide;* SBe also raised the Freedom 2 Speak Up figures with JPad stating she did not have these to hand but with agreement to forward these to SBe. **RECEIVED**	

	The Board RECEIVED the report	
	Integrated Safety Report: Q4 and Annual Report JPad presented the Annual and Q4 Integrated Safety report which was taken as read also noting the Board had been discussed in detail at the Integrated Governance Committee (IGC). Points of note for the Board were. Although there was a significant increase in unexpected deaths, these were primarily related to COVID and those related to suspected suicide were reduced significantly. The mortality governance work had driven significant change in the physical healthcare offered by the Trust, and this would be developed further this year. Violence and aggression remained a challenge and this year would see renewed focus including the low-level repeated incidents which have a cumulative effect on staff. Restrictive practice remained an area of focus for us with increased scrutiny and the launch of the MOSS Together strategy. JPad concluded by advising that the overall learning themes and actions were detailed at the end of the report with a sample of actions taken as the priorities for this year. **RECEIVE** **The Board RECEIVED the report**	
	Safe Staffing Report: Q4 and Annual Report JPad presented the Annual and Q4 Safe Staffing report which was taken as read also noting that it had been discussed in detail at the Integrated Governance Committee (IGC). JPad advised the report covered the inpatient nursing safe staffing levels for the year. Key Points for highlighting to the Board were. At the beginning of the pandemic the Board had agreed emergency safe staffing levels. Through careful management and regular roster scrutiny the Trust had not needed to use these due to a workforce who had been responsive to the ever-changing needs and increased demands. Overall, we had managed to achieve the safe staffing levels which had been agreed at the 6 monthly establishment reviews. Ongoing risks were in relation to the retirement profile of our workforce alongside the national shortage of nursing staff. JPad concluded reporting that this year would see a renewed focus on achieving a 0% vacancy rate for healthcare support workers, supporting our staff to develop and to become registered nurses, retaining our staff and enabling retire and return. No questions were put forward.	

	RECEIVE **The Board RECEIVED the report**	
	Infection, Prevention & Control: Q4 and Annual Report JPad presented the Annual and Q4 Infection, Prevention & Control report which was taken as read also noting to the Board it had been discussed in detail at the Integrated Governance Committee (IGC). JPad started by acknowledging the work of Jacky Vincent, DIPC, Debbie Pinkney, Consultant Nurse for IPC and Louise, HCA for IPC who had gone above and beyond in their duty throughout the pandemic. JPad asked the Board to acknowledge that IPC was far more than COVID and that although COVID had dominated this past year, the business as usual work for IPC had continued and indeed been strengthened. A detailed programme for this year was included in the report. No questions were put forward. **NOTE** **The Board NOTED the report**	
	Safeguarding: Q4 and Annual Report JPad presented the Annual and Q4 Safeguarding report which was taken as read also noting to the Board that it had been discussed in detail at the Integrated Governance Committee (IGC). JPad reported that Safeguarding had continued to be a priority for the Trust throughout covid. Through this, rather than take our 'foot off the pedal' we had strengthened practice and the way safeguarding is delivered to make it more robust. We had seen an increase in domestic abuse reported however this was in line with the national picture. The CCGs had gained assurance following our annual safeguarding section 11 child safeguarding assurance visit and our annual adult safeguarding visit. Priorities for the coming year were detailed within the report. No questions were put forward. **RECEIVE** **The Board RECEIVE the report**	
	Service User Experience: Q4 and Annual Report SBr presented the report which was taken as read. Points highlighted to the Board were. It had been a year of increased compliments and a drop in complaints and PALS enquiries. A piece of work on waiting times would take place to gain better understanding.	

	A key message was around feedback levels which were low. To address this focus was being given to digital solutions with a pilot already underway. SBr talked about Experience Champions and increasing their involvement. Improving the carers experience was proving a challenge with a piece of work taking place to find some real solution to this. Focus was also being given to widen the recruitment to carers network. SBr invited questions. PV raised the benchmarking data outlined in section 6.2 of the report asking if we needed to be move nuanced in how is presented considering the new external landscape. SBr acknowledged this, stating we needed to obtain more meaningful data. HE highlighted that the Quarterly and Annual reports were for RECEIVING rather than NOTING as outlined in the agenda. **RECEIVE** **The Board RECEIVED the report**	
052/21	**Covid-19 Update** JPad presented the report which was taken as read. Points of note for the Board were: In total there had been 199 service user deaths of which 15 were reportable. We currently have no cases in our inpatient or community services. There were currently 10 members of staff who were positive, 4 in the inpatient setting and 4 in the community. Trust continue to run incident management however this is more streamlined but with a note of caution that are able to step it up if required. Face, Space, Hands, Fresh Air and LFT are our key message and focus. JPad noted the Variant of Concern which was highly contagious. That the trust is part of system wide working with the setting up of a quarantine hotel in St Albans. JPad concluded noting we continued with our vaccination programme and encouraged the LFT twice weekly testing. JPad invited questions. **RECEIVED** **The Board RECEIVED the report**	
	PEOPLE	
053/21	**People & Organisational Development Report: Q4 and Annual Report** LT introduced the paper which was taken as read. Key headlines for the Board's attention were: During 2020/21 the NHS People Plan had been published. The year had been incredibly challenging however despite the backdrop of Covid our metrics were in a positive position.	

	Using a variety of virtual, written and video engagement had enabled us to continue to engage with all our people along with feedback via the Pulse and Annual staff surveys and Big Listen. In the year we have continued with our Health & Wellbeing work and had appointed to the post of Health & Wellbeing Manager. There was now a comprehensive package in place for all staff. The year had seen the launch of a new Occupational Health service, our Wellbeing Strategy and a Spring and Winter Wellbeing programmes. In terms of People Recovery, the plan was in draft and had been co-designed. We had also launched the 'Paying Witness' pillar of our recovery plan which saw us marking the national Day of Reflection. Overall, our people metrics continued to be positive however particular focus was being given to appraisal, mandatory training compliance and continuing to reduce vacancy rates. Sickness absence had improved and was now below target. It was of note that IPC measures would have contributed to this. Temporary staffing spend remained stable however use of bank had increased although this had ensured safe staffing levels. Appraisal compliance was currently at 84% and mandatory training 86% with recognition more work needed to be done. Questions were invited. ABa acknowledged the good work which had been undertaken and commenting it was a useful report. ABa referenced page 233 and asked about the staff participation numbers for the Winter Wellbeing programme with LT confirming the report figure of 402 was unique staff. TBr asked if there had been an increase to the employee assistance programme. LT confirmed the top reason for absence was ill mental health and so would likely see acuity in this in coming months. **RECEIVE** **The Board RECEIVED the report**	
	12:25pm BC left the meeting	
	Guardian of Safe Working: Q4 AZ presented the report which was taken as read. Of note to the Board were the below points: Q4 had seen an improving picture for exception reporting with all reports closed within the quarter. Support for Junior Doctors had been increased. Our low exception reporting was below the national and regional average. No questions were put forward. **RECEIVE**	

	The Board RECEIVED the report	
	OPERATIONAL & PERFORMANCE	
054/21	**Report of the Finance & Investment Committee held: 10 May 2021** DA presented the report which was taken as read providing the Board with a brief summary of the meeting. The meeting was held on the 20 May 2021 and had welcomed Jon Walmsley as a newly appointed NED. The Committee had received the Q4 Performance report which outlined the position remained challenging but with a strong position. Hot Spots were CAMHS, Older People, Learning Disabilities and Forensics and Adults. SBr had outlined to the Committee the due diligence undertaken when commissioning out of area placements and provided assurance. The Committee had received a report on the financial plan for the period to end of April 2021 and an outlook for months 1-6 with DA reporting that assumptions were broadly in line with those in the planning guidance. The report detailed an expected breakeven position. The Committee had received a report for the Delivering Value Programme which set out the 2020/21 targets and discussed the risks associated with the schemes relating to reducing expenditure on Out of Area Placements, noting this would be closely monitored. The Digital Strategy programme had seen increased visibility. The Committee had considered the draft Outline Business Case (OBC) which had been given detailed discussion and voiced strong support. It was noted that this would be considered later on the agenda. **RECEIVE** **The Board RECEIVED the report**	
	Performance Report Q4 KL introduced the report which was taken as read and drew the Board's attention to the below points: Overall, our performance had remained stable and strong given the backdrop of Covid and provided us with a positive picture. Key was the service transformation work and step change in performance. The consistent areas of pressure would be addressed in part by the transformational work which would help bed flow and capacity. KL noted there would be a complete performance review of all SBU's around the key metrics to ensure they were on top of risk assessments, care plans and mandatory training. KL concluded stating that all in all services had done remarkedly well to hold their performance over the past year.	

	RECEIVE **The Board RECEIVED the report**	
055/21	**Finance Report – Month 1** PR updated the Board with the financial report for Month 11. The paper was taken as read. Headlines for the Board's attention were: We continued to operate under the interim financial framework. The planning settlement expected to see a financial position better than plan in the first six months and this had been evidenced in the indications from month 1. The second six months would see more significant cost pressure particularly as COVID income was reduced/withdrawn. PR referenced Table 2 in the report which laid out the key assumptions. Paragraph 8 provided the headlines of the financial strategy noting 4 key mitigations. Paragraphs 8 through to 10 detailed the issues with income and pay with PR noting there had been a high level of Bank usage in April. PR concluded advising there had been several positive measures which we would continue with. Table 4 of the document provided a summary of the current position with the Capital Plan. The refurbishment of Oak ward continued to be developed. Work continued by the Delivering Value Management Group, in order to close the financial gap with a number of actions identified and these were set out in the body of the report. **RECEIVE** **The Board RECEIVED the Report**	
	STRATEGY	
056/21	**Essex Learning Disability Partnership** SBr presented the paper which provided the Board with an update on the development of the Essex Learning Disability Partnership (ELDP). As context SBr explained in 2018 ACE, EPUT and HPFT had formed a partnership (ELDP) with HPFT holding the lead contract. In 2020 it became HPFT and EPUT with ACE staff transferred to HPFT under a TUPE. HPFT is both Provider and Commissioner. In common with both the EoE Collaborative and the emergent Collaborative commissioning in Essex for the provision of specialist LD service is split. Local Commissioners had set out the long-term changes. The key drivers for this were: • Local and national vision for people with a learning disability including those with autism. • Learning from LeDeR reviews	

Action	• Transforming Care • Health inequalities, across Essex as a result of historic commissioning decisions rather than based on the needs of the local population • Lack of integrated services • The need for the development of innovative approaches to service provision and evidence of continuous quality improvement The approach would be co-produced with a clear governance structure in place with the 7 CCGs and would have a more integrated approach. There were 4 priority areas for 2021/22; Health Checks, Support Register, Frailty and Health co-ordination. Risks identified were Bed Review, stranded costs and the need for significant capital to support the unit. Recruitment to the nursing posts remained a challenge. SBr concluded reporting that commissioners had given positive feedback for the children's service with due diligence in place. Questions were invited. CD acknowledged the good work with the new ways of working and the positive feedback from Commissioners stating that it was d be key for the Bed Review to be part of the financial modelling and asked if there was an estimated timescale for when we may have this information. SBr agreed stating that progress in this had not gone at the pace expected. CD requested this was brought back for discussion at FIC. ABa questioned who was involved in the partnership with SBr providing assurance that the local authorities, voluntary sector and commissioning teams were all very involved. **The Board RECEIVED the Report**	
	GOVERNANCE & REGULATORY	
057/21	**Report of the Audit Committee held: 27 April 2021** CD presented the Audit Committee report and provided the Board with a summary from the meeting held 27 April 2021. There were no matters for formal escalation to the Trust Board. Focus for the Committee had been on year end. The Committee had held a Deep Dive on the draft Annual Accounts with CD commenting that she had been enormously impressed with the Finance team who had briefed FIC at 9am on the morning of submission to the centre. The Committee had discussed the positive year end with agreement for a 'page turn' meeting to be scheduled prior to sign off. The Committee had received and discussed several progress reports noting the Rostering and SafeCare report, which was advisory and had been a helpful exercise. The Committee received an update on the Safeguarding Audit Report, noting	

	the majority of the management actions related to data recording. CD reported the auditors had split the report so the Committee could see the issues. CD stated that even with the backdrop of Covid RSM had worked with the Trust to continue the internal audits. Issues that had been raised where matters of compliance rather than design. It was noted that KPMG had completed their interim audit work and no significant findings had been identified. The annual accounts meeting was scheduled for the 10 June 2021. CD reported that herself, HE and PR met before and after each Committee. An additional meeting to be held in July may be required. **RECEIVE** **The Board RECEIVD the report**	
058/21	**AOB** TC reported that Nick Carver, CEO at East & North Herts Trust had announced his retirement. SBe recorded a formal thank you to KL noting this would be his last Public board before his retirement and commenting that his departure would be a huge loss to the Trust. No further items of business were put forward.	
059/21	**Questions from the Public** No members of the Public were present.	
060/21	**Date of Next Meeting** The next Public meeting is scheduled for 29 July 2021 *Annual Accounts 10 June 2021	

Close of Meeting

Hertfordshire Partnership University NHS Foundation Trust

Minutes of the PRIVATE Board of Directors Meeting
Held on Thursday 10th June 2021
11:00 – 12noon
VIRTUAL

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Sarah Betteley | SBe	Chair
David Atkinson | DA	Non-Executive Director (from 10:30am)
Catherine Dugmore | CD	Non-Executive Director
Patrick Vernon | PV	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
Tim Bryson | TBr	Non-Executive Director
Jon Walmsley | JW	Non-Executive Director
Kush Kanodia | KK	Associate Non-Executive Director
EXECUTIVE DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Paul Ronald | PR	Director of Operational Finance
Keith Loveman | KL	Deputy CEO & Director of Strategic Finance
Dr Asif Zia | AZ	Director, Quality & Medical Leadership
Karen Taylor | KT	Director, Strategy and Integration
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Dr Jane Padmore | JPad	Director, Quality and Safety
IN ATTENDANCE	
Jane Twelves | JT	PA to Directors (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Maria Wheeler | MW	Deputy Director of Finance
APOLOGIES	
Diane Herbert	Non-Executive Director

Item	Subject	Action
	Welcome and Apologies for Absence SBe welcomed all to the meeting. Apologies for absence were received from Diane Herbert and Dr Asif Zia.	
	Declarations of Interest The Declarations of Interest were reviewed and agreed as an accurate record.	
	Annual Reports 2020/21 **a) Use of Corporate Seal** Board received a report setting out the use of the Trust's Corporate Seal. During the reporting period 1st April 2020 to 31st March 2021 there were 8 transactions; 7 relating to leases and 1 which relates to a Partnership Agreement. At an earlier meeting, Audit Committee had discussed the report and recommended approval by the Board. **The Board noted and approved the report setting out the use of the Corporate Seal.** **b) Use of Waivers** Board received a report detailing the use of the Waivers for the financial year 2020/21. During the reporting period 1st April 2020 to 31st March 2021 there	

	were 44 Waivers totalling £1,660K. In all instances a comprehensive review was undertaken to ensure the use of the Waiver does not compromise value for money. Audit Committee highlighted that 5 Waivers were authorised for purchase that exceeded £100K; two of which were COVID related where timescales were imperative; two were granted on specialist expertise and the remaining one was on continuity. CD assured the Board that the quality and reasons for Waivers has greatly improved. It has been an exceptional year and clear reasons have been set out for the use of Waivers. Audit Committee recommended the report was approved by the Board. **Board noted the report and approved the report detailing the use of Waivers.** **c) Losses and Compensation Payments** The Board received a report presented to Audit Committee on 10th June 2021 providing a summary of Losses and Special payments for the year 1st April 2020 to 31st March 2021 in line with the annual accounts process. Audit Committee noted there had been Losses and Special payments totalling £7,531 and following discussion, approve the report and recommend the write-offs to the Board. **The Board the noted and approved the report.** **d) Treasury Management** As part of the final accounts process and in accordance with the Treasury Management Policy a report on treasury management was presented. The Board reviewed the Treasury Management summary for 2020/21 and in particular; 1. How the favourable cash flow arrangements implemented by NHSE during COVID led to a significant reduction in the PDC dividend amount due. 2. The current situation where there is no opportunity to invest surplus cash other than within the government banking facilities which currently offer zero interest. 3. Strong cash balances will support the current OBC being finalised for the building of the new 54-bed inpatient unit. PR reported that the Trust has continued with positive performance through a difficult year. At an earlier meeting, Audit Committee discussed and noted the clear summary setting out the cash balances and that there had been no variation in how the Trust continued to pay suppliers during the year. Audit Committee recommended the report for approval by the Board. **The Board approved the Treasury Management Report.**	
	Annual Accounts 2020/21 **a) Draft Annual Accounts** A briefing meeting had been held with Non-Executive Director colleagues to review the Draft Annual Accounts on 7th June 2021, at which set out the background to the numbers was provided and questions were answered. PR reported that the Audit Committee has received regular presentations throughout the year; it had been an exceptional year and in relation to the financial accounts has seen in particular; • The Trust has met its financial control total • Available capital has been invested appropriately • There is sufficient cash to meet future requirements • The Trust has grown over the period with income growth over 7%	

PR reported that the accounts have been prepared in a consistent way as in other years. Under the rules of a Foundation Trust we are able to utilise our cash in an appropriate way.

CD advised that Audit Committee fully endorsed the summary of accounts and there were no specific items to be highlighted, she added that it was important to look at the accounts in context of overall performance and activity against the Annual Plan and confirmed Audit Committee recommended the accounts were approved by the Board. SB commended the hard work undertaken.

The annual accounts were approved by the Board.

b) Internal Audit Annual Report

i) Head of Internal Audit Progress Report

The Board received a short progress report and noted the positive opinion for 2020/21 internal audit. PR reported that RSM had managed to deliver a full Internal Audit programme in the year and have been working flexibly with teams. CD advised that in terms of the opinion, this is the same level of assurance as in previous years. RSM have acted as effective partners giving advice where needed especially in terms of the interim governance arrangements. RSM's overall perspective is that the Trust is doing well against its peers and whilst there are 16 overdue actions the Audit Committee were assured these would be picked up via the interanal processes and there would be further focus at the audit Commitee in July.

Board noted the Head of internal Audit Progress Report.

c) External Audit

i) Report of our Findings to the Audit Committee (ISA 260 Report)

The Board received the year-end report from KPMG and whilst the audit is not 100% complete, it is proposed that the Trust will receive an unqualified opinion. It was reported that following receipt of the draft financial statements KPMG had noted the significant increase in the Trust's accruals and deferred income balances and these were tested to verify existence and accuracy. It is expected that an unmodified Auditors Report on the financial statements will be issued and no significant weaknesses in arrangements to secure value for money were identified.

MW confirmed there had been regular contact with the external Auditors this year with regard to key areas;

- Valuation of Land and Buildings – KPMG advised that audit procedures had identified a number of adjustments to the land and buildings valuation due to incorrect measurement data or location being adopted by the valuer. It was agreed that it would be helpful to have a fixed asset register that would help with data.
- Revenue Recognition - A material increase in deferred income balance was identified and following testing one transaction was incorrectly recognised. This was reclassified and moved into payables.

CD reported that the report was positive and confirmed Audit Committee will pick up progress on management actions through the year.

Board noted the report.

ii) Management Representation Letter

At the earlier Audit Committee, the draft Management Representation letter was reviewed noting it was a standard format. Audit Committee recommended the letter for approval by the Board.

The Management Representation Letter was approved by the Board.

iii) Annual Report

The Auditors Annual Report provides a summary of the findings and key issues arising from the 2020/21 Trust audit and the report is prepared in line with the requirements set out in the Code of Audit Practice and will be published by the Trust alongside the annual report and accounts.

The following was highlighted;

- Accounts – An unqualified opinion on the Trust's accounts will be issued 14th June 2021; this confirms that KPMG believe the accounts give a true and fair view of the financial performance and position of the Trust.
- Annual Report – No significant inconsistencies between the content of the annual report and KPMG's knowledge of the trust were identified. KPMG also confirmed that the Governance Statement had been prepared in line with DHSC requirements.
- Value for Money – KPMG did not identify anything to report and the overview of the Value for Money work confirmed there are no weaknesses.

Board noted that the report would need to be submitted by September and would be shared with the Council of Governors and be uploaded onto the website.

Board approved the Auditors Annual Report.

iv) Opinion

KPMG had presented their report on the audit of the financial statements at the Audit Committee and advised that the Trust was issued with an unqualified opinion for the Annual Report and an unqualified opinion against Value for Money. Board were requested to note the report.

AB highlighted a typographical error to be amended on P176 of the pack under Identifying and responding to risks of material misstatement due to fraud; bullet point 4 – this should read "Using analytical procedures to identify any unusual or unexpected relationships". KPMG agreed to amend the final document.

Board noted the opinion issued by KPMG

d) Draft Annual Report including Annual Governance Statement

HE presented the Draft Annual Report including the Annual Governance Statement for 2020/21. Audit Committee had reviewed the content and endorsed the report for approval to the Board.

The draft report has been reviewed by KPMG who also confirmed they are happy with the completeness of the disclosures detailed. The report sets out the challenges throughout the year related to the Pandemic and beyond. It also highlights the Trust achievements and in particular receiving HSJ award as Mental Health Trust of the Year. It also emphasises significant issues of concern in line with both RSM and KPMG. Overall it is a fair and balanced account of the year.

	TC gave an overview of the work undertaken across the organisation stating the Trusts controls and governance had been robust. He noted that the final sentence stating that no significant control issues had been identified underplayed the amount of work undertaken to ensure robust governance was a credit to all teams. **Board endorsed and approved the Annual Report.**	
	Audit Committee Annual Report 2020/21 CD presented the Annual Report of the Audit Committee for 2020/21. The report outlines how the Audit Committee has complied during the financial year with the duties delegated to it by the Trust Board. During 2020/21 Audit Committee has considered a wide range of issues as well as its compliance requirements and has sought assurance with regard to areas of risk identified through review of the Board Assurance Framework and Trust Risk Register. CD also highlighted the Trusts response to the Pandemic and the work undertaken to help partners. It was agreed that the report provides a balanced summary of the work of the Committee during the year. CD thanked KL for all his support and responsiveness to changes and developments enabling the Committee to move forward. **Board approved the Audit Committee Annual Report 20/21.**	
	Any Other Business The Board acknowledged it was KL's last meeting before retirement. He was thanked for his work and support across the organisation. It was also the last presentation of Annual Accounts by PR; Board noted the excellent work by the Finance Team and the support of PR and formally thanked both KL and PR. There has been lots of fantastic work and really strong governance in driving the organisation to meet the challenges during an extraordinary year. CD was thanked for ensuring the Audit Committee continued to provide strong oversight in the systems of control during the pandemic.	
Date and Time of Next Meeting: The next meeting is scheduled for 29 July 2021		

Close of Meeting

Agenda Item 5

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 29 July 2021

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
20/5/21	**13**	Essex LD Partnership	FIC to consider risk associated with delayed bed consolidation in LD services in Essex		SBr	September 2021	A
20/5/21	**13**	Essex LD Partnership	Consider scheduling of future updates on Essex LD Partnership	Completed	HE	July 2021	G
20/5/21	**8e**	Service User Experience Report	Consider refining benchmarking date for SU Experience Report	Revised paper considered by July IGC meeting	SBr	July 2021	G
20/5/21	**6**	CEO Brief	Circulate F2SU Annual Report to Chair	Completed	KW	21 May 2021	G
20/5/21	**6**	CEO Brief	EoE Provider Collaborative Board – formal report to be presented at a Public Board		SbR	July 2021	G
20/5/21	**6**	CEO Brief	Report on the Niche demand modelling to be presented to a future public board	On the agenda	KT	July 2021	G
20/5/21	**5**	Matters Arising WLR Action Plan	HE to amend and finalise WLR action plan		HE	21 May 2021	G
20/5/21	**4**	Minutes of meeting held 29 April 2021	Amend and finalise minutes held 29 April 2021	KW has amended the minutes and saved as approved	KW	24 May 2021	G
29/4/21	**16**	Well Led Review	Confirm NED buddying	Final review to be completed in September	SBe/TC	June 2021	A
29/4/21	**16**	Well Led Review	Board to receive updates on WLR Action Plan		HE	September 2021	A

Board of Directors PUBLIC

Meeting Date:	29 July 2021	Agenda Item: 6
Subject:	CEO Briefing	
Presented by:	Tom Cahill, Chief Executive Officer	

National update

There is a significant level of activity nationally which is summarised below:

COVID-19

Nationally, over recent weeks the number of positive cases and hospitalisation rates has seen a significant rise, with the emergence of Variants of Concern. The lockdown restrictions were eased on 19 July 2021 but there were no changes to requirements in health and care settings. The vaccination programme continues with all people over 18 being invited. It is noted that everyone needs to remain vigilant and to ensure they adhere to social distancing and testing. The impact of the population being contacted by the Test and Trace system is being felt in all sectors of society and is being closely monitored in terms of impact on delivery of services in the NHS. There has also been recent national guidance to reduce the need for critical staff to self-isolate, within very clear parameters.

Health and Care Bill

On 6 July the Health and Care Bill was published. It follows proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in autumn 2019. It builds on the Integrating Care consultation and Department of Health and Social Care's (DHSC's) Integration and Innovation white paper published in February this year.

The majority of the Bill is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also formally merges NHS England and NHS Improvement, and gives the secretary of state a range of powers of direction over the national NHS bodies and local systems and trusts. Other measures proposed include putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; a new legal power to make payments directly to social care providers; the development of a new procurement regime for the NHS; and a new duty on the secretary of state to report on workforce responsibilities. An appendix is attached that provides more detail.

System Architecture

NHSE/I continue to publish guidance to support the changes to system working. In late June NHS England and Improvement (NHSE/I) published its final System Oversight Framework 2021/22 https://www.england.nhs.uk/nhs-system-oversight-framework-2021-22/ which was accompanied by the new oversight framework metrics. It sets out what trusts, CCGs and integrated care systems (ICSs) will be measured against. There are some changes in the final framework compared to the consultation document relating to autonomy for well performing trusts and the eligibility criteria for the financial performance for some trusts.

The oversight metrics are across domains of quality, access and outcomes; preventing ill health and reducing health inequalities; Leadership and capability; People and finance and use of resources.

National Leadership
Since the last Board meeting a new Secretary of State for Health Sajid Javid has been appointed. The appointment of the new NHS Leader is still underway with the interviews taking place in July.

NHS Birthday
The month of July saw the 73rd birthday of the NHS. It was marked by the NHS being awarded the George Cross with a personal message from the Queen. The award recognises all NHS staff past and present across all disciplines. The birthday was marked with a service of thanksgiving and commemoration at St Paul's Cathedral today. It was a very special occasion and the George Cross award made it even more poignant, particularly as it's only the third occasion it has been awarded to a collective body, country or organisation, rather than an individual

Mental Health Act
The government published its response to the Reforming the Mental Health Act White Paper consultation following a fourteen week public consultation. The government has confirmed it is taking forward a significant number of the proposals including: the introduction of four new guiding principles, increasing the frequency of automatic referrals to the Tribunal and the creation of the nominated person statutory role. The government will also seek to give appropriate powers to health professionals so that people in need of urgent mental health care can stay on an accident and emergency site pending clinical assessment.

Work will continue on developing a Bill to reform the Act and it will be brought forward when Parliamentary time allows. At the moment, we understand the government is aiming to undertake pre-legislative scrutiny at the end of this year and introduce the Bill at the start of the 2022 spring parliamentary session.

A new Act on its own will not be enough to improve how and where good quality mental health services are accessed. It is recognised that successful implementation of a new Act, and changes to policy and practice more broadly, requires an expansion of the mental health workforce and additional funding. Proposals that require additional funding continue to be subject to future funding decisions, including at the Spending Review 2021.

Consultation on new Mental Health Access standards
On 22 July NHSEI announced consultation on proposed new MH access standards for consultation.https://www.england.nhs.uk/2021/07/nhs-england-proposes-new-mental-health-access-standards/

The proposed new standards relate to: 'urgent' referral to a community based mental health crisis service; 'very urgent' referral to a community based mental health crisis service; patients referred from Accident and Emergency to mental health liaison (adults and children and young people); the starting of care following referral.

The new proposed standards come on top of existing measures of mental health access which relate to: Improving Access to Psychology Therapies (IAPT); first episode of psychosis and children and young people referred for assessment or treatment for an eating disorder.

The Trust will consider the proposals and respond to the consultation in line with the required timescale of 1 September 2021.

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.

ICS
The ICS Partnership Board meeting took place on 20 July 2021. The meeting received a detailed presentation of the Hertfordshire and West Essex ICS Mental Health COVID Recovery Plan, which

included a review of the impact of the COVID pandemic on the expected future population MH/LD need and anticipated demand on services. The Board will later consider a report on the Recovery Plan.

The meeting also spent some time discussing the plans for establishing in the ICS. In particular the meeting looked at ICS priorities and outcomes; the establishment of the Partnership and Board; development of Place, including accountability and associated governance and models for developing of Provider Collaboratives. The conclusion of this session agreed next steps for each element of the work to ensure the ICS is on track to go live with shadow ICS arrangements from quarter three and develop an agreed high level plan to support statutory establishment in April 2022.

It was noted that the outcome of discussion of changes to boundaries have been concluded and there will be no changes to the boundaries for Herts and West Essex ICS and other ICSs in the East of England. The process for recruiting the ICS chair and CEO is underway and aims to be completed by end of September.

South West Herts Health and Care Partnership (SWHHCP)
SWHHCP have focused on progressing Partnership development and setting their ambition for the next 18 months. This has included finalising the interim governance arrangements and developing the Shadow Partnership agreement. The SWHHCP intend to continue early discussions with the ICS on future arrangements, both during transition period and in final form.

Key developments within the SWHHCP Transformation priority areas are the draft Health and Care Strategy, which will now be refined and tested with patients and other stakeholders, with a plan to finalise in quarter three. Additionally the business case and implementation plan for the Virtual Hospital are in progress, with a planned implementation date of November 2021. Other priorities are the respiratory pathway, diabetes service, Children and Yong people and frailty.

East and North Health and Care Partnership
East and North Partnership continues to focus on transformation priorities alongside exploring the current and future capabilities and capacity required for the transition period and for full maturity. A Memorandum of Understanding is in draft form and is awaiting signature from a number of partners. Whilst taking some initial steps to explore potential future operating models, and governance arrangements ENHCP are continuing to focus on delivering transformation and developing the “best fit” structure around this to inform their way forward and the wider ICS system evolves.

Other areas that are being progressed are the in relation to both Community and Staff Engagement, with an initial Community Assembly taking place in August and wider staff engagement events planned for quarter three onwards.

A health inequalities workstream has been established, and an action plan is in development. Key inequalities for the SMI and LD populations have been identified, such as poorer outcomes in the respiratory pathway and work is now evolving to take this forward in Partnership. This will provide a good opportunity to explore the interface and relationship between the MHLD Collaborative and the Place-based Partnerships.

Hertfordshire Mental Health & Learning Disability (MHLD) Collaborative
The MHLD Collaborative continues to focus on delivering the transformation priorities alongside planning a strategic response to meet future demand. As the Collaborative enters the next phase of Partnership development, focus has been on gaining a collective understanding of current system pressures and priorities across the statutory health and social care and VCSE sectors. The Hertfordshire Mental Health Strategy 2021-26 is currently being coproduced, setting out ambitions to improve outcomes for people with mental illness, as well as contributing to overall population emotional and mental wellbeing. This strategy has a broad preventative and public health focus, shaped by the recommendations in the COVID Recovery Plan (Niche). The Public Consultation will commence in August, during which time stakeholder engagement events will continue, with a plan for final sign off in December by the Collaborative Board.

Immediate areas of focus for the next three months include

- Continuing the LD and SMI vaccination programme – positively vaccination of both groups are tracking above national averages.
- Responding to significant CAMHS demand with the development of a CAMHS liaison and paediatric liaison service.
- Recruiting to and mobilising the Additional Mental Health roles in Primary Care for East and North Herts and Herts Valley for 2021/22, implementation planned for October.
- Initiation of Autism Phase 2 pathway development

In the next period the Collaborative will also seek to further strengthen the governance structures underpinning the Partnership Board and, in the context of the broader ICS development, will also continue to explore future commissioning and governance arrangements, and seeking to finalise the Memorandum of Understanding and draft Partnership Agreement.

East of England (EOE) Provider Collaborative – New Care Models

Following approval by the six partner Boards, the Provider Collaborative went live on 1 July 2021. As the Lead Provider for CAMHS T4 and clinical leads for Forensic LD, the Trust will now be taking forward a programme of accelerated service transformation across the region in collaboration with partners and other stakeholders. Service users, parents and carers will continue to play an integral role in developing associated implementation plans and assessing the delivery of the programme outcomes. Due to this increased focus on transformation, the internal oversight arrangements have been reviewed, with the establishment of a New Care Model steering group and the appointment of the Executive Director of Service Delivery and Experience/Chief Operating Officer and the Managing Director- Learning Disability and Forensic SBU to undertake lead strategic roles. HPFT has delegated commissioning responsibilities to the newly formed collaborative Transformation and Commissioning Team, so that delineation from the Trust's provider responsibilities can be demonstrated.

Scrutiny attendance

The Trust attended the annual quality scrutiny by Hertfordshire Scrutiny Committee. The scrutiny was of NHS providers delivering services to Hertfordshire residents and concentrated on the impact of COVID-19. The Trust was one of four trusts scrutinised and was represented by Karen Taylor, Deputy CEO and Executive Director of Strategy and Integration, Dr Jane Padmore, Executive Director of Quality and Safety, Prof Asif Zia, Executive Director of Quality and Medical Leadership.

Feedback from Hertfordshire Scrutiny Committee was that the Trust provided a helpful report, responded well to questions on the day and there were no significant areas of concern. Following the day the Trust has been asked to provide further information on two areas: EMDASS and information on the engagement with patients and carer.

The Trust also attended a full meeting of the Hertfordshire Scrutiny Committee on 21 July 2021. The meeting received an update on the business case for inpatient beds in East and North Hertfordshire and in particular considered what the consultation requirements may be. The Committee supported the submission of the business case to NHSE/I and that a consultation should take place but were in agreement that, based on the level of engagement to date, a shorter period of consultation was acceptable.

Local Leadership Changes

It has been announced that Nick Carver, Chief Executive of East and North Herts Trust will be retiring at the end of the year. Adam Sewell-Jones has been announced as the new Chief Executive. He is currently chief executive of Newham Hospital and Group Director at Barts Health NHS Trust. Prior to this he was deputy chief executive at Basildon and Thurrock University Hospital NHS Foundation Trust and has had senior executive roles at NHS Improvement.

Jo Fisher has been appointed Director of Children's Services at Hertfordshire County Council following the retirement of Jenny Coles.

Trust-wide update

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

Operational update

Operational services continue to experience high levels of demand and acuity and complexity.

Children and Adolescent services remain an area of significant concern given the number of young people who continue to wait for access to specialist beds, in particular Eating Disorder beds. The Mental Health and Learning Disability Collaborative are continuing to lead on the four key actions that are looking at alternative ways to support young people waiting for beds in Acute Trusts and ultimately to provide alternatives to admission. The Trust is working closely with system partners, including Acute and Community Trust and Primary Care colleagues to develop a new model for paediatric liaison, that will include Matron and a support worker team based in the Acute trusts. It is anticipated the ICS will provide financial support. To support this cohort of service users we are continuing to integrate and to explore the development of an integrated pathway in the community including paediatric, mental health and dietetic input.

The CAMHS community eating disorder team continue to experience a high level of demand with over 100 young people now on the waiting list. Recruitment continues for additional posts that have been funded.

Demand for acute mental health beds has remained consistently high. To secure additional capacity a contract in partnership with a provider from the independent sector is being finalised. This will see the Trust have access to 10 additional beds from 1st August. There is currently a focus on bed flow and in particular the acute assessment pathway and links with Swift Ward. Using CQI methodology and building on the actions from the Clinical Summit the team are looking at ways to improve bed- flow.

Community services are under pressure with increased caseloads across a number of services : adult and CAMHS by 6%, Perinatal by 30% Adult Eating Disorders by 17% and CAMHS Eating Disorders by 30%. These are being closely monitored and are being reviewed alongside service hotspots, due to high levels of vacancies and some level of sickness. The management teams are actively triangulating and analysing of the information regarding the hotspots to ensure there is a clear understanding of the issues and to support the implementation of prompt mitigating actions. The reports on performance and the Annual Plan later on the agenda will cover the detailed aspects of this.

COVID-19 Update

Up until recently the number of service user inpatient cases has been at zero confirmed cases, but recently we have reported two cases. The number of cases for community service users has risen, reflecting levels of COVID circulating in the community. We are aware of rising community transmission and an expectation that COVID positivity will likely peak in Hertfordshire by the end of August. Oversight of the Trust's response is maintained through the incident command structure and through the COVID-19 risk register which, although streamlined continues to operate 7 days a week.

The number of confirmed trust staff cases has continued to remain in low numbers, however there has been a steady increase in the numbers of staff having to self-isolate / work from home due to family member contact or confirmed positive family cases. Services have reviewed the business continuity impact of staff having to self-isolate.

Whilst many restrictions are being lifted nationally on the 19th July, a number of important controls remain in place within the Trust including individual and environmental risk assessments and twice weekly Lateral Flow testing. This includes continued use of masks for staff and visitors in Trust work places. Incident command and CPAC have reviewed options for changing restrictions to mask

wearing and have concluded to make no changes at the current time which is in line with NHS current IPC guidance.

Changes are planned with regard to the NHS staff asymptomatic COVID-19 testing programme (Lateral Flow Testing) following development by Test and Trace of a national system to enable staff to self-report their results. This will see implement of the 'pull' model and the rollout of the national ordering and reporting systems to NHS staff. Staff will be able to order their own tests and organisations can choose whether to continue with their internal method of reporting results as per current practice, or whether to direct staff to reporting on the gov.uk website going forward. NHSE/I have set out their expectation that Trust Boards are sighted on a monthly basis on organisational compliance. It is proposed that this is monitored as part of IPC Board Assurance Framework which will be reported through the Integrated Governance Committee.

Our People

At the end of June, our vacancy rate increased to 11.74%, compared to our target of 10.5%, as a result of an increase in the establishment due to the creation of the new Trailblazer team within our CAMHS service. Our unplanned turnover rose to 10%, which is above our target level of 9%.

We have seen sickness absence increase to 4.83 % in June, compared to 4.68% in May, which is above our target of 4%. We continue to implement our wellbeing programme, with a range of virtual wellbeing activities offered to staff, such as exercise, craft, mindfulness and healthy eating. In addition, we held further support sessions for staff with long covid and staff affected by the continuing crisis in India. We also launched sessions for staff on 'Menopause and Me' and training for managers on supporting staff through menopause.

Our appraisal compliance has increased to 89% as at the end of June, compared to 84.3% in May and our target of 95%. Our statutory training compliance has increased to 91% from 89% in May, whilst essential training has increased to 83% from 81% in May, both against a target of 92%. We continue to implement our comprehensive recovery plan to ensure training reaches compliance swiftly following the impact of the pandemic during quarter three and four of last year.

During June, we continued to support leadership development through our Senior leaders Forum, training sessions on Compassionate Conversations, Management Fundamentals and Coaching as a Management Style. Applications for the eleventh cohort of our leadership academy also opened during June. The aim of the Leadership Academy is to identify and develop leadership talent at all levels within the organisation to ensure we continue to deliver great care and great outcomes for our service users, carers and their families and a great working experience for our staff.

We held two celebration events for our Inspire Award winners during June. The stories behind the contributions of our 37 worthy award winners made for, yet another, incredibly proud moment and an emotional event celebrating how our people go the extra mile and embody our values to provide outstanding care. The People and OD report later on the agenda provides more detail, in particular will pick up service and recruitment hotspots.

Finance 2021/22

Trust is reporting being on plan for the month of June and the year to date. The figures are driven by increased income in year which has been offset by increasing pay costs and continued pressure against external bed costs. Pay costs have increased in month across all types of pay spend, with substantive and bank due largely to additional enhancements in month, and agency due to high usage in Essex LD and Norfolk services. Trust expects to be on Plan for Half 1. With regard to Half 2 there is a degree of less certainty due to lack of information with guidance expected in September but level of confidence that this will also be on plan.

Senior Team

The process to recruit a new Chief Executive Officer has started following Tom Cahill's announcement to stand down from the role. The recruitment process is expected to be completed by the end of August 2021.

Governance

The Election process for the Governors is complete with the results announced on 9 July 2021. The elections have resulted in appointment of thirteen new Governors, who will start in post on 1 August 2021. A huge thank you goes out to Governors whose terms come to an end at the end of July 2021. There is a Governor welcome session planned for first week in August and a half day induction in early September.

The Trust held its Annual General Meeting on 21 July 2021. The meeting provided an overview of past year, including the annual accounts and highlights of the year. It was held virtually and was attended by 90 people. It provided an opportunity to describe the work of the Trust over the past year and also hear feedback and questions from the public.

Tom Cahill

Hertfordshire Partnership University NHS Foundation Trust

Appendix 1.

NHS Health and Care Bill
July 2021

1. Introduction

This paper provides a summary of the key proposals relevant to the Trust from the recently published Health and Social Care Bill 2021. Included is a link is to the On the Day Briefing from NHS Providers which provides further details nhs-providers-briefing-health-and-care-bill.pdf (nhsproviders.org)

The Health and Social Care Bill 2021-22 builds on the NHS Long Term Plan (2019), the *Integrating Care* consultation and the White Paper *Integration and innovation: working together to improve health and social care for all* (2021). The Health and Care Bill 2021-22 was introduced in Parliament on 6 July 2021 and had a second reading on the 14th July 2021.

Guidance will be issued in support of the Health and Social Care Bill which will provide further, more granular, details on how the Bill is to be interpreted. The Bill provides an enabling environment, with the guidance likely to reduce the scope for local interpretation.

2. Moves towards integration

The proposed legislation will see a move away from competition that was enshrined in the 2012 Act towards one of joint working, as envisaged in the NHS Long Term Plan (2019).

Whilst there are changes in compulsory competitive procurement, other areas including non-clinical will remain subject to the Public Contract Regulations 2015 rules. However, NHS England in 2019 spoke about a duty to collaborate, the Bill refers to a "duty to co-operate" but it is not clear what the significance of this change in wording is. Future guidance may clarify the definition of this change.

3. System working

The legislation brings on a requirement across levels to be mindful of the triple aim of:

- The health and wellbeing of the people of England.
- The quality of services provided or arranged by relevant bodies.
- The efficiency and sustainability of resources used by the relevant bodies.

However, the above does not need to be considered when making decisions related to services provided to a particular individual.

The Bill will allow Integrated Care Boards (ICBs) and NHS providers to form joint committees, or multiple providers, to make joint arrangements and pool funds. This could give rise to a range of governance and contracting structures and it is therefore important that we look to engage with the emerging ICB to develop structures suitable for mental health and learning disabilities.

4. Integrated Care System to be put on a statutory footing.

The Bill sees ICSs put on a statutory footing. Each ICS will have two component parts:

a) An Integrated Care Board (ICB) which will commission and oversee NHS services and will be held responsible to NHS England for spending and performance. A minimum requirement is to have a Chair, Chief Executive, and NHS provider representative, a primary care representative and a local authority representative. The ICB will be tasked

to develop a 5 year annual plan, to be updated annually and will take on the commissioning functions and duties of CCG. The CCGs within the system footprint must consult with relevant parties and propose the first ICB constitutions.

b) An Integrated Care Partnership (ICP) which with a wider range of partners is charged to develop an integrated care strategy to address broader health and social care needs of their local population and there is a requirement for local authorities and the ICB to have regard to this when creating a joint local health and wellbeing strategy.

The Bill formally seeks the abolition of Clinical Commissioning Groups on the same day as NHS England's duty to establish ICBs commences with the property, rights and liabilities being transferred either to an ICB or to NHS England. It is likely that there will be a period of transition with the change in structures which may impact the speed of progress.

ICB duties include improving the quality of services, reducing inequalities in access and outcomes, promoting education and training, enabling choice, promoting patient involvement, promoting innovation and research, promoting integration between health social care and wider services. ICBs will also commission primary care. NHS England will conduct a performance assessment of each ICB each financial year and have powers of direction over the ICB.

The Chair of the ICB will be appointed by, and may be removed by, NHS England with approval from the Secretary of State, but with no specific mention of input from system partners.

NHS Providers (see link) suggest that dependent on the make up of the ICB and ICP there could be an inappropriate imbalance which could undermine the principle of equal partnerships. They also point out that ICPs being established as joint committees rather than statutory organisations means that the duties and liabilities that could come from them lie with the individual members of the ICP, which could cause a conflict of interest.

The Bill will make it easier for ICBs to commission services collaboratively with other ICBs and system partners by permitting a wider set of arrangements for joint commissioning, pooling of budgets and delegation of functions.

5. **The end of NHS Improvement and a formalisation of its merger with NHS England.**
The Bill seeks to abolish Monitor and the Trust Development Authority (NHS Improvement) and merge their role with NHS England.

NHS England will have a duty to have regard to the likely effects of making any decision to exercise its functions on:

- Health and well-being of the people of England
- Quality of services provided, changes to prevention, diagnosis or treatment.
- Efficiency and sustainability across the NHS

This duty applies to ICBs and Trusts.

Clause 5 and 19 requires NHS England and ICBs to involve patients and carers in consultations. NHS England will have the power to appoint the Chair of a Trust replacing the Secretary of State's power, similarly NHS England rather than the Secretary of State with the consent of HM Treasury, may set financial objectives for trusts.

6. **Healthcare Safety Investigation Branch**
The Bill puts the Branch on a statutory footing.

7. **Powers of the Secretary of State**

The Powers of the Secretary of State proposed in the White Paper may have been extended with the Secretary of State being given powers to intervene earlier in service reconfigurations with Ministers being required to be informed of all service changes, including temporary ones due to operational pressures.

Powers of direction. The Bill proposes to break the link between the setting of the Mandate for the NHS, whereby Ministers seek to set the objectives that NHS England has to seek to meet, and the annual financial cycle allowing the Secretary of State to set a Mandate at any time. Breaking the link may lead to changes of direction after the annual planning and budgeting round have been completed.

The Secretary of State will have the power to direct NHS England in relations to their functions.

The Bill provides powers for the Secretary of State to transfer or delegate functions between specified arm's length bodies, with the power to abolish them should they become redundant as a result of any transfers.

There is a new power to allow the Secretary of State to direct NHS England to use payments to it for the purpose of integration and to direct how such payments may be used.

The Secretary of State has the power to veto any proposal from NHS England on the commissioning of specialised services and will have the power to prescribe a service if they deem it appropriate for NHS England, or someone acting on NHS England's behalf, to commission it.

8. Workforce Planning

The Secretary of State will be under a duty to publish at least once every five years a report describing the system for assessing and meeting the workforce needs for health in England**.** The Bill, however does not currently propose to develop long-term workforce projections

Changes to tariff have long been proposed and England has seen a move from tariff to block payments through the COVID-19 pandemic.

9. **Patient Choice**

Patient Choice is retained even though existing procurement and competition requirements are to be revoked.

10. **Mergers**

Competition and Markets Authority powers over trust mergers are to be removed with NHS England reviewing the proposals to determine whether they are in the best interests of patients and the taxpayer.

11. **Finances**

There is a requirement to meet financial objectives and balance, with NHS England having the ability to set additional and mandatory financial objectives for NHS Trusts and each ICB should seek to break even. NHS England may give directions to an ICB and its partner trusts to ensure that they do not exceed these limits.

NHS England will allocate a single system financial envelope to an ICB.

With the development of system working and new ways of collaborating with associated sharing of risk and challenge this could pose a wider risk to trusts.

12. **Capital Spending**

The Bill provides NHS England with the power to set capital spending limits for Foundation Trusts. This could potentially limit the ability for the FTs to deliver investment programmes, but

this is not certain. This is additional to current arrangements where Foundation Trusts agree their capital programme with the local system.

13. **Payment Scheme**

The legislation increases the flexibilities in the pricing process. Further guidance will be forthcoming. The statutory objections to national tariff which had been through the Competition and Markets Authority will go and NHS England will make its own decisions as to how to proceed.

14. **Other items**

Local Education and Training Boards will be abolished.

The Bill proposes to repeal the procedural requirements which require social care needs assessment to be undertaken by the local authority before a patient is discharged from hospital. It also repeals the provision which allows the NHS to charge a local authority, via a penalty notice, when discharge has been delayed due to a failure to arrange for a social care needs assessment, after having received an assessment and discharge notice.

There is a new duty for the CQC to conduct reviews, assess performance and publish reports on the regulated care functions of local authorities in England on adult social care and providing financial assistance to social care with the Secretary of State setting objectives and priorities for CQC assessments. The Secretary of State may direct an NHS trust or a Special Health Authority to exercise their functions in relation to this financial assistance.

The Bill seeks to enable shared and more effective use of data across the health and adult care system. The Health and Social Care Information Centre will be able to require private providers of health services to provide information it requires to comply with a direction from the Secretary of State. The Secretary of State can also require certain providers of adult social care in England to supply information. The Trust needs to determine how any improved information set can help the understanding of the service users journey along the whole pathway of care so that we can better support future delivery with partners in the Mental Health Learning Disabilities Integrated Care Collaborative

15. **Next Steps**

The Bill has had two readings and moves to the Committee stage.

It is expected that there will be additional guidance to support the Bill

16. **Issues**

The Bill does little to directly address issues with workforce and social care. These are two areas of particular concern across the NHS and which will have a significant impact on service users and NHS future working.

Whilst the Bill provides a wide umbrella for the development of Health and Social Care and will allow some flexibility at local level to determine how care can best be delivered its future success will be strongly influenced by the relationships and trust that exist between the parties involved.

Given the number of actors and the structures that exist at the different levels there will be a challenge to ensure that the multiplicity of strategies and plans that will be developed are aligned on the key themes.

Clarity of accountability in a complex system will need to be established as the systems mature to deliver efficient and effective support and care. With the changes happening at a difficult time for the NHS there could be a risk that developing structures and arrangements are faced with very significant challenges.

Parity of esteem for mental health is not mentioned and given the relative size of providers it is important that the Trust ensures that the voice of our service users and carers are clearly heard and their needs reflected in the strategy and plans.

Given the date of presentation of the Bill the timescales for implementing the results will be challenging.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 8
Subject:	Integrated Governance Committee Report: 15 July 2021	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Diane Herbert, Non-Executive Director, Committee Chair
Presented by:	Diane Herbert, 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 15 July 2021.

Action required:

The Board is asked to receive and note the report.

Summary and recommendations to the Board:

Summary

An overview of the work undertaken at the meeting held on 15 July 2021 is outlined in the body of the report. The Committee did not escalate any items for the Board to consider.

Highlights for the Board to note are:

1. The Committee members further noted that a review of the Disciplinary Policy was being undertaken in line with the Trust's usual policy review processes, although the existing policy met NHSI/E requirements.
2. Recommendation to the Board to approve the Board Assurance Framework, presented late on the agenda.
3. Assurance was provided regarding the review and closure of management actions from past internal audits relating to People and OD.
4. Reporting that ICO had formally closed the data breach case relating to the board pack, with no further action required.

Recommendation:

To receive and note the report.

Relationship with the Business Plan & Assurance Framework:

Strategic Priorities 1, 2, 3, 4 and 5. and associated Board Assurance Framework principle risks

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 regarding Equality, Diversity and Inclusion.

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

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

Seen by the following committee(s) on date:

Finance & Investment / Integrated Governance / Executive / Remuneration /Board / Audit

None.

1. **Introduction**

1.1 The latest Integrated Governance Committee (IGC) was held on 15 July 2021 in accordance with its terms of reference and was quorate. The meeting welcomed new members, Janet Lynch, Executive Director of People and OD and Bina Jumnoodoo, Interim Deputy Director of Nursing.

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

2.1 People and OD Group
The Group received a report from the People and OD Group meeting held on 1 July 2021.

The Committee noted the progress regarding the People plan, particularly the monthly report on workforce metrics. The Group had received the refreshed draft Recruitment and Retention Strategy, which had involved a wide range of stakeholders. There was also an update on the workforce planning work with SBUs.

A short update paper on HEE Workforce Development and CPD funding for 2021/22 was considered. The Group considered a paper on Respect Training and noted the efforts by the patient safety and workforce teams to mitigate some of the risks. It was recognised that despite the mitigations, this remained a high-risk area, and it was agreed to ensure that the Trust Executive were fully aware of the current challenges.

An update was provided on the communications and support offered to staff who needed to apply to the EU Settlement Scheme to continue living and working in the UK after 30 June. It was noted that there were now no staff with outstanding applications. The Group had received the Gender Pay Gap (GPG) report for the period ending March 2020. The meeting noted the report and the reduction in the percentages from March 2019.

It was reported that PODG had an update on people practices, linked to correspondence from NHSI and NHSE, which asked Trusts to undertake actions to ensure that HR policies and processes were compassionate, supportive and inclusive. It was noted that the PODG had discussed the Trust's response to the requirements in April 2021 and had considered an overview of plans, which included a full review of the Trust's Disciplinary Policy and work on "Just and Learning Culture".

In April, the PODG noted that all steps set out in the correspondence were in place, including board-level oversight of employee relations data and a decision-making panel responsible for suspension decisions and decisions about cases entering formal disciplinary action. The Committee members further noted that a review of the Disciplinary Policy was being undertaken in line with the Trust's usual policy review processes, although the existing policy met NHSI/E requirements.

The Committee noted the changes to the national requirements for trusts to undertake a quarterly staff friends and family test. The meeting received a draft refreshed Engagement Strategy, in line with NHS People Plan intentions and building on the strategy already in place.

In response to a question from Tim Bryson, it was confirmed that the Trust was involving stakeholders in the development of the workforce plans. Jane

Padmore outline the issues concerning Respect training confirming the priority was being given to staff who had not previously received the training and those working in secure units.

It was agreed that the September Committee would consider a more detailed report on the Gender Pay Gap.

There were not matters for escalation to the IGC.

2.2 Quality, Risk Management Committee (QRMC)
The Committee received a report from the QRMC, which had met on 2 July 2021. QRMC had received an update concerning COVID and incident management.

The QRMC meeting had received a report from West SBU. It set out the work done on the Acute Service Remodelling Project focusing on crisis and inpatient pathways and interface with the community to improve patient flow. The SBU had utilised CQI methodology to improve the use of observations in acute services, reduce restrictive practice and improve the inpatient handover process.

The committee noted that QRMC had received a detailed physical health update report and that CQI workstreams were providing a clear strategy for improvement. QRMC were updated on the simulation suite.

It was noted that QRMC had approved the Complaints, Concerns and Compliments policy. QRMC had reviewed the CQC insight report. It was confirmed that the Insight report is an intelligence report from CQC, shared with the Trust. In response to Patrick Vernon's question, it was reported that the Trust had addressed the two issues it raised.

There were not matters for escalation to the IGC.

2.3 Information Management and Governance Subcommittee (IMGS)
The Committee received a report from the Information Management and Governance Sub-committee. It was noted that the subcommittee received the Annual Information Governance report, which was being considered by IGC later on the agenda.

IGC noted that the committee received an update on the significant backlog of Freedom of Information and Subject Access Requests resulting from the redeployment of resources in response to the COVID-19 pandemic and agreed that a business for additional resources would be developed.

IMGS noted the ratio of reported data incidents compared against the number of breaches reported to the Commissioner and commented on the positive reporting culture in the Trust.

The Committee was updated on the work of IMGS to review the IM&T, and IG risk registers, noting that all risks had been updated in line with their current and agreed review dates. It was noted that no new risks were escalated to the Trust risk register.

IMGS received the May 2021 service report from HBL ICT and noted a decrease in contacts into the service desk. The main themes continue to be remote working, routine account administration and usage of collaboration

technology. During the reporting period, there had been no significant outages or cyber incidents

IGC noted that IMGS agreed to the decommissioning of TrustSpace but that a backup copy of the old TrustSpace will be taken stored securely. In response to Anne Barnard's question, it was confirmed that there had been three requests for information from the decommissioned intranet.

There were not matters for escalation to the IGC.

3. **Deep Dive – MOSSTogether Strategy**

The Committee received a detailed presentation regarding the MOSStogether Strategy. The strategy sets the direction for providing safe and effective services, enabling a positive experience for those who receive our services. It supports and builds upon the previous Making our Services Safer (MOSS) Strategy and supports the implementation of the Quality Strategy.

In particular, it sets out an approach that aims to ensure that safety is at the heart of everything we do to deliver our *Good to Great Strategy* and *Quality Strategy*. It ensures that safe services are provided so that people feel safe whilst receiving our services.

The Committee noted that it had had a 'soft' launch in 2020 owing to the COVID pandemic.

The Committee noted that the strategy has a 'menu' of proactive approaches and methodologies and has shared decision making at its heart. The presentation details a number of achievements that have been made to-date, with key areas of focus moving forwards.

Committee members welcomed the approach outlined in the strategy and presentation. In response to Tim Bryson's question, Jane Padmore confirmed that there are agreed measures linked with reducing harm and lengths of seclusion. Jane Padmore added that it would be beneficial for the culture of safety audit to be redone at the end of 2022. Jane Padmore confirmed that there is service user involvement in the restrictive practice committee.

4. **Governance and Regulation**

4.1 Trust Risk Register

The IGC considered and approved updates to the Trust's Risk register, including recommended changes to grading, new risks and updates concerning the mitigations. It was noted that there were thirteen risks across seven themes.

It was noted that two new risks were added to the register relating to CAMHS Eating Disorders Team demand exceeds capacity and national shortage of specialist CAMHS beds impacting on capacity of FHAU and a risk that service users are not placed in the most appropriate environment. Two risks were reduced relating to staff health and wellbeing and the delivery of services.

A proposal was made to remove the risk 'the implications for the Trust of unforeseen consequences arising from the end of the EU Exit transition

period on 31 December 2020 when the UK and EU's relationship will be governed by what is agreed in the future relationship agreement.'

It was noted that preparation for winter will be considered before the next version of the Trust Risk register being brought to the Board. The Committee agreed the proposed amendments to the register as proposed.

In response to Anne Barnard and Jon Walmsley questions, it was agreed that before the next update of the register, the Cybersecurity risk scoring and parameters would be reviewed. Also, a sense of scale would be provided concerning the risk relating to CAMHS eating disorders.

4.2 Board Assurance Framework

The Committee received an update on the revised Board Assurance Framework (BAF) that is in line with the Annual Plan for 20/21. This report provides an update on the latest iteration of the BAF. This version includes updated controls and lines of assurance together with the most recent dates for the assurance evidence. It also reflects the end of the interim governance arrangements in place for part of 2020 and that management of COVID-19 is part of Business As Usual. It has also been updated to recognise the establishment of the East of England Collaborative and Place Based Partnerships.

It was noted that the BAF would be reviewed during the year to consider the feedback from the Well Led Review. In particular, the dates for actions and RAG rating of assurances would be looked at.

The Board Assurance Framework was approved for recommendation to the Board to approve.

4.3 Bi-Annual Policy Review Compliance

The Committee received an update on the procedural documents for the Trust. It was noted that 86% of the total number of procedural documents had been reviewed and were in date. It was noted that a number of procedural documents expired at the end of June following the ending of the extension to the review date of those that were due in January 2021 or within the following six months. The committee was informed that the overdue reviews are in progress and due to be completed in quarter 2.

Over the reporting period, significant changes were made to a number of policies, primarily in response to the pandemic, best practice, learning from incidents and national guidelines.

5. **People**

5.1 Update on People Internal Audits

The Committee, in response to a request from the Audit Committee, received a report that provided an update on the progress made in relation to outcomes of nine internal audits carried out since 2017.

None of the nine audits undertaken during that period had resulted in substantial assurance, with three achieving reasonable assurance and six achieved partial assurance. In order to build confidence, further work is underway with RSM to provide further assurance against the key themes identified.

The Committee was updated on the management actions from the audits. It was noted that a significant proportion had been closed. The majority of the remaining ones relate to the workforce planning audit and are on track for completion. The Committee took assurance from the report and the work undertaken.

5.2 Quarter 1 Guardian of Safe Working

It was reported that there had been one exception report raised by our trainees and Trust doctors during the quarter, a significant reduction on the last quarter.

Overall, there has been a significant decrease in bank locum spend since the previous report. This results from the re-allocation of vacant LTFT shifts at the rota design stage to reduce rota gaps. In addition, sickness overall has reduced, which is reflected in the reduction of bank locum spend.

6. **Quality and Safety**

6.1 Unlawful detention in Places of Safety

The Committee considered a report that provided an update on the current position regarding the detention of people under Section 136 and where these have become subject to unlawful detention, having extended beyond 24 or 36 hours.

It was reported that during 2020/21, there had been an increase in the overall number of service users whose stay have extended 24 hours (or 36 hours in the case of a relevant extension) and therefore subject to unlawful detention. The emerging theme is that these numbers relate to individuals waiting for a mental health bed rather than any other type of delay. This has coincided with the growth in demand for the inpatient pathway, which has consistently seen out of Trust occupancy above 100% for the last 12 months. It was noted that there is a national context to this position, and HPFT is not an outlier.

The Committee was updated on the actions being taken to address this area of concern related to the service user's experience. The actions are linked with work underway to address the current challenges of flow through the system, the increase in mental health demand, and the longstanding issue of high use of Section 136 in the county.

The high number of unlawful detentions are recorded in the SBU risk register and monitored through the Quality and Risk Meeting and the Trust Risk Register. It was noted that system governance for this is through the Hertfordshire Section 136 Interagency Group, which reports to the Crisis Care Partnership Group and the MH/LD Collaborative Board.

In response to Anne Barnard's question, it was confirmed that every unlawful detention is reported on Datix but is not reported as a Serious Incident. Jane Padmore added that the Trust writes to all people unlawfully detained to make them aware of their rights and right to litigation.

6.2 CQC Update

Integrated Governance Committee received an update on the preparation for the Care Quality Commission (CQC). It was noted that the Trust has been and is currently engaged with the CQC through multiple avenues, including

Transitional Regulatory Approach (the TMA); Infection Prevention and Control Board Assurance Framework; Provider Collaborative Reviews - Essex Learning Disability and Herts and West Essex Children and Young People; Mental Health Act Reviews; Relationship management and regular engagement meetings and Live issues such as whistleblowing, CQC concerns and complaints as well as serious incidents.

The Committee was informed that nationally the CQC had begun a programme of announced well-led and unannounced core inspections. It is expected that the Trust will be visited within the next year. The Committee was updated on how the Trust will prepare for this visit, building on the work undertaken in preparation for and since the last core and well-led inspection and an overview of the recent CQC activity in terms of Provider Collaborative Reviews and MHA reviews.

The Committee welcomed the use of a "fresh pair of eyes" on the preparation work.

6.3 KL Inquest Conclusion from Coroner

The Committee received an update on the outcome of an inquest held before HM Assistant Coroner for Hertfordshire into the death of KL, the victim of a homicide in 2015 by a Trust service user. The Committee was informed that the Coroner returned a Narrative Conclusion, concluding that KL was unlawfully killed and that although there were a number of lost opportunities for information sharing between the public bodies and lost opportunities for further or additional measures to be taken within the criminal justice process, there were no acts or omissions by any of the public bodies which probably caused or contributed to KL's death. CL was singly responsible for KL's death.

HM Assistant Coroner for Hertfordshire considered that the evidence regarding knowledge of the Potentially Dangerous Persons process within Hertfordshire Constabulary, HPFT and the National Probation Service was not sufficiently widely understood by all. A Prevention of Future Deaths (PFD) report has been issued to all three organisations requesting dissemination of information and delivery of training regarding the Potentially Dangerous Persons process.

The Trust is required to respond to the Assistant Coroner's Regulation 28 Prevention of Future Deaths Report recommendation within 56 days.

7. **Quality – Effectiveness**

7.1 CQUIN: Quarter One

The Committee received an update on the CQUIN 2021/22 goals and work that is being undertaken. It was noted that the latest update received from NHSE in April 2021 stated that NHSE is not expecting CQUIN reporting to recommence until October 2021.

It was reported that there are eight CQUIN goals planned for 2020/21, which were rolled over into 2021/22.

7.2 Continuous Quality Improvement: Quarter One

The Committee received the quarter one report on Continuous Quality Improvement. The Committee was informed of the activity that had taken

place in the quarter, including training of new coaches and leaders and numbers of staff who had utilised the improvement hubs.

It was noted that experts by experience have received an introduction to CQI and are now embedded at the heart of most CQI projects. Service users and carers also now co-deliver training for new CQI leaders.

The report detailed that the overall CQI team has continued to implement improvements delivering tangible impact. Sixty Four projects are now active and being progressed through the stages of delivering improvement using the CQI approach.

The Committee agreed that as the Trust moves into the third year of CQI implementation, CQI governance will be picked up as a business as a usual activity with evidence reported through all the Annual Plan and Performance Report, rather than as a separate reporting item into the Integrated Governance Committee.

7.3 Practice Audit Implementation Group Report: Quarter One

The Committee received a report that detailed that the Practice Audit Implementation Group (PAIG) had approved ten Clinical audits since the last update. These audits have been conducted between 14 April and 17 June 2021.

The Committee was updated that the clinical leads review their audit findings and determine the level of concern/risk against an IMPACT score. These scores are ratified at PAIG, and a report was provided to the committee.

7.4 Annual Pharmacy and Medicines Optimisation Strategy Report

The Committee received the Pharmacy and Medicines Optimisation annual report, which set out the activities undertaken by the Pharmacy department and Trust colleagues to support the safe and effective use of medicines within HPFT across 2021/22.

It described the key challenge for the Pharmacy department, which related to the challenges associated with the COVID-19 pandemic. The key priorities for the department relating to managing medicines procurement and supplies; managing drug supply issues in both inpatient, community and primary care settings; provision of a safe clinical pharmacy service to inpatient and community areas

The team also led the successful staff and patient COVID -19 vaccination programme, working with acute hospitals and primary care network (PCN) vaccination sites, Trust clinics and inpatient vaccination clinics, working with providers in the ICS to support vaccination for SMI and LD patient populations.

In 2020/21, the Trust was awarded resources by the Department of Health and Social Care (DHSC) to implement Electronic Prescribing and Administration (ePMA). The implementation of ePMA will improve patient safety, improve quality and clinical governance and increase operational productivity.

The Committee noted that despite the challenges faced, the pharmacy department continued to innovate and share best practice. A pharmacist-led medicines optimisation clinic at Colne House was shortlisted at the Health

Service Journal (HSJ) Patient Safety Awards, and its evaluation was published in the Journal of Medicines Optimisation.

7.5 Quality Indicators 2020/21 and future indicators

The Committee received a report that set out the Trust's performance with regard to the 2020/21 Quality Indicators noting that there was not a requirement for them to be externally audit for this year but that they had been reported in the published Quality Accounts. The Committee was informed that performance against the CPA indicator has improved in the first quarter of 2021/22.

The report set out the agreed Quality Account priority Indicators for 2021/2022. The rationale for their choice was discussed as well as the targets for 2021/22. The Committee noted that ten priority indicators had been chosen, six of which were a continuation from 2020/21, and four were new indicators. It was noted that the reporting and auditing requirements for 2021/22 had not been published.

8. **Quality and Experience**

8.1 Quarter One: Service User Experience and Complaints

The Committee received the report as assurance with regard to the feedback received on Trust services. The report provided an overview of feedback: local surveys, national surveys, compliments and complaints, actions and learning from SBUs and the involvement programme during Quarter 1 2021-22. It was noted that 4% of the HPFT caseload, service users and carers in our care in quarter one provided some form of feedback, which was consistent with the previous quarter but is still lower than what was being aimed for.

The Committee noted that there had been an increase in the number of compliments and complaints received in quarter one compared to quarter four. The main themes of complaints were "care" and "assessment and treatment". There continued to be a focus on reducing the backlog in complaints caused by pausing the process due to COVID.

There had been an increase in the number of local surveys received in the quarter. It was noted that the main theme of qualitative thematic analysis across the surveys was "emotional and physical support" and "compassion." Negative comments related to "waiting" and "feeling safe," although comments were predominantly positive.

The Committee was updated on the work being undertaken to implement SMS texting to get feedback from service users, and the team continue to improve the capture of demographic information. The committee noted the range and depth of local engagement work.

In response to Anne Barnard's question, it was agreed that detail supporting the complaints information would be provided. It was also agreed to consider the provision of the data linked with involvement activities.

8.2 Board Stories Report

The Committee considered a report that set out the nine Board stories presented in the period September 2020 to March 2021. The Committee considered the feedback received from those that presented and members of

the Board and Council of Governors. It was noted that the feedback was positive, and further consideration would be given to how the feedback on the issues raised could be provided to those to present.

It was agreed that future reports on Board stories would be included in the quarterly service user experience report.

8.3 Information Governance Annual Report

The Committee received the Annual Report that provided a summary of the work of the Information Governance function within the Trust. It was noted that FOI and SAR demand had been high, and the impact of COVID-19 pressures has resulted in a backlog of work. The Committee acknowledged the fantastic work of the team during this period.

It was highlighted that there had a been 319 data incidents were reported through DATIX across the year, with seven meeting the threshold for being reported on to the Information Commissioner, demonstrating a strong culture of reporting. The Trust has also responded to a number of complaints made directly to the Commissioner by members of the public.

The Committee noted that the DPST 2020/21 had been submitted as "standards met", an improvement on previous years.

The Committee was informed that the ICO had reported that no further action was required regarding the Board pack data breach reported to them in 2020.

9. **Recommendations**

The Committee did not formally escalate any items for the Board to consider.

Board of Directors PUBLC

Meeting Date:	29 July 2021	**Agenda Item:** 8a
Subject:	Q1 report of GoSW	**For Publication:** Yes
Author:	Dr Snehita Joshi	**Approved by:** Professor Asif Zia, Director Quality & Medical Leadership
Presented by:	Dr Rakesh Magon, Deputy Medical Director	

Purpose of the report:

To present the Board with the Quarterly Guardian Report, covering April- June 2021.

Action required:

For the Board to receive the report.

Summary and recommendations to the Board:

During this quarter there was 1 exception report raised by our Junior Doctors.

Overall, there has been a significant decrease in bank locum spend since the previous report. This is a direct result of re-allocation of vacant LTFT shifts at the rota design stage to reduce rota gaps. In addition, sickness overall has reduced which is reflected in the reduction of bank locum spend.

Relationship with the Business Plan & Assurance Framework:

Summary of Implications for:

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

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

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

IGC on 15 July 2021

Guardian of Safe Working Hours Quarterly Report (Q1) April- June 2021

1) Executive summary

- This is the Quarterly Guardian Report, covering April- June 2021.
- During this quarter there was 1 exception report raised by our Junior Doctors.
- Overall there has been a significant decrease in bank locum spend since the previous report. This is a direct result of re-allocation of vacant LTFT shifts at the rota design stage to reduce rota gaps. In addition sickness overall has reduced which is reflected in the reduction of bank locum spend.
- The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of exception reporting process. All junior doctors including Trust doctors have the ability to submit exception reports.

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 79 doctors of different grades in training in the trust. Most of the trainee posts are in Hertfordshire. 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 2021

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	26	2	0	0	28
Specialist Registrars	15	1	0	1	17
FY2 trainees	8	0	0	0	8
FY1 trainees	8	0	0	0	8
GPST	16	0	0	0	16
Innovative GPST	2	0	0	0	2
Trust	10	1	1	1	13
Total	**85**	**4**	**1**	**2**	**92**

May 2021

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	25	2	0	0	27
Specialist Registrars	15	1	0	1	17
FY2 trainees	8	0	0	0	8
FY1 trainees	8	0	0	0	8
GPST	16	0	0	0	16

Innovative GPST	2	0	0	0	2
Trust	8	1	1	1	11
Total	**82**	**4**	**1**	**2**	**89**

June 2021

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	25	2	0	0	27
Specialist Registrars	15	1	0	1	17
FY2 trainees	8	0	0	0	8
FY1 trainees	8	0	0	0	8
GPST	16	0	0	0	16
Innovative GPST	2	0	0	0	2
Trust	8	1	1	1	11
Total	**82**	**4**	**1**	**2**	**89**

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

April 2021 – 92 Junior doctors (including Trainees/ LTFT/ Trust doctors)

May 2021- 89 Junior doctors (including Trainees/ LTFT/ Trust doctors)

June 2021- 89 Junior doctors (including Trainees/LTFT/ Trust doctors)

4) Vacancies

- The number of vacancies in this quarter is lower than in the last quarter. Stats are as follows:

- **April 2021- 1 WTE**
  1 Trust Doctor- Norfolk

- **May 2021 - 1 WTE**
  1 Trust Doctor- Norfolk

- **June 2021 – 1 WTE**
  1 Trust Doctor- Norfolk

- The outlook for August 2021 Junior Doctor changeover is looking positive as we currently have 2 Specialty Trainee vacancies (1 in Hertfordshire and 1 in Norfolk) both in which are going through advertising at present. We have also been allocated 4 additional integrated GPST post in which will further support the services.

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.

- There was 1 exception report raised by the junior doctors in this Quarter. Below tables provide the breakdown by department and grade of junior doctors.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General adult psychiatry	0	0	0	0
Learning disability and forensic	0	1	0	1
Old age psychiatry	0	0	0	0
Child and adolescent psychiatry	0	0	0	0
Total	**0**	**1**	**0**	**1**

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1/F2	0	0	0	0
GPST	0	0	0	0
CT1-3	0	1	0	1
ST4-6	0	0	0	0
Trust	0	0	0	0

- The reason for this exception report was due to additional hours worked for imminent discharge.

- All exception reports from previous quarters have been reviewed by the Guardian of Safe Working.

- HPFT has one of the lowest numbers of exception reports in the region.

6) Work schedule reviews

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

7) Fines

- No fines were issued during this period.

8) Locum spend

- During this quarter the total cost for bank & agency locums for the 1st on call rota was £17,262 and £3,570 for the 2nd on-call rota.
- There was a significant decrease of £27,426 on the cost of locum spend for the 1st and 2nd on call rota (combined) since last report. We foresee this will further reduce from August 2021.

- Out of a total of 64 gaps on the rota, 47 were successfully covered by using locum bank & 4 Agency locums, 12 were covered by cross covering with other on-call doctors and there were 0 instances where step down was required.

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

9) 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.

Summary

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

- The 1st on call rotas frequencies were two at 1 in 13 and two at 1 in 12 as of June 2021. From August 2021 all four rotas will be 1 in 13.

- The 2nd on call rota frequency was 1 in 16 with 4 SAS doctors underpinning as of June 2021. From August 2021 the frequency will be 1 in 15 with 4 SAS underpinning the rota.

- There has been 1 exception report in this quarter.

- In relation to sickness absence Medical staffing have a robust system in place to ensure accurate reporting as well as return to work interviews are taking place. Covid19 risk assessments are also being completed to ensure junior doctors are supported.

- Most of the gaps have been covered by Bank locums with some agency bookings.

- The Guardian of Safer working co-chairs a monthly Junior doctor forum that is run virtually. In addition there is also a weekly meeting held with Junior Doctor Reps, Guardian of Safe working, DME's and Medical Staffing in order for any concerns or questions to be raised and resolved in a timely manner.

Dr Snehita Joshi

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 8b
Subject:	Quality Account Priority Indicators	**For Publication:** Yes
Author:	Brid Kelly, PACE Manager	**Approved by:** Dr Asif Zia, Director of Quality and Medical Leadership
Presented by:	Dr Rakesh Magon, Deputy Medical Director	

Purpose of the report:

To provide the Board of Directors with an overview of our performance against the priority indicators for 2020/21 and introduce the agreed priority indictors for 2021/22 following a period of consultation.

Action required:

The Board is asked to note the performance on last year's quality indicators and to be aware of this year's agreed priority indicators.

Summary and recommendations to the Board:

Each year provider organisations are required to produce a Quality Account report.

Quality Accounts are an important way for the trust to report on quality and show improvements in the services we deliver to our local communities and stakeholders.

The Quality Account report forms part of the trusts Annual Report.

Within the Quality Account there is a section requiring the trust to identify which areas they plan to focus on over the next 12 months to improve patient safety, clinical effectiveness and patient feedback.

This report provides an overview on our performance against our priority Indicators for 2020/21 and agreed Quality Account priority Indicators for 2021/2022.

This paper provides an overview of which indicators were chosen, the rational why they were chosen and demonstrates how the target has changed from the previous year if the goal remains the same.

10 priority indicators were chosen. 6 of these are a continuation from last years and 4 are new goals.

Relationship with the Business Plan & Assurance Framework:

Summary of Implications for:

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

N/A

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

Executive Committee 16.06.21 , Quality & Risk Management Committee 30.06.21 IGC 15.07.21

Quality Account Priority Indicators

1. Background

1.1. Every NHS Trust is required to produce a Quality Report. The report includes information about the services the Trust delivers, how well the trust has delivered against agreed benchmark and includes plans for the following year.

1.2. Trust has submitted the quality accounts for the last year. Performance against these priority indicators is shown in appendix 3. Despite the pandemic, the trust has performed really well. One area which the trust didn't meet its target was CPA as all the face to face meetings stopped during the pandemic. All the CPA's are being arranged now and there is an improving trajectory.

1.3. Within the Quality Account Report includes a section called priority indicators, which describe areas for improvement in the quality of care provided by the Trust over the next 12 months.

1.4. They priority indicators must include:

- At least three indicators for patient (service user) safety
- At least three indicators for clinical effectiveness
- At least three indicators for patient (service user) experience

2. Priority Indicators 21/22:

2.1. NHS improvement has not informed NHS providers of any forthcoming mandatory indicators for 2021/2022.

2.2. The Trust has chosen specific areas to focus on quality over the next 12 months that are challenging and continue to drive quality. Please see appendix 1

2.3. Carers and Service Users have feedback to the Trust on what they would like to see the Trust focus on to improve quality. These suggestions helped choose the priority indicators. Please see appendix 2 for more details

Appendix1

	Service User Safety	Target
1	**Priority indicator/goal:** The percentage of service users who are followed up within 48 hours after discharge from psychiatric inpatient care during the reporting period. **Comparison to last year** This goal has changed from the target being 7 days to 48 hours and also the target group has changed from those service users on CPA, to now include all service users leaving hospital on discharge **Why choose this goal** The first few days following discharge can be a vulnerable period of time in an individual's life and we want to support their recovery in readjusting to life in their own community. We followed up every person who was discharged from our inpatient services that were on Care Programme Approach within 7 days. This is usually through face to face contact; under exceptional circumstances this may be via telephone.	≥=95% each quarter
2.	**Priority indicator/goal:** Reduction in the rate and percentage of service user safety incidents that result in moderate or severe harm **Comparison to last year** • < moderate - severe harm as consequence violence & aggression was at <54 last year • < moderate - severe harm as % of violence & aggression (baseline was 13% last year) **Why choose this goal** All incidents that occur in the Trust are reported to the NRLS which is a central database of patient (service user) safety incident reports. All information is analysed to identify any hazards, risks and opportunities to continuously improve the safety of service user's care. As a Trust we regularly review all levels of harm sustained to consider areas of learning and development, agree	· < moderate - severe harm as consequence violence & aggression (<49) · < moderate - severe harm as % of violence & aggression (baseline 11%)

	actions for implementation and also to share lessons learned as well as areas of good practice.	
3.	**Priority indicator/goal:** Rate of service users who have a completed risk assessment within the last 12 months. This includes risk to others and risk formulation. **Comparison to last year** The target remains the same as last year however a quarterly clinical audit will be conducted to ensure risk to others and risk formulation are included within the risk assessment **Why choose this goal** Risk assessment combines consideration of psychological and social factors as part of a comprehensive review to capture service users care needs, and to assess their risk of harm to themselves or others. This would be measured through an audit process	95% A quarterly clinical audit will be conducted to ensure risk to others and risk formulation are included within the risk assessment
	Clinical Effectiveness	
4	**Priority indicator/goal:** Reduction of the number of inappropriate out of area placements **Comparison to last year** New goal for this year **Why choose this goal** This means an inpatient unit that does not usually admit people living in the catchment of the person's local community mental health service, and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning.	Reduction in out of areas every quarter
5	**Priority indicator/goal:** Reduce the readmission rate within 28 days of being discharged from Adult acute hospital bed. **Comparison to last year** The target has reduced from 7.5% to 5%. **Why choose this goal** This indicator measures the percentage of admissions across all Trust services who have returned to hospital as an emergency within 28 days of discharge after an inpatient stay. It aims to measure our success as a Trust in helping individuals to recover effectively from illness. It has long been a health policy goal because it represents an opportunity to lower health care costs, improve quality, and increase patient satisfaction at once	Target of 5%
6.	**Priority indicator/goal:**	Target is 80% from

	At least one outcome measures to be used on all LD F inpatients (HONOS in all inpatient units) **Comparison to last year** New goal **Why choose this goal** Measuring health outcomes allows us to make decisions about how to best care for our service users and outcome measures help us predict the service users who might benefit most from a particular intervention. It helps us identify any improvement after an intervention is provided	Q2 onwards.
7.	**Priority indicator/goal:** Completed annual care plans within LD community services Herts and Essex **Comparison to last year** New goal **Why choose this goal** Due to the diverse range of services and professionals involved with service users, the SBU have a range of care plans currently in use (for example, specific ones for SLT/dietetic involvement) that are not PARIS care plans. It is proposed that an LD care plan will be completed within 30 days of allocation and 6 monthly thereafter for community service users	Launch LD care plans in Q1, Q2 20% ,50% for Q3 and 60% for Q4
	Service User, Carer and Staff feedback	
8	**Priority indicator/goal:** Rate of Service Users within MH services saying they have been involved in discussions about their care. **Comparison to last year** Remains the same as last year **Why choose this goal** Service users play a valuable and important role in partnership working to support their care and treatment. The care coordinator and clinical team should work collaboratively with an individual to develop treatment and support plans. This encourages partnership working between the service user and the care coordinator which promotes a respectful and inclusive relationship for the service user.	Target of 85%.
9	**Priority indicator/goal:** Appropriate Carer Essential Training is undertaken by all clinical staff **Comparison to last year** New goal	Set up a training programme and deliver to front line staff from Q3 onwards

	Why choose this goal Supports the implementation of the Trusts strategy in implementing the Triangle of Care	
10	**Priority indicator/goal:** Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them **Comparison to last year** Target Increased from 70% to 80% **Why choose this goal** We know that those organisations that treat their staff well provide better care for service users, therefore if our staff are recommending out trust to friends and family if they need them, then it's reflective of a good Trust to work for.	Target of 80%

Appendix 2

Feedback on Consultation in relation to Quality priorities

- Ensure that clinical pathways are aligned to the carer's pathway

- Carer aware training has been on hold for 2 years whereas previously this training was providing monthly. The Manager of Inclusion and engagement explains that this is currently restricted due to business continuity plans.

- Would like to see more joint up working with GPs and how would we know our current arrangements of working.

- SUs with severe and enduring mental health spend their lives in out of hospitals and the system. Lots of resource and money dedicated toward inpatient and rehab services but limited support in the community.

- There is not a sufficient amount of care coordinators. Would like more support during COVID in particularly around the choice of therapies available.

- Would like to see more support with people who have long term mental illness in particular access to evidence based taking therapies. Most mentally ill conditions result in early childhood trauma and trauma therapy is limited.

- How do you get psychiatric reports changed when they are in correct?

- Would like to see mental health first aid training rolled out across the community.

- Support staff to talk about their own mental health conditions.

- Would like to see more co production which would support changing the culture of the way we are working. An individual gave the example that although they have a diagnosis of border line personality disorder they actually were requesting support for their post-traumatic stress disorder but were offered DBD instead.

- It would be great to not have to relay my story my story each time I meet a different professional.

- More clarity is required re waiting lists. One individual stated that they are waiting for talking therapies and are on a waiting list for over a year and don't know how much more they would have to wait.
- Improve Shared decision making
- Would like to see more group work
- Would like to see the roll out of more pathways
- Would like to see more support for Carers.

Appendix 3

Quality Account: Priority Areas for 2020/21

Service User Safety		Target	Q1	Q2	Q3	Q4	Total
1	The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	≥=95%	96.98%	97.28%	96.04%	97.39%	96.90%
2	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)	N/A	Severe Harm 3 (0.26%) Death 37 (3.18%) Includes 26 Covid inpatient deaths 1160 Incidents	Severe Harm 2 (0.15%) Deaths 12(93%) 1284 Incidents	Severe Harm 4 (0.33%) Deaths 18 (1.5%) Includes 3 Covid Inpatient deaths 1199 Incidents	Severe Harm 0 Deaths 15 (1.19%) Includes 5 Covid inpatient deaths 1252 Incidents	Severe Harm 9 (0.18%) Deaths 82 (0.17%) Includes 34 Covid inpatient deaths 4895 Incidents
3	Crisis Assessment and Treatment Team – 4 hour wait to assessment	≥=98%	100%	100%	100%	100%	100%
4	Safeguarding – Social Care Assessments	N/A	50.2%	62.6%	56.9%	57.1%	57%
Clinical Effectiveness							
5	The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period (NHSI)	≥=95%	95.33%	97.69%	97.67%	98.26%	97.18%
6	Rate of Service Users saying they know how to get support and advice at a time of crisis	≥=83%	84.38%	85.19%	88.76%	90.48%	87.89%
7i)	Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (NHSI) The percentage of service users aged: **0 to 15**	≤=7.5%	0.0%	0.0%	0.0%	0.0%	0.0%
7ii)	**16 or over**	≤=7.5%	5.7%	6.2%	4.3%	1.9%	4.7%
8	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	≥=95%	88.58%	81.01%	87.70%	87.57%	87.57%
9	Service User experience in the community (Mandated)	N/A					7.3/10
10	Rate of Service Users saying they have been involved in discussions about their care	≥=85%	90.63%	85.19%	88.76%	85.37%	87.83%
11	Rate of carers that feel valued by staff	≥=75%	85.19%	95.45%	84.09%	95.45%	88.70%
12	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	≥=70%	84.98%	83.72%	N/A†	84.16%	84.28%

†Q3 Pulse Survey not carried due to Staff Survey

Board of Directors PUBLIC

Meeting Date	29 July 2021	**Agenda Item:** 9
Subject	Annual Quality Assurance for Responsible Officer and Revalidation 2020/2021	**For Publication:** Yes
Author	Abiemwense Giwa-Osagie, Revalidation Co-Ordinator	**Approved by:** Prof Asif Zia, Executive Director of Quality & Medical Leadership
Presented By	Dr Rakesh Magon, Deputy Medical Director	

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 the 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 doctors are regulated, improve the quality and safety of care provided to patients, and increase public trust and confidence in the medical system.

The Executive Director of Quality and Medical Leadership is the Responsible Officer and oversees the processon behalf of HPFT. As part of medical appraisal and revalidation within HPFT, a robust appraisal system for doctors is incorporated with trained appraisers and a bespoke IT system. All relevant policies were updated during COVID incorporating guidance from the NHSI, GMC and the Academy of Medical Royal Colleges.

This report informs the 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 those regular appraisals.

This report reports on quality assurance for responsible officers and revalidation carried by HPFT as at the 31st March 2021. Out of the 184 doctors linked to HPFT, 123 doctors completed their appraisal. Missing appraisals were due to long-term sickness in eight doctors, three doctors were on maternity leave, 21 doctors left the trust, and 29 approved missed appraisals were due to challenges of COVID-19 but were in line with national deferreal policy.

There were fifty-five doctors (55) due for revalidation during 2020/2021 within HPFT; however, doctors due between March 2020 and March 2021 had an approved deferral from GMC due to the challenges COVID. The RO approved 26 doctors with positive recommendations completed on time and no deferral recommendation.

This report assures that HPFT's responsibilities meet the frequency and quality assurance monitoring 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 21st July 2021.

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

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 seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1st April 2020 – 31st March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps 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). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

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.

[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]

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 executive management team of Hertfordshire Partnership University NHS Foundation trust can confirm that:

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

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

2. 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. The Trust also uses the 'Allocate' system for appraisals and Job planning purposes.

3. 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 following quality assessment of provision.
Allocate appraisal system restructured the system to be in line with the GMC guidelines. It enables both medical job planning and appraisal elements completion before an appraisal and job plan are signed off.

An appraisal portfolio of individual doctors 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.

4. 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 was implemented in 2018, while in 2020, this policy was ratified with COVID-updates.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions 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:

6. 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 for appraisal, revalidation and governance to all short term locum placement doctors as it offers to those who work substantively. Action for next year:

Section 2a – 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. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: Comments: Following the National Guidance from Professor Stephen Powis in March 2020 regarding the suspension of all medical appraisals until

further notice. The resumption of medical appraisals in September 2020 with a flexible approach. Similarly, GMC deferred all revalidations until March 2021.

2020/2021, 245 doctors at different times linked to HPFT for appraisal and revalidation. However, as of 31st March 2021, only 184 doctors are linked to HPFT for appraisal and revalidation. Of 184 doctors, 163 are due for appraisal in 2020/2021and 123 doctors completed. Of the remaining 61, 40 doctors were due for an appraisal with HPFT because they were employed more than nine months following the National guidance, and 21 doctors did not require an appraisal for the year because the Trust employed them for less than nine months.

The Breakdown of 61 missed appraisals is as following:

1) Long-term sickness: 8
2) Maternity leave : 3
3) Left the Trust: 21
4) Approved missed appraisals due to COVID: 29

HPFT adopted some of the elements of the Appraisal 2020 model, with a reduced requirement for preparation by the doctor and a great emphasis on verbal reflection and discussion in appraisal meetings. Below is the feedback from doctors were all positives;

• With the absence of uploading lots of evidence, the appraisee focused more on reflection and discussions.

• The appraisal meeting is a friendly and relaxed atmosphere where appraisees felt comfortable expressing themselves.

• Appraiser discussions on the appraisees' health and well-being, appraisees appreciated the support and resources suggested by the appraiser.

• More time for appraisees to reflect on their PDP goals and practice, clarification of all doubts and questions

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 2020/2021, the Trust reported that 40 doctors had an approved incomplete or missed appraisal. Eight doctors did not have an appraisal due to sickness and, therefore, a percentage of 75% compliance.

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.

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 50 fully trained appraisers during 2020/2021, as 22 new appraisers trained in December 2019.

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 held quarterly, 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.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

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 audit finding presented to the Board in December 2018 ensured the completion of three actions highlighted.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31st March 2021	184
Total number of appraisals undertaken between 1st April 2020 and 31st March 2021	123
Total number of appraisals not undertaken between 1st April 2020 and 31st March 2021	61
Total number of agreed exceptions	40

Section 3 – Recommendations to the GMC

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 fifty-five doctors (55) due for revalidation during 2020/2021 within HPFT; however, doctors due between March 2020 and March 2021 had an approved deferral from GMC due to the challenges COVID. The RO approved 26 doctors with positive recommendations completed on time and no deferral recommendation.

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.

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 and the deputy medical director will have a conservation with the relevant doctor with reasons regarding a decision to defer or non-engagement.

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 complaints 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.

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

All our doctors monitor the performance of all our doctors 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.

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 policy for Medical Staff. The key focus is on doctors about whom concerns are raised about their practice. In some extreme 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 to set up a process and protocol for detecting concerns about a doctor following the appropriate procedures, legislation and policies. In addition, 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.

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:

Comments: Appraisal is not a performance tool but may include performance information that requires reflection. Effective medical

[3] 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.

appraisal and subsequent revalidation will satisfy the requirements of Good Medical Practice and support the doctor's professional development.

The performance of all our doctors is monitored on an 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.

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 with the Agency RO by Trust RO.

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 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 the practice and conduct of HPFT doctors.

[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.

Section 6 – Summary of comments, and overall conclusion

Out of the 184 doctors linked to HPFT, 123 doctors completed their appraisal, with the remaining 61 doctors breakdown were attributable to long-term sickness were eight doctors, three doctors on maternity leave, 21 doctors leaving the trust, and 29 approved missed appraisals due to challenges COVID-19. There were fifty-five doctors (55) due for revalidation during 2020/2021 within HPFT; however, doctors due between March 2020 and March 2021 had an approved deferral from GMC due to the challenges COVID. The RO approved 26 doctors with positive recommendations completed on time and no deferral recommendation. This report assures that HPFT's responsibilities meet the frequency and quality assurance monitoring for responsible officers and revalidation. 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 executive management team of Hertfordshire Partnership Univeristy 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

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

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NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 10
Subject:	Report from Finance & Investment Committee – 21 July 2021	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** David Atkinson, Non-Executive Director, Chair – Finance & Investment Committee
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 21 July 2021.

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.

To receive and note the report. Noting that the Committee approved Business Case for CCTV and that a future meeting would be considering the Business Case for refurbishment of Lexden.

It was noted that the Trust would be making a submission for capital funding for the inpatient unit in East and North Herts in line with the national timetable.

Recommendation:

To note two items are recommended from the Committee to be approved by the Board, namely:

a) Business case for replacement windows at Kingfisher Court.
b) Business case for two safety suites – Astley Court and Beech ward.

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

Finance and Investment Committee 21 July 2021.

1. Introduction

1.1 The latest Finance and Investment Committee (FIC) was held on the 21 July 2021 in accordance with its terms of reference and was quorate. Maria Wheeler, Director of Finance, Performance and Improvement was welcomed to her first meeting as a Trust Board Director.

2. Deep Dive – Model for Improvement

The Committee received a presentation on the model being used in the Trust to help analyse services and pathways. The Committee were informed on how it can be used and how it helps create a baseline of information to help forecast and plan.

Members of the CAMHS and Acute Community Mental Health Services attended and gave practical examples of how they have used the model. They set out how they had used it to transform services but also to enhance the experience for both service users and staff. It was noted that the information from the model supported conservations with commissioners who have been very complimentary about the model. It also provided 'real time' data on all parts of the pathway, thereby enabling continuous and proactive improvement.

All members of the Committee welcomed the model and recognised how helpful it was. Following a question from Jon Walmsley the data sources were confirmed and the process for accessing information clarified.

3. Capital Investment Programme – Quarter One

The Committee received a report that provided an update on the Capital Investment Programme for quarter one. The Committee noted that the capital allocation for the Trust 2021/22 was confirmed at £16.1m of the ICS total allocation of £69.5m. It was noted that the Trust had made a bid for further funding and was awaiting confirmation from NHSE/I.I

It was noted that the latest forecast incorporated the disposal programme. The report detailed that the planned expenditure included several elements, including: completion of 20/21 schemes; essential and routine works on estates and IM&T; the progression of the new inpatient facility and five significant capital developments. Namely major refurbishment of Oak ward; further safety suites; the refurbishment of Lexden; the extension and upgrade of camera technology and roll out of the second year of the Digital Strategy.

It was reported that the programme is largely on plan and the Committee were updated on the exceptions. It was noted that the team would look to capitalise on any opportunities to bring projects forward, subject to due diligence, and appropriate governance processes.

In response to Catherine Dugmore's question it was confirmed that the scheme for the refurbishment of Oak Ward would meet requirements of COVID and would be an improvement for service users. It was confirmed that discussions were ongoing with Hertfordshire County Council with regard to the Stewarts.

The Committee was informed that there had been a recent announcement from NHSE/I regarding opportunities to submit a case for capital as part of a national

hospitals programme. It was noted that the Trust were likely to put forward the Business Case for East and North Herts inpatient beds. It was noted that the recent scrutiny meeting had been supportive of the Trust submitting the business case.

The Committee was also informed on the ongoing discussion with the owner of the land for the preferred site for the inpatient beds in Stevenage. It was noted that Committee members would be kept up dated on these discussions.

4. Business Cases

The Committee considered a number of business cases that form part of the Capital Investment Programme for 2021/22.

4.1 Kingfisher Court – Replacement Windows

The Committee was informed of the estimated cost of this project and inclusion of element of contingency. It was noted that the cost had been estimated by the Trusts Cost Advisors and if approved will go through a full procurement process, to ensure value for money is achieved.

The Committee noted that the replacement windows will remove the inherent ligature risk existing within the current window design. Currently mitigations are in place but these severely reducing the quality and comfort of the environment for service users. The proposed replacement of the windows significantly enhances the environment and comfort for the service users.

The benefits of the new windows in terms safety and avoidance of litigation were noted. It was noted that due to cost of the scheme hat FIC would need to recommend the scheme for Board approval.

The Committee approved the business case and recommended it to the Board for approval.

4.2 CCTV Installation – Warren Court & Albany Lodge

The Committee were informed that the estimated cost is lower than expected, whilst noting that the costs have been estimated by the Trust cost advisors, but if approved will go through a full procurement process, to ensure value for money is achieved.

It was noted that the scheme would vastly improve safety for staff and service users, reduce the need for physical observations, improve the experience for service users and help towards lowering the number of incidents of violence and aggression. It also expected that the existence of the cameras will deter SUs from causing damage to property and if incidents did occur the equipment provides good evidence to support any prosecutions.

The Committee discussed issues relating to maintaining service user privacy. It was noted that the Trust already had CCTV in areas and that it was considered the least obtrusive and restrictive approach.

In response to David Atkinson's question it was confirmed that the Trust had a policy and protocol in place regarding access and storage of the recorded footage. It was noted that CQC were supportive of the appropriate use of CCTV.

The Business Case was approved.

4.3 Lexden – Refurbishment of the Assessment and Treatment Centre

It was reported that the Lexden site is subject to proposals for a new 15 bedded unit; however this new build if approved will not be operational for 2-3 years. This project aims to address many of the immediate safety and environmental issues and support staff managing some of our most challenged service users.

The Committee was informed that it is acknowledged that it would be difficult to undertake a full structural renovation of the building and instead a targeted restructure was proposed, thereby providing the Trust with an opportunity to invest in a practical solution to the long term safety difficulties the unit has experienced.

The Committee noted that the business case was currently being finalised and will be going to the Executive in the next few weeks. Due to its value it requires both FIC and Trust Board approval. The Committee agreed that due to the likely value of the Business Case and length of time the Trust would be operating from the site that an extraordinary Finance and Investment Committee would be established prior to the scheduled meeting in September to consider the Business Case.

4.4 Safety Suites

The Committee considered the business case for the second phase of capital investment to create a further two Safety suites at Astley Court and Beech Ward. It was noted that investment is required to improve the environments which are used to support service users when they are often at their most vulnerable and at risk. It was noted that it will address the focus of the Care Quality Commission (CQC) on safety, restrictive practice, and the facilities available to best care for service users; and on reflections from their visits to the existing facilities.

It was reported that the proposed investment continues a significant increase in the capacity and quality of safety suite provision. This phase will continue the learning from the previous design with a separation of living and sleeping areas as well as access to outside space. It was noted that the detailed designs had been shared with CQC who were very positive about the proposal.

Due to the cost of the scheme it was noted that FIC would need to recommend the business case to the Board for approval.

The Committee approved the business case and recommended it to the Board for approval.

5. National Cost Collection Update and use of benchmarking

The Committee received a report that updated it on the National Cost Collection (NCC) work. It was noted that the NCC replaces Reference Costs, which used to be the mandated cost collection and that NCC is a hybrid of patient-level costs (PLICS) and aggregate cost collections. It was reported that this informs a number of national workstreams e.g. the Model Health System, the Getting it Right First time (GIRFT) and national tariff prices.

The data it provides will be used by the Trust to see things from a different perspective to share information with the benchmarking network, and for internal deep dives into services.

The Committee were informed that the submission for 2019/20 was made in January 2021, later than usual, due to the Pandemic. The submission window for the financial year 2020/21 is from 6th September 2021 to 29th October 2021. It has been agreed to submit near the beginning of the submission window as NHSEI will be reviewing early submissions for issues, enabling a resubmission should any issues be found.

The Committee noted that the 2020/21 collection is key to enabling improvements in costing processes within HPFT, both in the way activity data is recorded, and the introduction of superior methods of allocating costs. This alongside continued involvement with benchmarking nationally, the Trust will continue to improve the information HPFT has available in order to both aid decision-making throughout the Trust, and take part in ICS-wide work such as that on Population Health.

6. Commercial Update

The Committee received an update on the business development work underway including contract negotiations. It was noted that discussions with commissioners continued to be positive and Trust is near finalising the contract for 2021/22.

The Committee noted the additional funding that had been received and the bids likely to be submitted. The Committee noted the transfers of services that had been completed.

It was clarified that the proposal with regard to the transfer of Essex Learning Disability Partnership, Children's Learning Disability Services (CLDS) was subject to further due diligence and would be considered by both the Executive Team and FIC.

In response to Anne Barnard's question regarding possible opportunities in Essex it was confirmed that they would be viewed in line with the Trust's strategic plan for services and in particular how they fit with clinical pathways. Karen Taylor added that this approach was true for the consideration of any new business opportunities.

7. Annual Plan Report – Quarter One

The Committee received a presentation on the quarter one Annual Plan performance. It was noted that significant progress has been made across all seven Strategic Objectives. With 75% of year end outcomes are on track to be fully delivered; 25% not currently on target, however actions will be taken to recover the position. It was reported to the Committee that although progress had been made the Executive Team were tracking and responding to possible areas of concern, linked with safety, workforce and demand for services.

In response to Catherine Dugmore's question the Committee were updated on the weekly and monthly processes in place to track performance and how they aid the identification of areas where mitigating actions are needed. The Committee were updated on the specific actions underway to address emerging areas of concern, noting the role of the Integrated Governance Committee.

It was noted that the Annual Plan would be updated to include outcomes relating to CAMHs Easting Disorder Services and the Digital Aspirant programme.

8. Financial Summary: End of year 2020/21 and Quarter One.

The Committee noted that the Annual Accounts and Annual Report process for 2020/21 was completed on time, with sign off at the Audit Committee on 10 June, submission to NHSEI on 16 June, and the final formatted Annual Report submitted for laying before Parliament on 28 June. The Accounts received an unqualified audit opinion with no areas of significant concern noted.

The report detailed the financial position as of 30 June 2021. The reported position is of being on plane for the year to date. It was noted that the figures are driven by driven by increased income in year offset by increasing pay costs and continued pressure against external bed costs. The Committee considered the key variances within the yearend position.

The Committee was informed that income for Half 1 had followed similar arrangement as those seen in 2020/21. It was noted that there was less certainty with regard to Half 2, with COVID-19 income expected to be removed or reduced, and higher levels of efficiencies required. Planning guidance is expected in September which creates some uncertainty.

It was noted that the Trust expects to continue to be on plan for Half 1, and relative high level of confidence that be on plan for Half 2, whilst noting was subject to details of the expected guidance.

9. Performance Report

The Committee received a report that detailed the performance of the organisation up to month two of 2021/22 against the 68 national, regional and local indicators. It was note that demand for all services had fully recovered to at least pre-COVID levels. Referrals are consistently higher in Adult Community Services; CAMHS Community Services; Adult Eating Disorders and CYP Eating Disorders. EMDASS and older people continue to see a drop in caseload volumes.

The Committee received the report that set out the underperforming areas.

Michael Thorpe agreed to pick up a discrepancy directly with Jon Walmsley.

10. Delivering Value Efficiency Programme Update

The Committee received a report that set out that the initial Programme target value was set at £7.0m for 2021/22. The current Programme has a forecast delivery of £6.56m against a value reported in June of £6.65m. Work continues to look to close the gap and deliver the full £7m.

It was noted that the Programme continues to be developed and monitored through the Delivering Value Management Group, with a level of volatility in a number of scheme areas, but particularly in out of area placements, though with a new scheme having been developed to close this gap. Progress also continues on completion of Quality Impact Assessments (QIAs) which are key to the delivery of the programme with no adverse impact on quality and safety for service users.

It was reported that where required, additional Programme / Project Management support has been and will continue to be secured to ensure the Programme maintains the necessary pace. And that it remains expected that the value will be fully achieved within 2021/22.

In response to a question on the QIA process it was agreed that the chair of the Integrated Governance Committee would be consulted on a potential briefing on the process at a forthcoming IGC meeting.

11. East of England Provider Collaborative

It was reported that good progress had been made with the Collaborative with all contracts signed, finance agreed and the establishment of the central commissioning team. The Committee considered the focus areas for the central finance team relating to: the establishment of an accurate database of the private sector contract details; ensuring robust activity reporting to maintain an accurate forecast of variations in cost profile; resourcing and set up of the bed management staffing and systems; progression with the clinical design group priorities and monitoring of the overall financial position.

12. Digital Strategy

The Committee received first of what will be a regular report on the Digital strategy. It was reported that the Digital and Innovation Board (DIB) is responsible for the delivery of the implementation plan of the Digital Strategy. The 2021-22 Annual Plan includes 15 distinct projects which will deliver significant benefits to service user, carer and staff experience as well as to safety and effectiveness of services.

It was reported that progress in quarter one had been positive with funding being received from NHSx for remote care and the implementation project for electronic prescribing and medicines administration underway. Delays in the digital correspondence / hybrid mail and digital outcomes projects are not forecast to impact the end of year position.

The Committee noted that capital spending is currently in line with the plan but there was a cost pressure relating to replacement of older laptops.

It was agreed that consideration would be given to the recognition of digital inclusion and accessibility in the strategy.

13. FIC Committee Planner

The Committee noted the planner. It was agreed that Head of Corporate Affairs and Company Secretary would update in preparation for 2022/23 committee meetings.

14. Recommendation

To receive and note the report.

To note two items recommended from the committee to be approved by the Board, namely:

c) Business case for replacement windows at Kingfisher Court.
d) Business case for two safety suites – Astley Court and Beech ward.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 10a
Subject:	Performance Report: Quarter 2021/22	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director of Improvement and Innovation	**Approved by:** Paul Ronald, Executive Director, Performance Improvement
Presented by:	Paul Ronald, Executive Director, Performance Improvement	

Purpose of the report:

To inform the Trust Board of the Trust's performance against both the NHS Oversight Framework (NHSOF) targets and the Trust Key Performance Indicators for Quarter 1 2021/22

Action required:

To:-

- Critically appraise the information presented
- Consider the areas of performance noted and evaluate the associated actions
- Seek any additional assurance or information required

Quarter 1 Summary

The number of performance indicators that have been met or exceeded has fallen in Quarter 1 (48%). It is important to note that critical KPIs including access into all services (in both crisis and referrals), safety and safe staffing are strong. However, pressure from increased referral demands (c. 1000 additional service users) and acuity (57% adult inpatient admitted under the Mental Health Act) are stretching services and are compounded by 'hotspots' of high vacancies in some services.

We are responding by sourcing extra beds, recruitment & on-boarding support to increase staffing, accelerating digital spend where we can, and rescheduling non priority work. We are also strengthening our Single Point of Access services to provide early interventions where possible and onward referrals to partners where appropriate to do so. However, the reduction in performance for our KPIs reflects the pressure we are under.

As COVID-19 infection rates are continuing to grow across the county we are reviewing and preparing our business contingency planning for a potential third and fourth wave. We have learned vital lessons from waves one and two and are clear on what to expect and how to react in the best interest of our service users and staff should the need arise.

Our forward looking forecast position for services for Q2 and Q3 is:

- CAMHS referrals returned to pre COVID levels at the start of Q1 2021, and then increased by a further 6%, which will persist until schools break for summer holidays;
- Adult referrals were 20% higher in Q1 and we expect this to grow to be 22% in Q2, with an upward growth trend. This is in line with national guidance of 10%-30% growth
- Older Adult referrals to continue a slight (2%) downward trend throughout Q1 and will continue to reduce in Q2
- LD&F referrals to stay at the same levels as previous years
- IAPT referral volumes were down 15% in Q1 as the increase in acuity meant more service users were referred into Adult MH services, however we forecast a return to commission IAPT referrals in Q2

Areas of Strong or Improved Performance

Despite service pressures, the following areas saw continued strong performance in Quarter 1:

- People with a first episode of psychosis began treatment within two weeks of referral in 87.5% of cases (target – 56%)
- People using our IAPT services met the recovery criteria in almost 54% of cases (target – 50%)
- People who need an inpatient admission were seen by Adult Crisis Assessment and Treatment Teams in 95.5% of cases to see if there was an alternative to admission.
- All service users who needed to access our Adult Crisis Assessment and Treatment Teams in Quarter 4 were assessed within a 4 hour period (target – 98%).
- Children and Young People needing routine assessment were seen within 28 days in 97.2% of cases (target – 95%) and 95.7% those needing urgent assessment were seen within 7 days (target – 75%)
- People accessing our EMDASS service received their diagnosis within 12 weeks in 80.73% of cases for June (target – 80%).
- Across all our services 98% of people received treatment within the 18 weeks wait standard (target – 98%)
- People who were discharged from adult inpatient care had a follow up within 3 days in 92.8% of cases (target 90%) and within 7 days in 96.9% of cases (target 95%).
- Our service users told us that they would recommend our services to friends and family, if they needed them, in 88.5% of cases (target - 80%) and 91.7% of people said that they knew how to get support and advice at a time of crisis (target – 83%)
- 91.7% of our service users told us that they have been involved as much as they wanted in discussions about their care.

Areas of Concern/Focus

At the end of Quarter 1, 32 (49%) of 65 indicators were below our performance standards. The majority of these relate to areas that were already known as underperforming and were exacerbated as a consequence of the continuing COVID 19 pandemic but are now on recovery trajectories.

The key areas of note for Quarter 1 were:

- Inappropriate out of area placements have increased over the quarter with a total of 1,125 out of area days against a target of 1037. This equates to circa 12 additional beds. The Trust is experiencing a high demand for Adult and CAMHS beds, which reflects an increase in complexity in the community. The situation in Hertfordshire is reflected nationally, with a shortage of beds and an increase in out of area placements.

- Children and Young Persons referrals meeting the 4 hour waiting time standards in CRISIS fell below the target set in quarter 1 achieving 88.89% (target 95%). Ability to meet the target is directly related to the number of children and young people presenting to the service. Service continues to have a high number of referrals with 405 in Q1 receiving intervention.

- Improving Access to Psychological Therapy (IAPT) Services: A gap between access targets and actual rates of access continues to be seen across our IAPT services during Quarter 1. However all IAPT services are in line with their recovery trajectory for the year.

- The rate of people on CPA who have had a review in the last 12 months was 90.46% in Quarter 1 (target – 95%), improving by almost 3% on the Quarter 4 position, despite capacity issues, staffing deficits and high caseloads. As services moved through restoration, performance has improved on a month on month basis. Improvement to continue in to Q2

- The rate of service users with an up to date risk assessment has increased over Quarter 1 from Quarter 4 position to 91.82% against a target of 95%. The primary reason for underperformance is

the large caseloads held by some of our medical staff resulting in difficulty in managing the risk assessment process. Local management actions include individual improvement plans with trajectories. The deputy medical directors are leading a CQI to simplify risk assessment recording in PARIS to provide a long term solution.

- The rate of people experiencing First Episode Psychosis and received cardio-metabolic checks remains below target at 79.44% (target – 95%). The Trust has focused on improving Physical Health over the current year and there is now a trajectory in place, with additional physical health clinics, to recover performance by the end of Q2 2021/22. 86% of our service users on the Care Programme Approach received cardio-metabolic assessment and treatment (target – 95%). The target increased to 95% from 65% in Quarter 1 as part of the Annual Plan physical health improvement measures.

- PDP and Appraisal rates improved in Quarter 1, reaching 89.13% (target – 95%). A re- launch of the appraisal requirement backed by a revised and simplified form is expected to further improve performance.

- Turnover rates have increased to 19% at the end of Quarter 1.

Conclusion & Recommendation

At the end of Quarter 1, 31 of 65 indicators were below our performance standards, however our performance across principal KPIs remains strong. We are experiencing demand, acuity and workforce pressures and are responding by increasing beds, improving recruitment and retention, and adopting innovative and digital ways of working, and supporting the wellbeing of our staff.

The Trust Board is asked to:

- Critically appraise the information presented
- Consider the areas of performance noted and evaluate the associated actions
- Seek any additional assurance or information required

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

Performance reflects the requirements of the Annual Plan, SBU Business Plans Assurance Framework

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

N/A

Equality & Diversity and Public & Patient Involvement Implications:

N/A

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

All targets

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

N/A

Hertfordshire Partnership University NHS Foundation Trust

Performance Report Quarter 1 2020/21

Contents

1. Summary

1.1 Service Recovery

New referrals into the Trust both via SPA, trusted assessors and internal referrals in Q1, have tracked significantly higher than the same period as last year until the last week in June when referrals tracked closely. Current quarterly referrals were up on pre-COVID averages by approximately 15%.

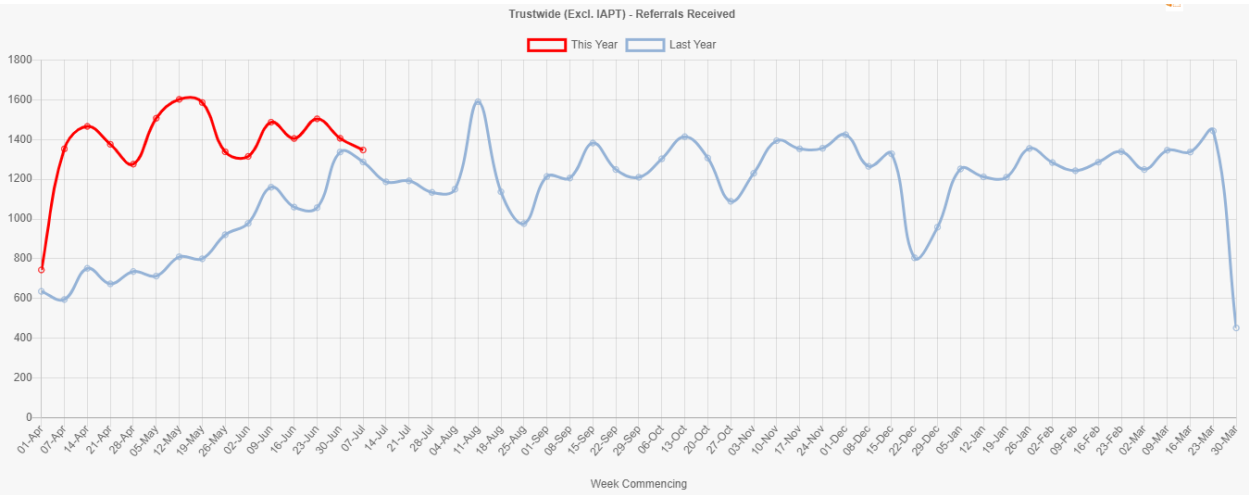
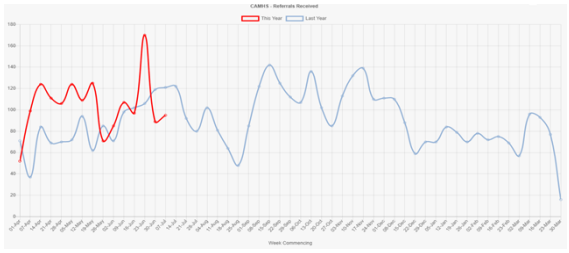
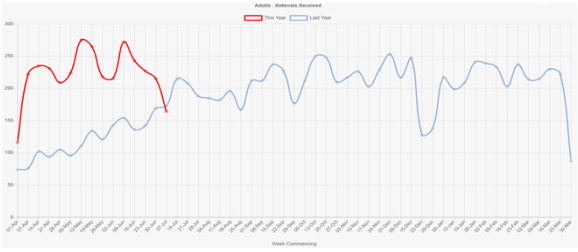
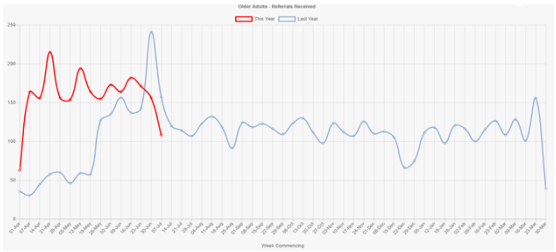
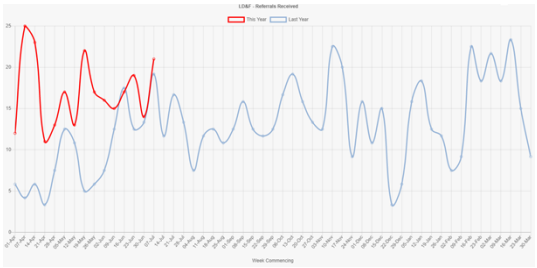
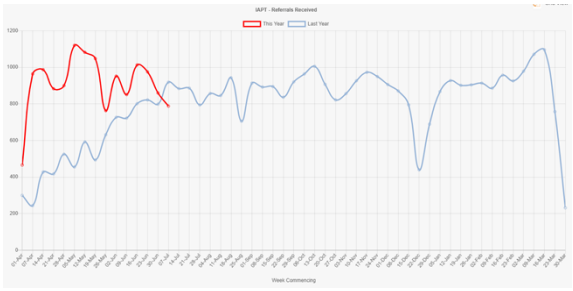


Figure 1 – Referrals into HPFT

Referrals into most of the services are showing an increase on this time last year for the majority of the quarter:

- The profile of referrals into CAMHS tracked significantly higher last year throughout the majority of Q1 until the last week of May, when a further, seasonal, dip was seen that corresponded to the schools half term. This was followed by a peak in referrals at the beginning of June as schools recommenced.
- Adult referrals have been tracking considerably higher than Q1 of last year and pre-covid levels throughout the quarter. There was an increase in referrals at the beginning of April where levels remained consistent up until the end of June.
- Older adult referrals have tracked at similar levels to pre covid throughout the quarter until the end of June when referrals saw a dip where levels were similar to last year.
- IAPT referrals have tracked at a higher level to Q1 last year throughout the whole period but saw levels decrease at the end of June where they tracked closely to last year.
- LD referrals tracked higher than last year at the start of the quarter but began to track very closely to last year's referrals from the start of June up until the end of Q1.

Table 1 - Recovery by Service

CAMHS 	Adults 
Older Adults 	LD&F 
IAPT 	

1.1 Forecast

The forecasts below look to predict the number of referrals into HPFT services every week over the period of Q1 and Q2 2021/22.

The tables show:

- The 2019/20 baseline (the previous normal)
- Expected demand based on trend analysis and research
- The range of referrals based on national planning guidance

These tables were produced to support the planning **submission into NHSI/E.**

CAMHS Community Services Forecast

	April–June – referrals / week	July – Sept - referrals / week	Oct- Dec – referrals / week
HPFT Baseline 2019/20	**178**	**150**	**184**
HPFT Forecast 2021/22	**216**	**160**	**195**
Planning Guidance 2021/22	**220-260**	**176-208**	**215-254**

CAMHS demand started to return within 2 weeks of children and young people returning to school in early March 2021. We know from lockdown data from phase 1 and 2 that it takes 12 weeks for the suppressed demand to work through services before returning to normal levels (2019/20 baseline levels of 200 referrals per week during school term time).

For that 12 week period during phases 1 & 2 we saw an average increase in referral rate of 8%. Therefore, we can reasonably forecast an average of 216 per week from April to end of June. From July to September we expect to see normal referral rates to return (200 per week) and then a reduction during the school summer holidays to 115 referrals per week.

Schools were disrupted throughout 2020/21 which means we do not have accurate historic data about generated demand levels from COVID 19. However, we have been instructed to plan for a generated demand of 10%-30% (NHS Planning Guidance). This would mean an increase from 200 per week to between 220 and 260, new referrals every week.

Adult Community Services Forecast

	April–June – referrals / week	July – Sept - referrals / week	Oct- Dec – referrals / week
HPFT Baseline 2019/20	**206**	**224**	**212**
HPFT Forecast 2021/22	**260**	**282**	**255**
Planning Guidance 2020/21	**217-269**	**246-291**	**248-296**

From July 2020 there has been a step change in the volume of new referrals every week into Adult services, from a consistent 220 referrals per week to a new baseline of 280 per week. The trend for adult referrals is still continuing upwards, overall.

The planning guidance from NHSI/E suggests that we add 10%-30% on previous baseline figures but our own experience is that demand is at the higher end of that range for the next 2 quarters.

Older Adults Community Services Forecast

	April–June – referrals / week	July – Sept - referrals / week	Oct- Dec – referrals / week
HPFT Baseline 2019/20	**120**	**120**	**120**
HPFT Forecast 2021/22	**116**	**116**	**116**
Planning Guidance 2020/21	**No guidance issued**	**No guidance issued**	**No Guidance Issued**

There has been a slight (2%) trend downwards in Older Adult referrals over the last 2 years and we expect this to continue over the next 2 quarters.

There are no specific overall national volume guidelines for this year from NHSI/E, however there is an expectation that dementia services will increase to support improvements in diagnosis.

LD&F Community Services Forecast

	April–June – referrals / week	July – Sept - referrals / week	Oct- Dec – referrals / week
HPFT Baseline 2019/20	**9**	**9**	**9**
HPFT Forecast 2021/22	**9**	**9**	**9**
Planning Guidance 2020/21	**No guidance issued**	**No guidance Issued**	**No Guidance Issued**

Referral volumes in LD&F have been consistent over the last 4 years. They dipped slightly during the COVID-19 period due to some referral routes slowing for a while, but quickly returned to normal levels.

Again, there are no overall volume guidelines indicating an increase or decrease in LD&F service over the next 2 quarters.

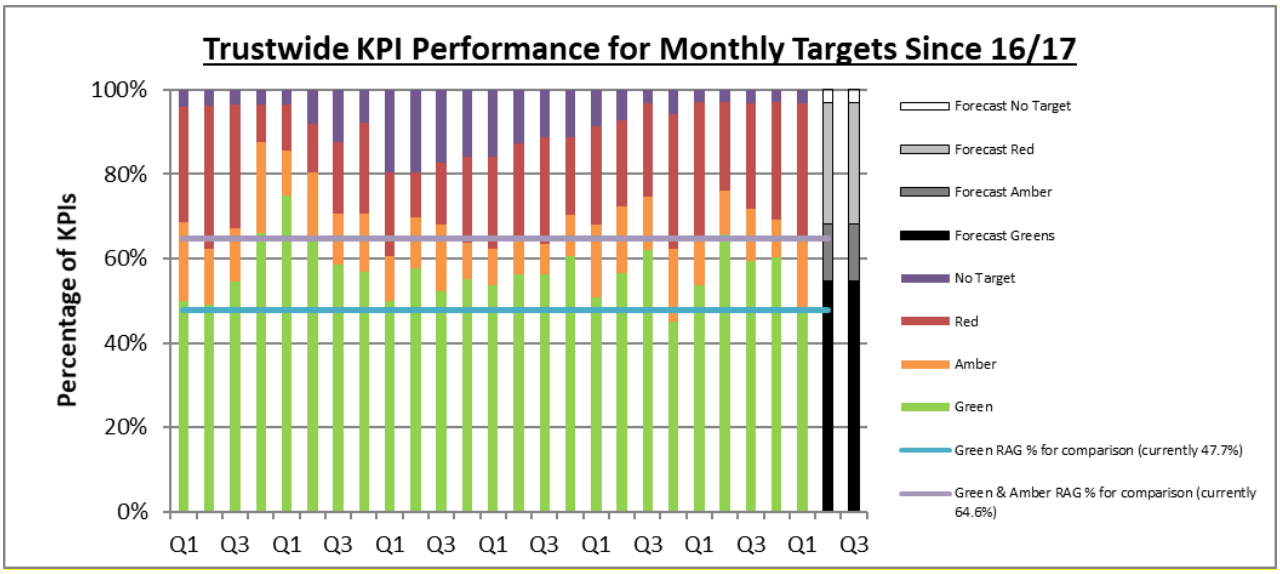
1.3 Performance Overview

31 of the 65 (48%) performance indicators measured in Quarter 1 are meeting or exceeding our performance standards (c/f 41 of 68 (60%) Q4). We move into Quarter 2 in a stable position with our Access and Safe and Effective indicators and have seen some improvement in our Workforce Indicators in the areas of PDP and Appraisal and Mandatory Training, but a challenge with increasing turnover rates.

Of the 65 Key Performance Indicators monitored in Quarter 1, overall performance is as follows:

- 31 (48%) are maintaining or exceeding performance levels (on target)
- 11 (17%) are almost meeting target performance levels (close to target)
- 21 (32%) are not meeting our performance standards (underperforming)
- 2 (3%) are currently monitored but no formal performance target set

Table 4 – Comparison of Performance on KPIs by Quarter



1.4 Activity Summary

The table below provides a summary of some of the key areas of activity across the Trust during Quarter 1. Referrals into the Single Point of Access in Q1 2021 (16,970) are circa 18% higher than for the same period in 2019/20 (used as comparison due to abnormally low figures in Q1 2020 due to COVID 19) but represent a 10% increase on Q4 referrals (15,464).

Table 5 – Summary of Quarter 4 Activity

Summary of the Activity across the Trust during Quarter 1	
245 adult acute admissions in Q1	151 Starters, 169 Leavers at the end of Q1
3,030 people on CPA in Q1	7,760 new spells of care in secondary mental health and LD services in Q1
6,766 discharged from secondary mental health services in Q1	403 inpatient beds in Q1
111,882 secondary mental health face to face, virtual and telephone contacts Q1	9,285 people entering treatment in Wellbeing Services in Q1

1.5 Reporting Categories

The remainder of this paper provides an overview of performance using the five main reporting categories for the Trust:

- NHS Oversight Framework - NHS Improvement
- Access to Services
- Safety and Effectiveness of Services
- Workforce Indicators
- Financial Indicators

2 NHS Oversight Framework

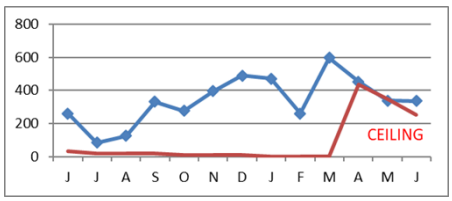
2. 1 Summary of Position

There are six Key Performance Indicators under this domain:

- People with First Episode Psychosis receive treatment within 2 weeks of referral (89.5% target – 60%)
- Data Quality Maturity Index (97% target 95%)
- Improving Access to Psychological Therapies (IAPT) (18 week access – 99.97% target 75%)
- Improving Access to Psychological Therapies (IAPT) recovery (53.16% target 50%)
- IAPT waiting time to receive treatment (within 6 weeks – 97.85% target 95%)

Five have been met in the quarter; with Inappropriate Out of Area Placements not meeting the performance standard

- Inappropriate Out of Area Placements (Target 1037 days in Quarter 1)

KPI	Trend	Q1 Status/Action
Inappropriate Out of Area Placements (OAPs) for adult mental health services. (Target 1037 bed days)		**Q1 Performance: 1,125** Performance against this target has been variable over the last 12 months, with placement days ranging from 500+ to under 100 per month. **Action:** Trajectory in place to have 0 placements by the end of Q2

3 Access to Services

3.1 Summary Position

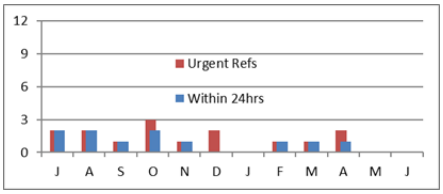
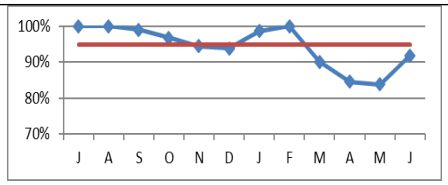
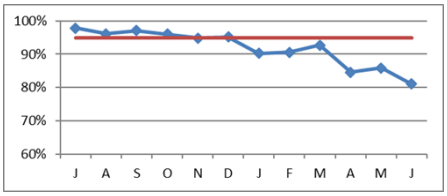
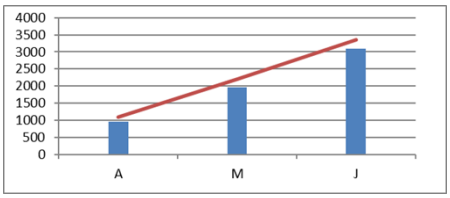
In Quarter 1 the Trust met 12 out of 25 targeted access indicators. Accessing mental health services remains a key area. The significant improvements that were seen in 2019/20 have continued to be upheld throughout 2020/21 despite the COVID challenges.

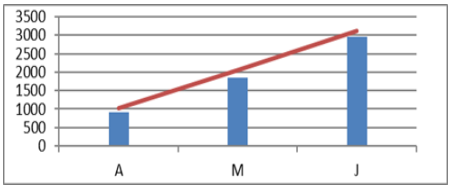
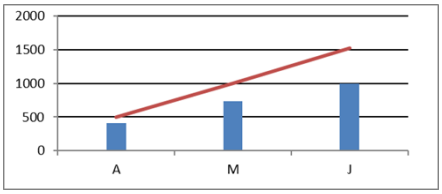
3.2 Areas of Strong/Improved Performance

- People needing urgent assessment for Eating Disorder Services were seen within 96 hours target in 100% of cases in the quarter
- Children and Young People needing routine assessment were seen within 28 days in 97% of cases (target – 95%) and those needing urgent within 7 days were seen in 95% of cases (target – 75%)
- Children and Young People for Targeted Services were assessed within 28 days in 88% of cases (target 85%)

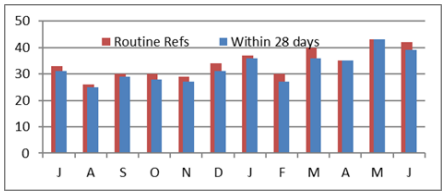
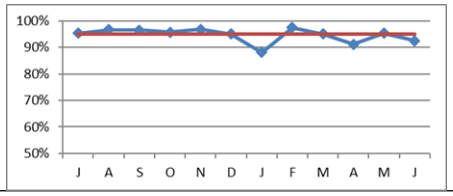
3.3 Access Indicators currently underperforming

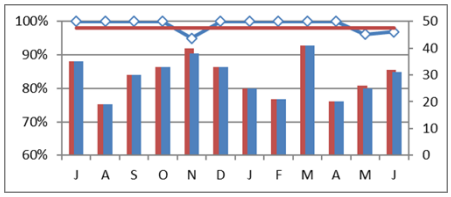
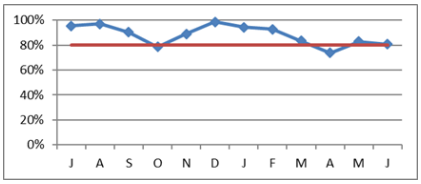
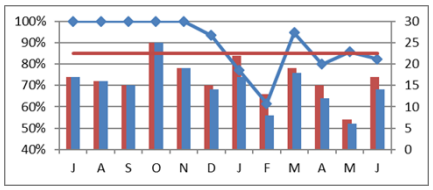
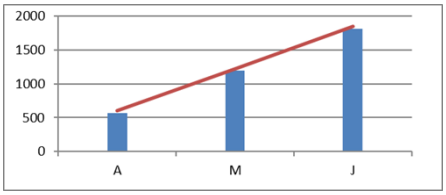
Below is an exception summary for those Key Performance Indicators that have not achieved performance standards

KPI	Trend	Q1 Status/Action
Urgent Referrals to ACMHS meeting 24 hour wait (Target 98%)		**Q1 Performance – 50%** This target is usually met, but due to low numbers of urgent referrals a small number of service users seen outside of the 24-hour window can mean the target is not met. In April 1 person was seen outside of the 24-hour window, was subsequently seen and is safe. **Action:** N/A
CAMHS referrals meeting crisis 4 hour wait (Target 95%)		**Q1 Performance – 86.74%** Ability to meet the target is directly related to the number of children and young people presenting to the service. Service continues to have a high number of referrals with 405 in Q1 receiving intervention. **Action:** Recruitment of new staff who will be in post in September, further recruitment to take place to be able to meet increased demands of the service.
SPA referrals with an outcome within 14 days (Target 95%)		**Q1 Performance – 83.66%** **Action:** Continue to fund 24x7 advice and support line (SPA and First Response).Thorough review of SPA (5 months) including commissioners and GPs. Done by December and put into funding discussion with commissioners. SPA re-model Ability to split reporting to ascertain impact of new ways of working by end of June with first report in July 2021.
Number of people entering IAPT treatment (Herts Valleys CCG) (Target 3348)		**Q1 Performance – 249 behind target** A new Digital Team has been set up to flex capacity across the services. A contract is also being negotiated with IESO to provide further flexibility at Step 3 and to allow for short-term funding not via the core block contracts. We are aiming for a cost per case contract to manage variations in demand and income. Discussions with commissioners have been taking place regarding making changes to the staffing

		skill mix to meet increasing demand for Step 3 interventions. **Action:** Currently meeting 93% trajectory. Trajectory for recovery: Q1: 85% Q2: 100% Q3: 100% Q4: 100%
Number of people entering IAPT treatment (East & North CCG) (Target 3119)		**Q1 Performance – 151 behind target** A new Digital Team has been set up to flex capacity across the services. A contract is also being negotiated with IESO to provide further flexibility at Step 3 and to allow for short-term funding not via the core block contracts. We are aiming for a cost per case contract to manage variations in demand and income. Discussions with commissioners have been taking place regarding making changes to the staffing skill mix to meet increasing demand for Step 3 interventions. **Action:** Currently meeting 95% trajectory. Trajectory for recovery: Q1: 85% Q2: 100% Q3: 100% Q4: 100%
Number of people entering IAPT treatment (West Essex) (Target 1524)		**Q1 Performance – 525 behind target** **Action:** West Essex is moving to a new, independent provider in July. Our focus is now to ensure as smooth a transfer as possible to the new service.

3.3.1 Access Indicators – Almost Met

KPI	Trend	Q1 Status/Action
Routine referrals to Eating Disorder Services (Target 98%)		**Q1 Performance – 97.50%** The increase in the number of referrals received by the service has impacted on its ability to meet the 28 day wait. May and June saw the highest number of assessments completed (40+ per month) since the beginning of the service. Referrals have increased by 26% and caseloads by 17%. **Action:** Additional resource has been provided internally for the service, to help its ability to meet increased demand. Talks are underway with commissioners as to how to maintain service quality with the current level of demand.
Routine referrals to community		**Q1 Performance – 92.92%** Capacity issues in the NW and SW Quadrant have affected performance and

mental health team meeting 28 day wait (Target 95%)		are likely to continue to fail to meet target until these issues are addressed. NW have experienced a deficit in medical staffing, whilst SW is holding high vacancy levels of all staff. We are having difficulty in securing locum medical staff at capped rates. **Action:** A temporary skill mix review using CQI methodology in the NW is under consideration. A number of actions in SW have been agreed, to continue to pursue agency staff, review all referrals currently booked to breach, allocating a staff member undertake brief assessments for all ADHD/ASD referrals.
Learning Disability Services meeting 28 day wait (Target 98%)		**Q1 Performance – 97.44%** 2 service users were seen outside of the 28 day wait time due to inability to engage with service users, the LD Service made every attempt to contact both service users without success. **Action:** **N/A**
EMDASS Diagnosis within 12 weeks		**Q1 Performance – 79.14 %** The dip in Q1 performance was predicted due to staffing issues in the South West which have now been resolved. Waiting times for diagnosis recovered to over 80% in May and June. **Action:** **N/A**
CAMHS Targeted 14 day wait to contact with social worker (Target 85%)		**Q1 Performance – 82.05%** 7 service users were seen outside of the 14 day wait time, due to some late pass ons from SPA or Social Workers not being available in Children's Services. **Action:** Social worker availability has increased in the latter part of the quarter and no further action required if this continues. SPA process for passing on children to the targeted 14 day service to be reviewed.
Number of people entering IAPT treatment (Mid Essex) (Target 1852)		**Q1 Performance – 42 behind target** A new Digital Team has been set up to flex capacity across the services. A contract is also being negotiated with IESO to provide further flexibility at Step 3 and to allow for short-term funding not via the core block contracts. We are aiming for a cost per case contract to manage variations in demand and income. Discussions with commissioners have been taking place regarding making changes to the staffing skill mix to meet increasing demand for Step 3 interventions. **Action:** Currently meeting 98% of trajectory. Trajectory for recovery: Q1: 95%

		Q2: 100% Q3: 100% Q4: 100%

4 Safety and Effectiveness of Services

4.1 Summary Position

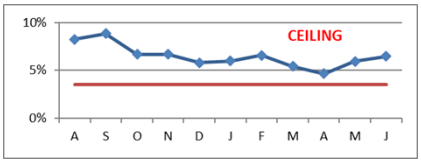
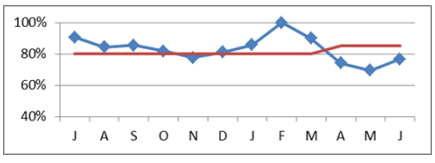
There are 25 Safety & Effectiveness Key Performance Indicators of which 12 have been fully met, 4 were almost met, and 9 where further improvement is required.

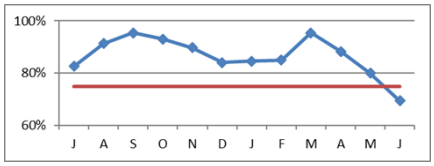
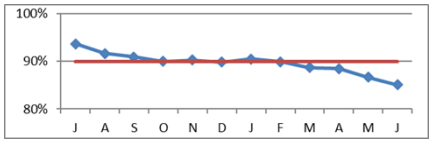
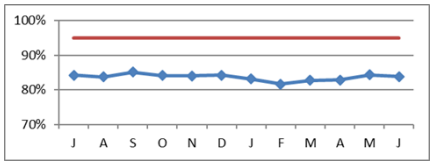
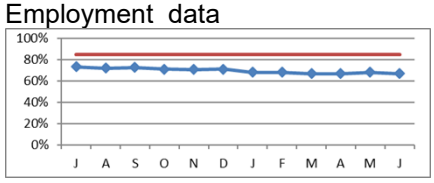
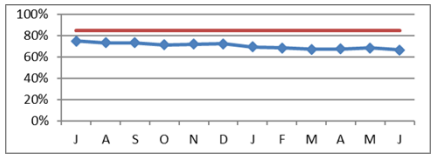
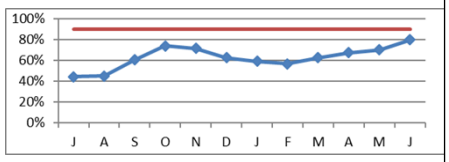
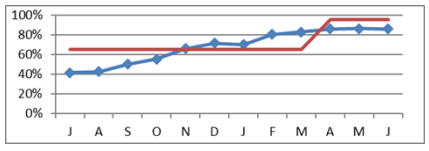
4.2 Areas of Strong/Improved Performance

- All of our IAPT services achieved 50% or more of their clients reaching recovery levels in Quarter 1.
- People leaving our inpatient services received a follow-up contact within 7 days in 96.8% of cases (target - 95%) and within 3 days in 92.8% of cases (target - 90%).
- Our service users told us that they felt they would recommend our services to friends and/or family if they needed them in 88.48% of cases (target – 80%)
- They also told us that in 91.67% of cases they knew how to get support at a time of crisis (target – 83%)
- Service users told us they have been involved in discussions about their care 91.67% of cases (target – 85%).

4.3 Underperforming Indicators

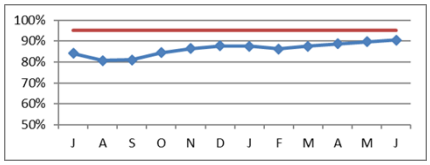
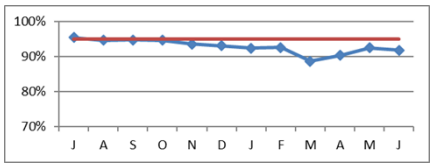
Below is an exception summary for those Key Performance Indicators that have not achieved performance standards:

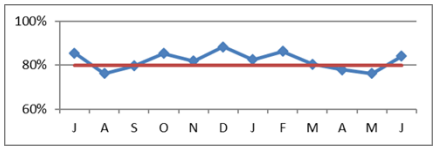
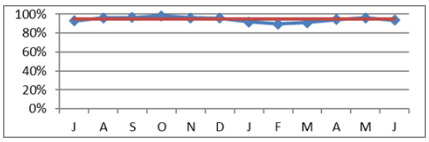
KPI	Trend	Q1 Status/Actions
Delayed Transfers of Care (DTCs) (Target 3.5%)		**Q1 Performance: 5.1%** High levels of delay in Adult Acute services due to insufficient placements available for people with complex care needs. Shorter delays in older adults' services, but with higher turnover – some instances of placements not being able to take older adults due to COVID outbreaks. Some instances of delays due to foreign nationals having expired visas and people seeking asylum without papers or funding agreed. **Actions:** Implementing recommendations of joint HPFT / Regional review of practice, including better community and acute engagement through the clinical review meetings. Key new post of Integrated Flow Service Manager to take accountability and responsibility for actions on DTCs has taken up post in June.
Rate of Acute Inpatients reporting feeling safe (Target 85%)		**Q1 Performance: 76.67%** Low response rate makes results volatile: Inclusion and Engagement Team CQI to PDSA feedback rate and channels in 'new normal' operating environment.

		Actions: Currently on track to recover by end of Q2.
Rate of carers that feel valued by staff (Target 75%)		**Q1 Performance: 69.44%** Low response rate makes results volatile: Inclusion and Engagement Team CQI to PDSA feedback rate and channels in 'new normal' operating environment. **Actions:** Currently on track to recover by end of Q2.
Data Completeness against minimum dataset for Ethnicity (Target 90%)		**Q1 Performance: 86.11%** Possible decreased focus on data quality during the COVID emergency **Actions:** 95% by the end of Q3, to be achieved by culture change.
Percentage of eligible service users with a PBR cluster review (Target 95%)		**Q1 Performance: 83.80%** As focus on PBR clustering declined so did performance and is not currently seen as a priority – it has, however, stayed relatively stable. **Actions:** TBC
Mental Health Services Data Set submissions to NHS Digital Employment & Accommodation (Target 85%)	Employment data  Accommodation data 	**Q1 mean performance: 67%** Recording of employment and accommodation were historically poor but rose steadily with the introduction of SPIKE and the DQ initiative to the highest level they have been in May but have been on a slow downward trend since June. HPFT Benchmarks well against other trusts for these indicators. **Actions:** Re-instate Data Quality exercise. Head of inclusion and engagement leading a CQI project to recover and reposition MHSDS from a data quality focus to care and safety focus.
Cardio-metabolic checks for people with psychosis (Target 90%; FEP 90%; Community CPA 95%)	**Run Chart – FEP**  **Run Chart – Community CPA** 	**Q1 performance:** **FEP = 79.4%** **Community CPA = 82.7%** Underperformance has been caused in part by inconsistent recording practices across quadrants & teams. A steady increase in performance has taken place since June 2020, which is attributable to a greater focus in Community Teams on carrying out health checks. Community teams have reached 86.34% against an increased target of 95%, whilst FEP continues in line with its recovery trajectory of 90% by the end of September, at 79% in June

		– a 10% increase on May performance **Actions:** A trajectory for improvement is has been set with PATH and CPA. FEP: Recovery by September for PATH Teams. CPA: On track to reach 95% target by end of 2021/22.

4.3.1 Safe and Effective Indicators – Almost Met

KPI	Trend	Q1 Status/Action
The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months (Target 95%)		**Q1 Performance: 90.46%** During the Covid-19 pandemic, implementation of the Business Continuity Plan meant that CPA reviews did not take place for a number of months, and as a result there has been a growth in the number of CPA reviews not completed (backlog). When compared with pre-Covid, it is possible to see that this is something the teams were managing well. **Action:** E&N SBU have low numbers of overdue reviews (the maximum is 8 in any one team) and should be able to recover target by early Q2. West SBU have a higher number of reviews overdue, with the main areas for improvement being Watford and St Albans. The SBU is currently re-setting recovery trajectories for each team.
Rate of service users with a completed up to date risk assessment (Target 95%)		**Q1 Performance: 91.82%** Several issues have impacted on performance for this indicator. There are a number of service users in the SW adult Quadrant who have not been allocated a care co-ordinator; service users transferred from ACE in Essex LD Services without risk assessments; the roll over from the initial push on risk assessments at the beginning of the COVID pandemic; but the predominant reason for under performance is the large medical caseload carried by some of the consultants that makes it difficult to monitor and update risk assessments. **Actions:** 1) Local management actions include individual improvement plans with trajectories. 2) Deputy Medical Directors leading a CQI to simplify risk assessment recording in Paris for long term solution.

Rate of service users saying they are treated in a way that reflects Trust values		**Q1 Performance: % 79.89** **Actions:** Low response rate: Inclusion and Engagement Team CQI to PDSA feedback rate and channels in 'new normal' operating environment. Target has been met in June.
Rate of service users saying staff are welcoming and friendly (Target 95%)		**Q1 Performance: 93.75%** There were a low number of responses to this indicator (48), due to the COVID Pandemic there have been a low number of Having Your Say forms returned. The results are therefore not as reliable **Actions:** Low response rate: Inclusion and Engagement Team CQI to PDSA feedback rate and channels in 'new normal' operating environment.

5 Workforce

5.1 Summary position

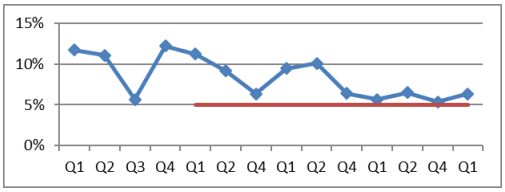
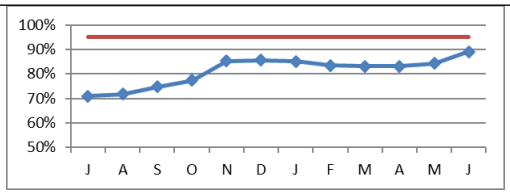
There are 7 Key Performance Indicators routinely monitored in Quarter 1. Three indicators were met in the quarter, 4 were unmet and one was almost met.

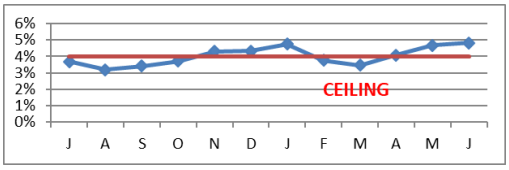
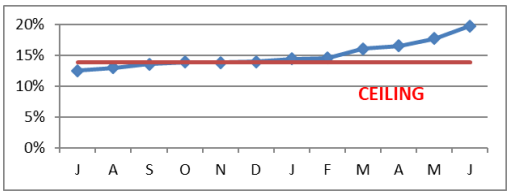
5.2 Areas of Strong/Improved Performance

- Improvement in Training rate to 91.33%
- PDP and Appraisals have improved to 89.10%.

5.3 Underperforming Indicators

Below is an exception summary for those Key Performance Indicators that have not achieved performance standards:

KPI	Trend	Q1 Status/Action
Rate of staff that report experiencing physical violence from service users (Target 5%)		**Q1 Performance: 6.36%** The Quarter 1 figure of 6.36% is a small increase on Quarter 4, but remains at a similar level to the corresponding period last year. **Actions:** Peer review; Environmental review; Recruitment & Retention; Admission & Discharge pathway and the management of DTOC; Additional Team Support/OD support, Task and Finish Group to focus on reducing violence towards staff.
Rate of staff with a current Personal Development Plan and appraisal (Target 95%)		**Q1 Performance: 89.10%** This target has been difficult to achieve, although we are now at a higher point than for the same period last year. **Actions:** It was agreed at Operational Partnership Group (OPG) and Trust Management Group (TMG) with senior leads that

		all staff who are non-compliant will have an Appraisal by the end of June 2021. The HRBP's are sending out weekly appraisal reports within their respective areas and working closely with the managers to improve compliance. Therefore, work to further increase compliance will continue.
Sickness Rate (Target 4%)		**Q1 Performance:** **Actions:** The HR Business Partners are carrying out a deep dive into the number of days, occasions of absence and reasons for absence due to sickness. This will provide us with an understanding as to why there has been an escalation in the sickness absence KPI and enable us to advise managers accordingly regarding support for staff, OH and EAP interventions and facilitated discussions.
Turnover Rate (Target 13.9%)		**Q1 Performance: 19.75%** The turnover rate has steadily increased in the last 3 months; it was, 16.48% in April ,17.72% in May and 19.75% in June. Our unplanned turnover rate at the end of June was 10.04% which is over the our target of 9%. **Actions:** The turnover rate is significantly over the Trust target. Further investigations into the turnover rate have shown that this was as a result of planned turnover and that unplanned turnover remains only slightly over the target. In addition, we have launched our people recovery strategy, which comprises 5 key pillars, one of which is 'Keeping Our People'. Retention therefore continues to be a focus and a deep dive into retention is being undertaken in our May Recruitment and Retention group meeting.

6 Financial Resources

6.1 Finance Overview

The Trust has reported a position on Plan for the month of June and the year to date, a surplus of £30k in month and of £85k for the year to date. As part of this position, £2.6m of COVID-19 income has been received. These figures are driven by increased income in year offset by increasing pay costs and continued pressure against external bed costs.

Ref	Financial Indicator	Target	Current Period Numbers (June 2021/22)	Current Period (June 2021/22 UNLESS STATED)	Previous Period (May 2021/22 UNLESS STATED)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (July 2021/22)
F1	To Achieve Surplus in year (not including PSF)	25k (surplus)	£30k (surplus)	£30k (surplus)	£25k (surplus)	£5k	On plan	↔
F2	Use of Resources (formerly Financial Service Risk Rating)	1		1	1		Currently 1 and expecting to remain so	↔
F3	NHSI Agency Price Caps: (*wage caps no longer reported to NHSI) - monthly number of shifts breaching price caps reported weekly to NHSI in period	Reduce to Zero		274	282		Figures as per NHSI weekly submission. Figure based on full weeks that contain days in the reporting period. Current period figure includes weeks commencing: 31/06/21 07/06/21 14/06/21 21/06/21	↔
F4	Delivering Value (cash releasing efficiency savings in Financial Year)	£7,000k savings target	Current estimate of savings requirement for the year is £7,000k	Current savings programme totals £6,548k for the year	Current savings programme totals £6,752k for the year	Reduction of £204k	Further work being completed to close the gap and identify further savings	↔

7. Benchmarking

Benchmarking (Source January NHS Benchmarking Network Tracker – Appendix 4).

This report covers three elements of performance benchmarking based on the monthly NHS Benchmarking Network Tracker for January 2021.

1. System Context in January 2021
2. Key National Findings
3. HPFT comparator insight

April to June has seen the highest demand for Adults and CAMHS services that the trust has recorded. The predicted 10-30% growth in demand for services was seen as new referrals up 20% against our 2019-20 baseline and overall increases caseloads of 6%.

Nationally, there have been 5 themes emerging in January that have been witnessed by most trusts (not all have been witnessed at HPFT):

- A steady return to face to face contact from February 2021 onwards. (seen at HPFT)

- A reduction in the number of video and telemedicine contacts delivered as face to face services return. Telephone contact still remains high (similar at HPFT)
- National bed occupancy rates have risen month on month throughout Quarter 1(not seen at HPFT, occupancy levels at or near 100%)
- An increase in the proportion of admissions under the Mental Health Act, is now considered to be a result of referral route slowdown and closure during Covid - 19 (witnessed at HPFT)

In comparison to other Mental Health and LD trusts, HPFT continues to benchmark well for performance but in terms of our demand, activity and capacity we tend to appear at the extreme ends of the comparison charts. [Note: This is a result of the methodology used by NHS benchmarking which makes it harder for different sized trusts to compare. For instance, it appears that where HPFT offers services beyond county lines, such as IAPT and LD, there is no adjustment for extra populations. As a result it appears that we have higher levels of admissions and activity]:

- Community
  - IAPT – 2nd highest referral and activity levels in the country. Top half for digital contacts.
  - CAMHS referral rate 3rd lowest in the country per 100k of the population, however caseloads and contacts (digital and face to face) are both close to the average across the country.
  - MH Community adults and older adults – lowest quadrant referrals for adults and older adults per 100k population. Upper quartile for service users seen within a month. Top quarter for digital contacts.
  - LD and ASD – highest quadrant of referrals per 100k of the registered population. 4th highest for caseload and digital contacts, and 6th highest contact level for all provider trusts.
- Inpatient Services
  - Adult acute bed provision and admission rate per 100k population, lowest 10%. Lowest quartile for adults admitted under MHA. Top 10% bed occupancy rate.
  - Older adult bed provision and admission rate per 100k population, upper half. Occupancy rates lowest 10%.
  - CAMHS bed occupancy rates are in the top quartile at 90%+.
  - LD admissions are 3rd highest in the country and occupancy rates are in the top quartile.

The NHS Benchmarking report confirms and supports our internal performance reporting narrative of strong perfromance, high activity levels and a shift to digital. It provides evidence that the extra demand we are seeing for Eating Disorder and Mother and Baby services are national rather than local trends. And finally it re-inforces our understanding of bed provision pressures which are due to being at the lower quartile for all services apart from older adults where we have average (mean) levels for the population size we serve.

8. Quality Account – Priority Indicators

In Quarter 1, of the ten reportable indicators, two were above target:

- Rate of service users saying they have been involved in discussions about their care
- Staff recommending trust services to friends and family

Four of the indicators did not meet target in Q1:

- The percentage of service users who are followed up within 48 hours after discharge from psychiatric inpatient care during the reporting period.
- Rate of service users who have a completed risk assessment within the last 12 months.
- Reduction on the number of inappropriate out of area placements.

- Reduce the readmission rate within 28 days of being discharged from Adult acute hospital bed.

There are four indicators that were not reportable at the time of writing:

- Reduction in the rate and percentage of service user safety incidents that result in moderate or severe harm.
- At least one outcome measures to be used on all LD F inpatients (HONOS in all inpatient units) – Reporting from Q2
- Completed annual care plans within LD community services Herts and Essex – Reported Annually.
- Appropriate Carer Essential Training undertaken by all staff at all levels – Reported Annually

Performance against these indicators can be found in Appendix 3.

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9. Summary

This report has evidenced the performance of the Trust during Q1 2021/22. In light of COVID-19, overall performance continues to remain relatively strong and stable despite the challenges faced. The ability to maintain flow across our Adult and CAMHS beds continues to be a priority.

The vaccination rollout across staff and service users has been incredibly successful with further work ongoing to support access to vaccination for service users. It remains essential that we maintain good lateral flow testing discipline and IPC into the foreseeable future. As the rate of Covid 19 infection rises and country relaxes lockdown is to even more critical that we maintain our IPC and testing standards.

Demand rises are being experienced in CAMHS and Adult services and there are some service areas reporting doubling in referrals (eating disorders, perinatal services, IPS). Ongoing focus will be required to support these services both through resourcing and by improving and innovating service delivery.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 11
Subject:	Annual Plan 2021/22 - Quarter 1 Report	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director of Improvement & Innovation	**Approved by:** Karen Taylor, Deputy CEO / Executive Director Strategy & Integration
Presented by:	Karen Taylor, Deputy CEO / Executive Director Strategy & Integration	

Purpose of the report:

To present the Quarter 1 Annual Plan report.

Action required:

To receive the report.

Summary and recommendations:

About the Annual Plan

The Annual Plan comprises of seven objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust needs to take and the milestones to be reached, by quarter, in order to deliver the Trust's agreed outcomes for the year. At the end of each quarter each objective receives two RAG ratings which indicate:

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

Forecasts for the end of year annual plan outcomes continue to be influenced by the ongoing COVID-19 pandemic which means trajectories, although based on best information available at the time, may be further impacted during Quarter 2 to 4.

Summary

April to June 2021 (Quarter 1) has been both a challenging and positive period for the Trust, with our teams continuing to deliver great care despite pressure from increasing demand and acuity presenting into services.

We have continued to work with our system partners across Hertfordshire, Essex, Buckinghamshire and Norfolk and have made considerable progress against what we set out to achieve for our service users, carers and our people. We have achieved the majority of our milestones for the quarter.

The Table below shows overall performance by Strategic Objective – demonstrating outcomes at the end of Quarter 1 against the milestones set, and progress towards the end of year outcomes. At the end of Quarter 1:

- six out of seven objectives met the milestones for the quarter
- four out of the seven objectives met the end of year outcomes. Key areas to note are the increased number of suspected suicides during the quarter, increased out of area placements, IAPT referral rates, and progress with social care placements.

Q1 Annual Plan Performance

Q1 Milestone RAG rating	Objective		End of Year RAG projection
	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 through the delivery of effective evidence based practice	
	4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	
	5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	
	6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	
	7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	

Conclusion

Significant progress has been made across all seven Strategic Objectives. At the end of Quarter 1, 75% of year end outcomes are on track to be fully delivered (40/53 outcomes). 25% (13 outcomes) are not currently on target, however actions will be taken during Quarter 2 to mitigate this and recover the position. It is important to highlight that the ongoing Covid19 pandemic may form a significant factor in our ability to deliver our plans during 2021/22.

Recommendation

The Trust Board is asked to receive the Q1 Annual Plan Report, noting delivery against the plan to date and projections for the remainder of 2021/22.

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

Summarises progress against Annual Plan (all objectives)

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

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

Equality & Diversity and Public & Patient Involvement Implications:

None noted

Last seen by:

Executive Committee 21.7.21 and FIC (presentation only 21.7.21)

TRUST ANNUAL PLAN 2021/22

QUARTER 1 PROGRESS REPORT

1. Summary

April – June 2021 (Quarter 1) has been both challenging and positive period with our teams continuing to deliver great care despite facing increasing demand for services and recovering from an exhausting 18 months following the COVID19 pandemic.

We have continued working with system partners across Hertfordshire, Essex, Buckinghamshire and Norfolk and we have delivered the majority of what we set out to achieve for our service users, carers and our people. We made considerable progress across our seven strategic objectives, with four (out of the seven) objectives fully on track to achieve the planned end of year outcomes (RAG rated Green).

2. About the Annual Plan

The Annual plan comprises of seven strategic objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust will take and the milestones to be reached, by quarter, to deliver the Trust's agreed outcomes for the year. At the end of each quarter each objective receives two RAG ratings providing:

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

3. Quarter 1 - Progress against End of Year Outcomes

Significant work has taken place during Quarter 1 to support the Trust to achieve the year end outcomes and the detail in Appendix 1 demonstrates this. At the end of Quarter 1, four (out of seven) objectives are on track to fully deliver the planned end of year outcomes (RAG rated Green).

At the end of Quarter 1 overall 75% of year end outcomes are on track to be fully delivered (40/53 outcomes). 25% (13 outcomes) are either not on track/or at risk of not being fully achieved. Plans are in place to support delivery of all outcomes

during Quarter 2 to Quarter 4. However it is important to note that although our resolve and ambition remains to deliver the commitments in full, the ongoing Covid19 pandemic may impact our ability to deliver our plans during the remainder of 2021/22.

Table 1 End of Year RAG outcome- as at Q1

	Objective	Q1 RAG rating
1	We will provide safe services, so that people feel safe and are protected from avoidable harm	5/8 (63%)
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	5/8 (63%)
3	We will improve the health of our service users through the delivery of effective evidence based practice	4/5 (80%)
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	5/7 (71%)
5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	5/6 (83%)
6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	7/9* (78%)
7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	9/12 (75%)

The Amber rated objectives are as follows:

Objective 1 – Safety

This objective was rated Amber due to an increase in suspected suicides during the quarter. As is normal practice, all incidents are reviewed to identify any key issues/areas of learning. In addition, a deep dive to identify any themes across the incidents is also being undertaken.

Objective 2 – Experience

This objective was rated Amber due to the slower than planned progress made with Connected Lives programme, Out of Area placements remaining high and IAPT falling behind commissioned referral targets in Q1.

Objective 6 – Joined up Care

This objective has been rated Amber due to the higher than target numbers of inappropriate out of area beds and delays to transfer of care.

4. Performance against Quarter One Milestones

At the end of Quarter 1, six out of seven objectives met the majority of key milestones.

Table 2 – Q1 milestones RAG rating

Objective		Q1 RAG rating
1	We will provide safe services, so that people feel safe and are protected from avoidable harm	5/9 (56%)
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	11/11 (100%)
3	We will improve the health of our service users through the delivery of effective evidence based practice	11/15 (73%)
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	13/15 (87%)
5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	9/12 (75%)
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	11/11 (100%)
7	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	12/12 (100%)

Objective 1 – Safety

This objective was rated Amber due to slower than planned progress to strengthen care plans and shared decision making with service users, our review of violence and aggression best practice, and opening new safety suites. It is anticipated this work will be taken forward during Quarter 2.

5. Conclusion

Significant progress has been made across all seven Strategic Objectives with the Trust on track to deliver against the majority of year end outcomes identified. At the end of Quarter 1 60% of year end outcomes are on track to be fully delivered (40/53 outcomes). 40% (13 outcomes) are either not on track/or at risk of not being fully achieved. Plans are in place to support delivery of all outcomes during Quarter 2 to Quarter 4. However it is important to note that although our resolve and ambition

remains to deliver the commitments in full, the ongoing Covid19 pandemic may impact our ability to deliver our plans during the remainder of 2020/21.

Appendix 1 – Annual Plan - Outcomes

	Objective	Predicted			EOY	Year End Outcomes Commentary
		Q1	Q2	Q3	Q4	
1	We will provide safe services, so that people feel safe and are protected from avoidable harm					There have been 14 suspected suicides between April – June 2021. Each is being investigated individually and thematically to understand what we can learn in order to prevent deaths in the future. We continue to work across the system to prevent suicide with initiatives including 'Spot the Signs,' 'Stay Alive' and through social media to reach vulnerable individuals. Levels of harm as a result of violence and aggression in inpatient services are improving as a result of training and focus on safety at the start of every shift.
2	We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience					Building refurbishments for Forest house, Oak, Albany Lodge, and Lexden are progressing. Co-production plan is agreed with delivery plan established and Having Your Say survey result show improved engagement activity in Q1. IAPT volumes are behind commissioned targets. The number of social care placements have not reduced in Q1, however, our Connected Lives programme is reporting good progress and confidence we will meet our 2021/22 commitments.
3	We will improve the health of service users through the delivery of effective evidence based practice					Progress for physical health has been accelerated throughout Q1 with checks completed for all service users on the SMI register, and further innovation through the Blue box project roll out. Training in the simulation suites is progressing well. However, progress around greater psychological awareness in services, and social care and wellbeing plans are behind target.
4	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment					Staff support through Wellbeing services has been further strengthened in Q1 with the 'Here for You' service and Spring wellbeing programme. Executive engagement events have supported local listening, understanding and shaping of recovery action plans. Vacancy rates are improving but the target was not met for Q1. Staff retention & vacancy rates have improved in Q1 against pre-COVID baselines, however we have not achieved all of our workforce targets for Q1. Work is underway to recover this in Q2.
5	We will improve, innovate and transform our services to provide the most effective, productive and high quality care					We continue to see an acceleration of innovation and improvement across the trust in 2021/22. A culture shift is evident in the volume and maturity of digital interaction with service users, our internal and external collaboration capability, automation, & improvements to data & information systems. We are running behind target for automating clinical outcomes and key BI dashboards in SPIKE, which will need to be recovered in Q2-3 to deliver on population health and other data led service delivery opportunities.
6	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with partners					Good working relationships have been established and developed with our partners across the system leading to jointly designed and implemented services. Demand remains high, and access times remain a key priority – with adults and CAMHS under significant pressures. Key programme of work agreed with partners for CAMHS T4. We have seen modest reductions in the number of inpatient admissions and length of stay in Q1, however out of area placements and delayed transfers of care remain high.
7	We will shape and influence the future development & delivery of health and social care to achieve better outcomes for our population(s)					The MHLD Collaborative continues to develop and lead transformation across Herts. During quarter 1 partners have been working together to review the underpinning governance in line with the ICS development. This will be a key focus in Q2. The EOE Collaborative went live in July 21, with a continued focus on improving care and beginning to mobilise the new clinical pathways. CAMHS bed management and redesign of clinical pathways remains a key focus.

Appendix 2 – Annual Plan 2021/22 - Quarter 1

Commentary against Milestones and Outcomes

Strategic Objective 1 (Owner JP)	Q1 Key Actions / Milestones	Q1 Milestones Rating
We will provide safe services, so that people feel safe and are protected from avoidable harm **Key Priorities** • We will continue to work with system partners to prevent suicides • We will keep service users and staff physically and mentally safe, reducing the avoidable harm they experience • We will ensure the least restrictive practice is appropriately used to support service user recovery • We will implement and follow best practice infection prevention & control practice across our services	• Work with public health & other system partners to deliver the Suicide Prevention Strategy, including awareness of 'Stay Alive' suicide prevention App. • Review & fully implement MOSStogether, including embedding safety huddles for service users • Adopt new service users engagement approaches ensuring the appropriate, least restrictive practice, real time monitoring and support to local teams. • Rigorous application of Infection Prevention & Control policies and behaviours by increasing support & training to staff • Review & strengthen the approach and role of peer experience listeners on inpatient units • Continue opening best in class new seclusion/safety suites • Strengthen care plans using shared decision making with service users and carers - including plans for crisis management and relapse prevention • Introduce the "Just Culture Guide" to support teams to embed our Just and Learning culture • Review, develop and implement best practice to managing violence and aggression	
	• **Commentary:**	
	• Safety suites at Warren court, Broadland clinic, Dove ward and 4 Bowlers green in final stages of completion. • All IPC policies have been updated and all training is now online with recent donning and doffing module • Good evidence of partnership working to prevent suicide including Spot the Signs and the rollout of Stay Alive • The Just Culture Programme continues to develop with new policies and guidance developed in Q1 • CQIs under way for service user and carer engagement and ideas are scheduled for implementation in Q2. • Best practice review for violence and aggression is underway and due to complete in Q2. • RESPECT training has a large backlog and additional training capacity recruited to recover the position in Q2.	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
There have been 12 suspected suicides during Q1. Each is being investigated individually and thematically to understand what we can learn in order to prevent deaths in the future. We continue to work across the system to prevent suicide with initiatives including 'Spot the Signs,' 'Stay Alive' and through social media to reach vulnerable individuals. Levels of harm as a result of violence and aggression in inpatient services are improving as a result of training and focus on safety at the start of every shift.	• 10% reduction suspected suicides baseline < 40 for year (14 in Q1) • Suicides relative to total Contacts with HPFT. Baseline 4.75^{-4} (5.21^{-4}in Q1) • 85% service users report feeling safe across adult & CAMHS inpatients (71.5% in Q1) • < service user to staff moderate - severe harm through violence & aggression (<2.3% -Q1: 0.87%) • < service user to service user moderate - severe harm through violence & aggression (<2.3% - Q1 2.28%) • 98% SI action plans - Day 60 post SI (100% Q1) • 95% SI actions implemented by date set in action Plan (100% Q1) • > % staff reporting feeling safe (82% baseline) (88% in Q1)	

Strategic Objective 2 (Owner SB)	Q1 Key Actions / Milestones	Q1 milestones Rating
We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience **Key Priorities** • We will improve service user experience of accessing our services and receiving treatment • We will involve our service users and carers in the design and delivery of services and their care • We will provide safe, high quality environments where our service users are cared for and our staff work	• Strategic co-production plan agreed and ratified at ELDP with delivery working group established • Expansion of membership of ELDP governance arrangements to include Experts by Experience and production of easy read papers as appropriate. • Way in Team recruited to support the centralisation of the Personalised Assessment Plan process • Dynamic support register and health coordination process • Sign-off of final Rehab Hospital at Home Business Case with stakeholder engagements • Connected Lives: Evaluate Pre-Pilot feedback and further develop 1st Quadrant Pilot Plan • Independent co-production organisation identified and commissioned to support LDF SBU • Agreement of use of outcome measures to be used with community LDF teams • Agreement of pump priming funding from Commissioners to expand Hertfordshire and Norfolk Forensic community services. • Targeted engagement & development work with PCNs to ensure good take up of ARRS • IAPT: Review health inequalities / population health data for IAPT services Upgrade to Forest house, Oak ward , Lexden and Albany Lodge	
	Commentary: Establishing Coproduction plan in LDF services has been progressing with stakeholder engaged in developing the strategy. Way in team is established to ensure sufficient clinical and non-clinical staff are recruited to support the centralisation Dynamic support register SOP is agreed Consultation of preferred Rehab Hospital at home model with key stakeholders and project underway Connected Lives Practice Development Plan to underpin wider implementation including communication plan, service level training plan and Practice Delivery pages now all on The Hive. Life star outcome measure agreed	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
Building refurbishments for Forest house, Oak, Albany Lodge, and Lexden are progressing. Strategic co-production plan is agreed with delivery plan established and HYS survey result show improvement in engagement activity in Q1. IAPT volumes are behind commissioned targets. The number of social care placements have not reduced in Q1, however, our Connected Lives programme is reporting good progress and confidence we will meet our 2021/22 commitments.	• HYS survey results for Service users (93%) • Forest House development • Oak & Albany Lodge upgrade significantly progressed • E&N Herts bed provision final business case approved • Lexden refurbishment • Carers awareness training • IAPT access KPI (8876. Target 9843) • Reduction in the number of social care placements made • Reduction Out of area placements (1385 in Q1)	

Strategic Objective 3 (Owner AZ)	Q1 Key Actions / Milestones	Q1 Milestones Rating
We will improve the health of our service users through the delivery of effective evidence based practice **Key Priorities** • We will improve the care, support and outcomes for service users who are in need of additional support or at risk of admission • We will support our service users to be physically healthy by improving the physical health support, intervention and care available • We will support our service users to live their lives as independently as possible	• Additional support & improved community interventions for recurring inpatient service users • Define Community rehab offer to avoid re- admission • Implement a new integrated CYP crisis service • New Outpatient model scoped and Scope for evidence-based care completed with pathways • Identify / evaluate gaps identified in National audits to evaluate evidence-based care • ELDP Bed Review -Initial appraisal of sites for bed consolidation • Engage service users in research activity across the Trust, focusing on specific clinical pathways • Ensure all service users receive physical health checks appropriate to their protected characteristics, co-morbidities, and medications and roll out of annual health checks in ELDP • Roll out of Blue box project in MHSOP community and funding for adult and LD secured from NHSX • Support/training front line staff to avoid acute attendances/admissions and improve physical health data • Simulation suites technology installed, and staff received simulation training • IAPT teams to promote and provide early intervention by proactively reaching out to hard to reach • Support service users to reduce tobacco dependence and nicotine addiction • New social care & wellbeing plans for better planning & shared decision making with service users • Cross SBU working to ensure consistency in service changes across primary and secondary care support greater access to psychological therapies	
	Commentary:	
	High risk meeting has been initiated across ACMH, Crisis and acute services Community Rehab paper submitted to TMG for review, expected to go to trust board for approval in Q2 Recruitment campaign for new CYP Crisis team is underway Design underway to define new outpatient model and its protocols including Depression and Assessment and treatment pathway POMH-UK Topic 9d for antipsychotic prescribing in people with learning disability and POMH-UK audit of Lithium audit Research board is now established Registered nurse and HCA physical health course developed	

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
Progress for physical health has been accelerated throughout Q1 with checks completed for all service users on the SMI register, and further innovation rollout through the Blue box project roll out. Training in the simulation suites is progressing well. However, progress around greater psychological awareness in services, and social care and wellbeing plans are behind target.	• Training programme in place for Inpatient and for Community Services • Demonstrate improved outcomes on new pathways for service users • Social care and wellbeing plans in place and outcomes recorded • 95% CPA physical health checks (Q1 – 86%, improving steadily) • Reduction in readmission for service users with PD (Base11% - Q1 13%)	

Strategic Objective 4 (Owner JL)	Q1 Key Actions / Milestones	Q1 Milestones Rating
We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment **Key Priorities** • We will improve the employment experience of our people, including support to improve their health & wellbeing and to help them to rest and recover post Covid 19 • We will ensure all our people feel valued, included and able to fulfil their potential through the development of our just & inclusive culture • We will develop our collective leadership culture to support all of our staff to feel empowered and engaged	• Paying witness – Schwartz rounds and team sessions to share and honour experience. • Implement our Spring Wellbeing Programme and ensure high engagement • Implement support for shielding staff returning to the workplace • Promoting the Here for You Service to ensure high uptake • Appoint a Board Wellbeing Guardian • Encouraging time off to rest and launching the additional day's annual leave • Providing a choice of reward: an extra day's leave or the ability to sell this back for £100 • Finalize our people recovery and staff survey action plans • Continuing our Inspire Awards • Refreshing our attraction offer to attract newly qualified nurses, international nurses and address hot spot areas • Developing our just and inclusive culture programme of work • Engaging with staff networks, through Good to Great Roadshows • Developing a Trust wide workforce plan • Checking in with our staff at our next Big Listen and achieving high engagement- this was postponed to Q3 following significant 'recovery engagement' events held in Q1 • Launching our refreshed appraisal approach – new template signed off in June; policy to be ratified by JCNC in July.	
	Commentary: • Various activities of paying witness completed e.g. personalised pack of seeds for all staff to plant and exec team planted a bulb for every life lost • Launching the additional 2 day's annual leave to say thank with personalised thank to all • Continued engagement with staff at all levels to finalise recovery and staff survey action plans	

Summary:	Key Outcomes at Year End	Year End Outcomes
Staff support through Wellbeing services has been further strengthened in Q1 with the 'Here for You' 'service and Spring wellbeing programme. Exec led engagement events have supported local listening, understanding and shaping of recovery action plans. Vacancy rates are improving but missed target for Q1. Staff retention & vacancy rates have improved in Q1 against pre-COVID baselines, however we have not achieved all of our workforce targets for Q1.	• Health and Wellbeing score >6.6 • < Reduction in staff reporting bullying/harassment by manager • Develop our Just and Inclusive Culture across the Trust • Significant improvement in the experience of our BAME staff and staff with a disability. • Big & Little Listen events • <10.5 % vacancy rate by year end (Q1 – 11.2%) • < 9% unplanned turnover rate by year end (Q1: 10%)	

<table>
<tr><th>Strategic Objective 5
(Owner MW/JP/PR)</th><th>Q1 Key Actions / Milestones</th><th>Q1 Milestones Rating</th></tr>
<tr><td rowspan="3">We will improve, innovate and transform our services to provide the most effective, productive and high-quality care

Key Priorities
• We will support, enable & encourage our people to continuously improve the care and services we provide
• We will continue to introduce new digital capabilities that will enable teams to innovate and improve service user, carer & staff experience as well as the safety and effectiveness of our services
• We will continue to release time to care by supporting staff to work more effectively and flexibly, including providing better and simpler access to information</td><td>• 45 staff trained in CQI
• Progress of Life QI usage
• Improvement in our 6 focus areas demonstrated on Life QI
• CQI Forum established in each SBU
• ePMA deployment started
• External funding secured for creating the new digitally enabled pathways
• Further develop demand, activity & capacity modelling capacity across the Trust
• Deliver our ‘Time to Care’ programme
• Align estate with new agile working culture
• Hybrid mail contract awarded, and implementation started
• Digital outcomes live in perinatal and adult eating disorder services and rollout plan for other services agreed
• Implement a Trust productivity, quality and pathway dashboards</td><td></td></tr>
<tr><td colspan="2">Commentary:</td></tr>
<tr><td colspan="2">• CQI training exceeded target and has maintained over 30% of staff represented from BAME background
• 113 staff signed on Life QI which is 50% increase from Q4 and 64 active projects on Life QI covering 6 focus area
• CQI forum is supporting local teams to learn and share together and funding agreed for E&N innovation hub.
• ePMA project work with Civica initiated. As is process completed for As Is’ process meetings completed for Acute adult, Older adult, CAMHS, LD&F, Rehab, 136 suite with good HPFT Nurse/Doctor representation acute
• Additional NHSX funding has been secured for Blue box rollout. An external provider to run its delivery
• Digital outcome live is on track to be implemented in July 2021
• Modelling for Improvement is providing team level insights across the trust</td></tr>
<tr><th>Summary:</th><th>Key Outcomes at Year End</th><th>Year End Outcomes Projection</th></tr>
<tr><td>We continue to see an acceleration of innovation and improvement across the trust in 2021/22. A culture shift is evident in the volume and maturity of digital interaction with service users, our internal and external collaboration capability, automation, & improvements to data & information systems. We are running behind targets for automating clinical outcomes and key BI dashboards in SPIKE which could impact our ability to deliver on population health management and other data led service delivery opportunities - a key focus for Q2</td><td>• Digital Strategy finalised – focus for the next 5 years
• Streamline & develop Electronic Patient Record system to support delivery of care and system interoperability
• 180 staff trained in CQI
• 20 EBE trained in CQI
• West and E&N CQI hubs established
• HYS: I am easily able to make changes at work >82% (Q1: 78%)</td><td></td></tr>
</table>

Strategic Objective 6 (Owner KT/SB)	Q1 Key Actions / Milestones	Q1 Milestones Rating
We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners **Key Priorities** • We will Improve community adult and older peoples' services and care aligned with Primary Care Networks • We will improve access and delivery of care for those people with a learning disability across the Trust • We will improve the range and access to crisis services in conjunction with Hertfordshire partners • We will work with partners across Hertfordshire to deliver earlier intervention and support for Children and Young People	• New community model for adult & older people (in Watford & Lower Lea Valley) evaluation • Continue to develop our Primary Mental Health model with PCNs engaging with expert by experience • Monitor and ensure all red rag rated SUs have an Annual Health Check (AHC) in ELDP • Develop an annual health check training pack within ELDP • Identify resource implication for Health co-ordination • Frailty tool trialled with red rag rated cohort in South West Essex locality • Community Outcome measure tool agreed • LeDeR work to include the set up and start of a Frailty workstream with system partners. • Bowel Health CQI project to be implemented in Buckinghamshire • Norfolk Most Capable Provider programme to commence. • Crisis evaluation against the fidelity scale • Expansion of Mental Health Support Teams in schools (MHSTs) - Roll out teams to Stevenage and Watford	
	Commentary: Complete evaluation of new community model in advance of the roll-out of Transformation funding (22/23) AHC training aligned to GP champion to increase engagement and specific area targeted based on needs in ELDP Frailty tool initial analyses shows a positive response in South West Essex locality and across Herts a system wide Frailty group has been established Lifestar outcome measure tool has been agreed and next phase of train the trainer to start Bowel health CQI commenced to link with LeDeR recommendations Primary Care Model and new roles are a key focus for Q2	

Summary:	Key Outcomes at Year End	Year End Outcomes
Good progress made in Q1, with the foundations in place for the remainder of the year. Key areas of focus in Q2 will be CAMHS, Crisis pathway and work with acute Trusts, and access times remain a key priority. We have seen modest reductions in the number of inpatient admissions and length of stay in Q1, however out of area placements and delayed transfers of care as still high.	• Essex Local integrated teams established and access improved by 'Way in' service • >Improved service user and carer experience (Q1 89% of baseline 88%) • <inpatient admissions – baseline 365 (Q1 359) • <LOS • <crisis presentations (645 in Q1 of baseline 902) • 95% CAMHS access <28 day (97% in Q1) • CAMHS Crisis Business case approved • Adult < reduced time to treatment and ongoing care • < out of area placements (1385 in Q1)	

Strategic Objective 7 (Owner KT)	Q1 Key Actions / Milestones	Q1 Milestones Rating
We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s) **Key Priorities** • We will lead the development of the Hertfordshire Mental Health & Learning Disabilities Integrated Care Partnership (MH & LD ICP) • We will advocate for and ensure mental health & learning disability services are developed across populations we serve • We will work with regional partners to develop and deliver New Models of Care for those with specialist mental health and learning disabilities	• Develop draft MHLD Collaborative MOU • Develop draft Governance framework • Develop draft Commissioning Hypothesis • Coproduce MHLD Collaborative 5yr Strategy • Finalise 2021/22 Transformation programme • EOE Provider Collaborative agreement signed by Trusts • CAMHS T4 Lead Provider Contract negotiated • Collaborative achieves "Go Live" in July • Young Person and Parent/Carer Steering Group established • Operating standards and procedures in place for EoEPC Transformation and Commissioning Team	
	Commentary: **Hertfordshire MHLD Collaborative.** Good progress during the quarter, continued focus on transformation and moved into the next phase of developing the commissioning and governance arrangements. We have now completed the work taken forward in Partnership with Niche to understand the impact of Coved on the mental health and learning disability population across Herts and West Essex and develop a recovery plan. **East of England Provider Collaborative** Developed high level accelerated transformation plans for CAMHS and Forensic LD, implementing phase 1 of the Bed Management and SPA on behalf of the collaborative and finalising the documentation to enable Go Live.	

Summary:	Key Outcomes at Year End	Year End Outcomes
The MHLD Collaborative continues to develop & has been leading MHLD transformation and responding to local pressures within the system to deliver Long Term Plan commitments and Transforming Care. Key focus in Quarter 2 is the Primary Care Model and establishing the Collaborative ICAG.(integrated clinical advisory group) The EOE Collaborative went "Live" in July 21, with a continued focus on improving care and beginning to mobilise the new clinical pathways.	• Transformation programme in place with partners engaged • HWE ICS continues to prioritise & invest MH & LD • HWE ICS population health model continues to develop • Mental Health Investment Standard is met within 2020/21 • MH & LD is overtly prioritised within the ICS strategy and delivery • Place based ICPs focusing on, and including MH & LD in future delivery model • East of England (EOE) Provider Collaborative established • LTP/operating commitments delivered for 2020/21 • Out of area placements for service users requiring specialist beds • Delivery of new crisis pathway & CAMHS pathways with partners across Hertfordshire • Delivery new Community model including PCNs • Plans for development of services across EOE under development • Number of inpatient stays for an Eating Disorder	

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 12
Subject:	Annual Accounts 2020/21 & Financial Position for Quarter 1 2021/22	**For Publication:** Yes
Author:	Sam Garrett, Interim Deputy Director of Finance	**Approved by:** Maria Wheeler, Executive Director of Finance
Presented by:	Maria Wheeler, Executive Director of Finance	

Purpose of the report:

The report sets out a summary of the yearend for 2020/21, and the financial position to 30th June 2021, with an early indication of the expected positon for the remainder of Half 1 and for Half 2.

Action required:

To review the detail provided on the current and projected financial position for the year 2021/22.

Summary and recommendations

Completion of 2020/21 Annual Accounts

The Annual Accounts and Annual Report process for 2020/21 was completed on time, with sign off at the Audit Committee on 10th June, submission to NHSEI on 16th June, and the final formatted Annual Report submitted for laying before Parliament on 28th June. The Accounts received an unqualified audit opinion, with 3 unadjusted audit differences (below the audit materiality threshold), and several recommendations (none at Priority 1, which would have been deemed fundamental and material), which are under review by the Trust.

Quarter 1 2021/22

As per the Flash position which came to the Executive Team on 30th June, the Trust has reported a position on Plan for the month of June and the year to date, a surplus of £30k in month and of £85k for the year to date. As part of this position, £2.6m of COVID-19 income has been received. Income and expenditure figures are shown below:

Financial Position to 30th June 2021 £000	June Plan	June Actuals	June Variance	YTD Plan	YTD Actuals	YTD Variance
Income incl. COVID-19*	**24,016**	**23,855**	**(161)**	**71,920**	**71,550**	**(370)**
Expenditure	**23,987**	**23,825**	**161**	**71,835**	**71,465**	**370**
Surplus / (Deficit)	**30**	**30**		**85**	**85**	

These figures are driven by increased income in year offset by increasing pay costs and continued pressure against external bed costs. Key variances within the yearend position are as follows:

- Income below Plan by £370k to date, due to delays in some investment areas; OFFSET by
- Pay also below Plan due the same investment areas not having had staff appointed; AND

- Non-pay below Plan again due to the same investment areas; OFFSET by
- Secondary Commissioning above Plan due to continued high activity particularly for external beds.

Pay costs have increased in month across all types of pay spend, with substantive and bank due largely to additional enhancements in month, and agency due to high usage in Essex LD and Norfolk services, some of which will attract additional income from commissioners; inpatient usage in Hertfordshire also remains high. Secondary commissioning spend did decrease in month, but overall this was more due to there being one fewer day in June than to decreasing pressure. Some additional costs have been prudently provided for against the Mitie contract, given the nature of this relatively new contract.

In terms of income Half 1 continues with similar arrangements to 2020/21 with block payments being made. Significant additional income is expected from SDF and SR monies, with only those amounts currently being spent included within the position currently. Discussion continues with Hertfordshire commissioners to finalise the income position for the year, and this is expected to be completed imminently.

Half 2 remains less certain with COVID-19 income expected to be removed or reduced, and higher levels of efficiencies expected. Planning guidance is now not expected until September however the Trust needs to act to mitigate against these factors as far as possible.

It remains fully expected that the Trust will report on Plan for Half 1, and also for Half 2, those with a degree less certainty at this point given the lack of information. This will continue to be monitored and fed back.

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

Financial Plan for 2021/22

Summary of Financial, IT, Staffing & Legal Implications:

Achievement of Financial Control Total

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

Executive Team 14th July 2021 and FIC 21st July 2021

1. **<u>Update on 2020/21 Yearend Completion</u>**

1.1. The Annual Accounts and Annual Report process for 2020/21 was completed on time, with sign off at the Audit Committee on 10th June, submission to NHSEI on 16th June, and the final formatted Annual Report submitted for laying before Parliament on 28th June.

1.2. The Accounts received an unqualified audit opinion, with 3 unadjusted audit differences, which were below the audit materiality threshold. There were a number of recommendations: none at Priority 1 (which would be deemed fundamental and material); 5 at Priority 2; and 3 at Priority 3. The recommendations predominately related to the processes of valuation of the Trust's estate, and assessment of income against IFRS15, they are all under review by the Trust and were subject to a separate presentation at the Audit Committee on 19th July.

2. Quarter 1 Summary

2.1. The Trust has reported a position on Plan for the month of June and the year to date, a surplus of £30k in month and of £85k for the year to date. As part of this position, £2.6m of COVID-19 income has been received.

2.2. Main figures for the month and year to date are shown below:

Financial Position to 30th June 2021 £000	June Plan	June Actuals	June Variance	YTD Plan	YTD Actuals	YTD Variance
Income incl. COVID-19	24,016	23,855	(161)	71,920	71,550	(370)
Pay	15,853	15,856	3	47,586	47,287	(299)
Sec Comm	2,768	2,816	49	8,511	8,716	206
Non-Pay & Overheads	5,366	5,152	(214)	15,738	15,462	(276)
Total Expenditure	23,987	23,825	161	71,835	71,465	370
Surplus / (Deficit)	**30**	**30**		**85**	**85**	

2.3. Main variances are as follows, with further detail within Section 3 and 4:

2.3.1. Income below Plan by £370k to date, due to not having released as much SDF income as was expected at this point of the year, due to delays in some investment areas; OFFSET by

2.3.2. Pay also below Plan due the same investment areas not having had staff appointed; AND

2.3.3. Non-pay below Plan again due to the same investment areas; OFFSET by

2.3.4. Secondary Commissioning above Plan due to continued high activity particularly for external beds.

2.3.5.

3. Background

3.1. Half 1 sees the continuation of the COVID-19 contracting and funding arrangements adopted during 2020/21. Planning guidance will be issued in Quarter 2 setting out the financial regime for Half 2, however this is now not expected until September. There have been changes made to payments reflecting additional services in Norfolk and Buckinghamshire, as well as reductions in Essex IAPT services.

3.2. Block contract arrangements have remained in place, with contract negotiations ongoing with Hertfordshire. Baseline figures are agreed and further confirmation is expected imminently in terms of exactly which service developments will be funded from MHIS, SDF and Spending Review monies.

3.3. The main block payments from CCGs and NHSEI, along with the Hertfordshire Social Care block payment, equate to c. 90% of the Trust's income. There is also income available a number of smaller contracts (such as for SRS), and from other sources such as Education and Training income from Health Education England (including backfill monies for IAPT trainees); these are in line with 2020/21 plus inflation. In addition there is the release of old year SDF monies to match spend.

4. Income Position

4.1. For the year to date there is £370k less income than Plan, this is due largely to assumptions made within the Plan around the Hertfordshire block income arrangement and currently being prudent around the amount of income released against cost.

4.2. The following table shows additional income expected this year against both Hertfordshire (including SDF and SR monies, but excluding carried forward amounts) and other contracts. The bolded "total" row has an increase of £17.6m which is likely to increase in coming weeks as full SDF and SR monies are agreed, though the likely national requirement to increase efficiencies in Half 2 will reduce in part.

Contracts	20/21	21/22	Change	% Change
Hertfordshire incl. SDF/SR	188,042	204,945	16,903	9%
Non-Herts	55,164	55,896	732	1%
Total*	**243,206**	**260,841**	****17,635**	**7%**

*total position is shown normalised for the loss of Essex IAPT contracts and the Provider Collaborative; the latter will be pass-through only

**expected to increase as only includes items already contractually confirmed as coming to HPFT

4.3. CQUIN has been included for the year to date at 100% with no penalties, this position will continue for at least Half 1 of 2021/22, though CQUIN is now being actively discussed with Commissioners.

4.4. SDF and Spending Review funding for 2021/22 have recognised values, with details of how this funding will be deployed still under discussion, which includes how much HPFT will receive. Some 2020/21 SDF carried forward income has also been included in the position to match expenditure incurred in Quarter 1.

4.5. In addition to carried forward SDF and HEE salary support monies, there are a number of carried forward income items from the Hertfordshire contract that are expected to be spent in the coming months and will be released as the costs are incurred. These include, but are not limited to: IAPT "Chatbots" (£243k), Digital X Aspirant (£250k), and Staff Wellbeing Hub (£186k).

5. Expenditure Position including Key Variances

Pay

5.1. Pay is below Plan by £370k to date due to vacancies, not yet fully covered, particularly against new and expanded services. However spend did increase significantly in June (by £290k), and bank and agency spend remains above Plan, largely due to continued high acuity in inpatient areas.

5.2. Substantive Pay increased by c. £110k in month, this was largely due to an increase in enhancements paid in June (for the May bank holidays, as these are paid in arrears); additional amounts relate to an adjustment for recharges out, and a small increase in fte (c. 3.00). Bank Pay increased by c. £80k in month, again this was largely due to the enhancements being paid in June. Agency Pay increased by c. £100k, largely in Norfolk and Essex LD due to an individual in Norfolk who has extremely high needs and where commissioners have agreed to fund additional agency staffing, and exceptionally high acuity in Essex LD. Inpatient areas in general across the Trust remain high for both bank and agency related to continuing high acuity, including for Hertfordshire Adult inpatients as well as Essex and Norfolk.

5.3. Part of the plan to address bank and agency spend is the most efficient use of Electronic Rostering and of Safe Care; a senior role to lead on this work has been agreed and will start soon. Additionally a number of Internal Audit actions are being taken forward which will improve controls and reduce inappropriate use of staffing.

5.4. Recruitment continues on a proactive basis with currently c. 110 individuals having start dates or offers awaiting confirmation of start date; if all these join HPFT this would equate to a c. £250-300k per month pay cost, and may allow for bank and agency cover cost reductions. Posts relating to the transformation programme will largely be covered by income not currently being released into the position.

5.5. An estimation of the Pay award has been provided at 1% in line with the initial government NHS pay offer, c. £135k per month, which would be funded from existing income.

Secondary Commissioning

5.6. Secondary Commissioning has overspent against Plan for the year to date by c. £200k, however spend did decrease in June by £119k, largely due to a lower number of days in the month.

5.7. Activity at the end of each quarter along with current activity and against expected levels is shown below. It is of concern that beds have also been difficult to procure and therefore spend could have been higher had they been available. For this reason, and to ensure better quality and care closer to home, discussions are taking place with a private provider to purchase additional beds on a block basis.

Sec Comm Activity	Expected	Q1 20/21 Avg	Q2 20/21 Avg	Q3 20/21 Avg	Q4 20/21 Avg	Q1 21/22 Avg	Current
CAMHS OOA	8	12	18	21	18	13	10
Older Adults	0-1	0	0	0	0	1*	1
Adult Acute	2	8	5	9	13	13	13
Adult PICU	4-6	4	4	6	4	9	9
Adult Long Term	30	35	35	34	31	30	28

*1 was awaiting an adult bed, 1 was placed due to exceptional reasons as could not be admitted to an HPFT bed

Overheads and Non-Pay

5.8. Other Direct costs and Overheads are below Plan by £275k, this is largely due to the level of income being uncertain and therefore a number of associated non pay costs have also not yet flowed through in line with the Plan. Within this however there is some provision for additional costs such as against the Mitie contract where costs to date are in line with those expected but where there is a degree of risk given such a new contract.

6. COVID-19 Income and Expenditure

6.1. For Half 1 there continues to be a flat rate of income to cover COVID-19 costs. Current areas of spend against this are as follows:

6.1.1. Pay costs particularly relating to Incident Command, C-CATT, junior doctors on-call, and weekend cover, though at a reduced level with both Incident Command and weekend cover having been stepped back to a large extent during Quarter 1. However, costs of isolation are now starting to increase again.

6.1.2. Continuing costs relating to IPC such as deep cleaning and uniforms, from Mitie as well as other suppliers, and other non-pay elements of the incident response. There have been no further Fit Testing costs since May.

6.1.3. Additional external bed provision / secondary commissioning costs, for CAMHS T4 in particular.

6.2. A number of these costs are continuing to reduce with the incident response having been stepped back, however the indirect costs of COVID-19 remain, in particular relating to external bed pressures, as well as increased acuity and "catch-up" activity being experienced in many areas. Costs which have not been removed by Half 2 will present a risk to the Trust's financial position and will need to be managed accordingly. The other risk remains the need to step back up the Pandemic response, with Incident Command having recently moved back to twice per week due to increasing numbers locally, and issues with staff absence due to required isolation.

6.3. PPE remains provided nationally and not funded by the Trust, though this was accounted for in the Trust's accounts at the financial year end and is expected to be in 2021/22.

7. Delivering Value Programme

7.1. Progress continues with 14% achieved in Quarter 1 of the c. £7.0m target for the year. The year-end forecast shows shortfall against the full target at £6.5m, however every effort is being made to seek new opportunities to ensure the full programme is delivered.

7.2. Although Half 2 planning guidance is not expected until late September, it has been suggested a higher efficiency ask will be expected in the second half of the year. The additional efficiency requirement has assumed current covid related costs will reduce to meet the extended target. This presents a further potential financial risk for the Trust.

8. Balance Sheet and Cash Flow

8.1. The full Statement of Financial Position is set out as an Appendix. Main changes in month are as follows:

8.1.1. Receivables increased in the month by £1.9m, predominately related to payment of invoices to Hertfordshire County Council (HCC) for the Social Care element of the block contract, which has not yet been received; this has been chased and payment is now expected mid-July.

8.1.2. Payables and accruals increased by £1.5m in month, predominately related to an increase in capital accruals as the capital programme accelerates as per the Capital Plan.

8.1.3. Deferred income decreased by £1.0m in month, relating to LDA funding received in advance for Quarter 1, and release of STP deferred income to match expenditure incurred.

8.2. Cash balances remain very positive, at c. £70m, although there was a fall in month related to the HCC block contract not yet having been received, and increased capital payments for the safety suites project.

9. Capital

The capital resource limit for 2021/22 was confirmed at £16.1m. This comprises of gross expenditure of £20.9m and capital receipts from disposals of £4.8m.

9.1. In Quarter 1 expenditure was £3.9m, with the full amount forecast to be spent at the yearend. The full detailed capital report has been present to and reviewed by the Finance and Investment Committee.

10. Summary and Forward Look

10.1. This paper outlines the current position, which is a small surplus for the year to date; this has been reported as per Plan. This is driven by significant additional income but offset by increasing pay costs and continued pressure against secondary commissioning costs.

10.2. Going forward, cash block payments continue for Half 1, but guidance around arrangements and planning for Half 2 is unlikely to be available until September. Potential impact is as follows:

10.2.1. COVID-19 income may not continue into Half 2, or may continue at a lower level

10.2.2. An increase in efficiencies from Half 2 has been highlighted but the exact amount is not yet known

10.2.3. There will be a need to work within the ICS to ensure that the whole system is in balance, which could impact on HPFT

10.3. Therefore to continue to deliver a position on Plan the Trust needs to ensure the following:

10.3.1. That pay controls remain in place with bank and agency costs reducing as substantive recruitment takes place, and ensuring best use of rostering;

10.3.2. That external bed costs are stabilised and brought down wherever possible;

10.3.3. That the Delivering Value programme continues to be progressed and amounts realised as expected with any slippage identified early and mitigated with other developments;

10.3.4. That any remaining financial risks from COVID-19 are carefully monitored and reported on.

10.4. The Trust continues to expect to report on Plan at break even for Half 1, with the position in Half 2 less certain at present, but still expected to deliver on Plan.

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 13
Subject:	People and Organisational Development Report, Q1 2021/22	**For Publication:** Yes
Author:	Maria Gregoriou, Associate Director of People	**Approved by:** Janet Lynch, Interim Director of People and OD
Presented by:	Janet Lynch, Interim Director of People and OD	

Purpose of the report:

To provide an update on the People and OD activities during Quarter 1 and key metrics/outcomes achieved during the period.

Action required:

To receive the report.

Summary and recommendations to the Board:

The People and OD Q1 Report sets out the key workforce metrics and activities that flow from the Trust's annual plan, our People Plan Priorities and the NHS People Plan. The Q1 information includes:

Vacancy rates: have increased from 11.19% in Q4 to 11.74% in Q1, although bank and agency fill rates remain above 91% for registered and non-registered nursing shifts, which ensures that we can maintain safe staffing levels and care. Recruitment activity remains very high with 332 people (286 WTE) in the pipeline. Time to hire has reduced.

Sickness absence rates: sickness absence has continued to increase, up to 4.54% for the quarter, with a significant increase in musculoskeletal and back problems, although recording of causes of sickness is still showing some gaps. SBU sickness rates vary from 3.58% (Essex and IAPT) to 6.03% MH West Herts. Work has been completed to review sickness hot spots and the causes of sickness and this is being shared with the Trust Management Group on 21st July.

Turnover: annualised turnover has increased to 19.74%. with unplanned turnover now at just over 10% and the stability rate having fallen back slightly. There were 151 new starters in Q1 and 169 leavers with a net loss of 18.

Appraisal rates: compliance is now at just over 89%, with weekly monitoring and reporting in place, much improved from Q4.

Statutory and essential training: statutory and essential training is now very close to target at 91.33%, again much improved compared with Q4, although it continues to be impacted by pauses in training and absences. Respect training continues to be a focus for attention, although newly recruited trainers, additional venues, and increased cohort sizes, are expected to improve compliance.

ER cases: the number of cases remains at 6. Whilst 2 cases closed as expected in June, 2 additional cases were opened. The 2 longest cases are due to conclude by mid-July. Currently there are 5 suspensions, 2 regarding non-work issues and 1 regarding the alleged

assault of a service user where an investigation has commenced.

The Board is asked to note the Q1 update and the work that is being undertaken to support delivery against the annual plan, HPFT People Priorities and the NHS People Plan, as well as the actions being taken to improve the position moving forward. Given the pressures within services and for staff, there will be a renewed focus on recruitment and retention and health and wellbeing during coming months.

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 and Public & Patient Involvement Implications:

N/A

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

N/A

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

Executive Team July 2021

Hertfordshire Partnership University NHS Foundation Trust

People and Organisational Development Report
Quarter 1: April – June 2021

1. Introduction

The purpose of this report is to update the Board on the Quarter One performance against the key people and organisational development (OD) metrics and activity as set out in the Annual Plan. The report summarises the activities undertaken to improve performance against the agreed targets and outlines the planned activities for the next period.

2. Context

During this Quarter, we have implemented our refreshed People Plan Priorities, which flows from the Annual Plan and the NHS People Plan. Our Annual Plan states under Strategic Objective 4:

We will attract, retain and develop all our people with the right skills and values to deliver consistently great care, support and treatment	• Improve the employment experience of all of our people, including support to improve their health & wellbeing and to help them to rest & recover post COVID19 • Ensure all our people feel valued, included and able to fulfil their potential through the development of our just & inclusive culture • Develop our collective leadership culture through the implementation of 'Great Teams' to support our staff to feel empowered & engaged

Our HPFT People and OD Plan sets out the detailed actions to support this objective. Our People and OD Plan flows from the following strategies:

- Our Good to Great Strategy: Great Care, Great Outcomes - great people, great organisation, great networks and partnerships, safe, effective, positive experience
- Our OD Plan: Great teams, just & learning culture, diversity & inclusion, health & wellbeing, values (welcoming, kind, positive, respectful, professional), underpinned by engagement
- Our Recruitment, Retention & Reward strategy: attract, reward, retain
- We Are The NHS: People Plan 2020/21 - action for us all

The NHS People Plan identified the following four key themes:

- **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

And the following People Promises:

Our HPFT people and OD priorities for Q3 and the remainder of this financial year are, therefore:

- Health and wellbeing
- Great teams, great people
- Equality and inclusion
- Engagement
- Our values
- Just and learning culture

This report summarises our performance in relation to the key people performance indicators and the activity that supports each of our key people and OD priorities.

3. Q1 performance

Appendix 1 sets out the Q1 performance against a range of people and OD indicators.

4.1 Vacancies

The vacancy rate has increased since Q4, currently standing at 11.74% (last quarter was 11.19%) and above our target rate of 10.5%. This is in part due to new posts in our establishment that have not yet been recruited to including 14.40WTE posts in the CAMHS trailblazer teams in June.

However, the level of vacancies remains a concern and is a priority for the coming period. Our highest vacancy rate is within the Allied Health professional's staff group with 24.72% this quarter, with our highest vacancy numbers being at band 3 and 4. The vacancy rate in registered nursing is at 20.49% in Q1; however, this will significantly reduce in the coming months as 57 newly qualified nurses obtain their pin registrations, with the vacancy rate projected to be 15% as a result. A registered nursing recruitment campaign will also begin at pace with a rolling programme of activity and prioritising our key high-risk areas.

At the end of Q1, we had 448.12 vacant posts, however there are 254 new starters in the recruitment pipeline, including 65 registered nurses and 37 health care support workers.

International recruitment of 10 mental health nurses is also underway, with interviews planned to take place over Q2 although start dates are likely to be staggered through 2022.

Following receipt of central funding from NHSE/I, the recruitment campaign to fill HCSW roles had a significant impact on the vacancy rate for this staff group. The vacancy rate is down from 24% (116.4 FTE) and is currently at 14% (87 FTE). Recruitment activity will continue in order to fill the remaining vacancies and bring the vacancy rate down further over Q2.

There have also been three Advisory Appointment Committees (AAC) to appoint consultant medical staff in Q1, with three appointments being made as a result. Three further AAC panels are planned for Q2. Three specialty doctors have also been appointed.

4.2 Turnover rates

Our turnover rate has steadily increased steadily this quarter to the end of June 19.74%. There were 151 new starters in Q1 and 169 leavers with a net loss of 18. Our highest number of leavers and starters have been in the additional clinical

services staff group, this includes our health care assistants at band 2, 3 and 4. We had 16 new registered nurses start with us in Q1 and 27 leavers. Our exit questionnaires tells us that our top five reasons for leaving are employee transfer, relocation, retirement, work life balance and promotion. Work is underway to create internal development pathways for all our staff and making the transfer into sideways moves easier for staff to gain experience at HPFT rather than leave.
The overall turnover rate includes both planned and unplanned turnover, for example, fixed term contracts and rotational staff. The unplanned turnover rate remains healthy at 10.04% in Q1 as does our stability rate of 84.66% which has been impacted by our leavers in Q1.

4.3 Sickness Absence

The sickness absence rate is currently at 4.54% this quarter compared with Q4 at 3.99%. This increased in Q1 by 0.55%, however remained slightly lower than the same period of the previous year (5%) and was only slightly higher than our target of 4%.

Points to note include:

- Ongoing work to improve the recording of causes of sickness to reduce incidence being recorded as “unknown”.
- At the end of Q1, instances of coronavirus in the community were rising and this has mirrored by an increase in staff absence due to Covid-19;
- Significant work across the Trust regarding health and wellbeing to promote self-care and support staff, which has kept absence due to mental ill health lower than might otherwise be expected. Our people have consistently reflected back to us in our pulse surveys that the overwhelming majority (90%) believe that the Trust takes positive action in relation to staff health and wellbeing as result of the comprehensive package of support we have put in place.
- A deep dive into the number of days, occasions of absence and reasons for absence due to sickness, correlations with vacancy rates, annual leave and DATIXs. This will improve our support for managers and staff, and OH and EAP interventions and facilitated discussions.

4.4 Appraisals

Over the last quarter the appraisal rate has been improving and is currently at 89.10% in comparison to this time last year at 71.78%.

The appraisal rate had been gradually decreasing for some time up to the end of Q1; the coronavirus pandemic undoubtedly contributed to a more significant decline in compliance. This has now increased from 83.15 % at the end of Q4 to 89.10% at the end of Q1. We launched our pilot of a refreshed approach to appraisal conversations during Q3. The new approach is a strengths based appraisal conversation, which research tells us leads to more effective appraisals, which in turn lead to better outcomes for service users. The refreshed approach also offers a simplified form so that the length and complexity does not not act as a barrier to compliance, nor the quality of the conversation. The aim is to ensure a positive, constructive conversation that recognises the contribution of each of our people, thanks them and leaves them feeling valued, with a clear set of objectives, clear support and development in place to help achieve their work objectives and their career aspirations and ensure clarity on how each individual can continue to contribute to the Trust and our equality and inclusion agenda. Feedback from the pilot has been overwhelmingly positive and we will fully launch the new appraisal

conversation tool in Q4.

4.5 Mandatory Training

Our overall mandatory training rate at the end of Q1 was 91.3% compared with 88% at the start of the quarter. Compliance had been affected by the pause in training delivery during the first wave of the pandemic. Whilst many training courses moved online and additional face to face training was put in place to address the backlog, this was not fully resolved and was further impacted by the next phase of the pandemic during December. As a result of the changing context, face to face training, except for Respect training, was paused during the course of December. The pandemic also impacted the ability of staff to complete their training. All training has resumed during Q4 and robust plans are in place to ensure we meet full compliance during 2021/22.

As part of restoration work taking place, some courses were moved to eLearning courses (i.e. Fire Safety). All courses that must be undertaken face to face have resumed and dates have been commissioned and put on Discovery for the remainder of the current financial year. All face to face Training is taking place with IPC measures in place to limit the risk of infection (which has reduced the amount of delegates that can be trained at any one time). These arrangements have been fully risk assessed. Reminders are being sent to staff via Discovery and staff are actively booking themselves onto courses. Some weekend training is additionally taking place for Respect to assist with the backlog and there are an additional 2 trainers who have been released from their substantive roles to help in this area of training. Communications regarding available courses has been sent out Trust wide and ongoing communication is sent to MDs, Service Line Leads, Heads of Nursing and HRBPs to be shared with staff. It is envisaged that this will have a positive impact on our capacity and ability to train our staff in RESPECT.

4.6 Temporary Staffing

During Q1, 26,499 bank and agency shifts for registered nursing and HCA posts were requested across the Trust. 20,913 shifts were filled by bank workers and 5,586 were filled by agency workers.

This is a total fill rate of 91.2%, 72% bank fill rate and a 19.2% agency fill rate. Temporary staffing pays spend made up 16% of the total pay spend, with agency spend at 4.16%.

The Agency Locum usage at end of the quarter was six, covering vacancies. This is predicted to reduce to 4 in Q2, due to positive recruitment to both Consultant and Specialty Doctor vacancies.

3.7 Employee Relations Cases

The number of cases remains at 6. Whilst 2 cases closed as expected in June, 2 additional cases were opened. The 2 longest cases are due to conclude by mid-July. Currently there are 5 suspensions, 2 regarding non-work issues and 1 regarding the alleged assault of a service user where an investigation has commenced.

4. Other People and OD Activity

The following items represent some of the key People and OD activities over the last quarter.

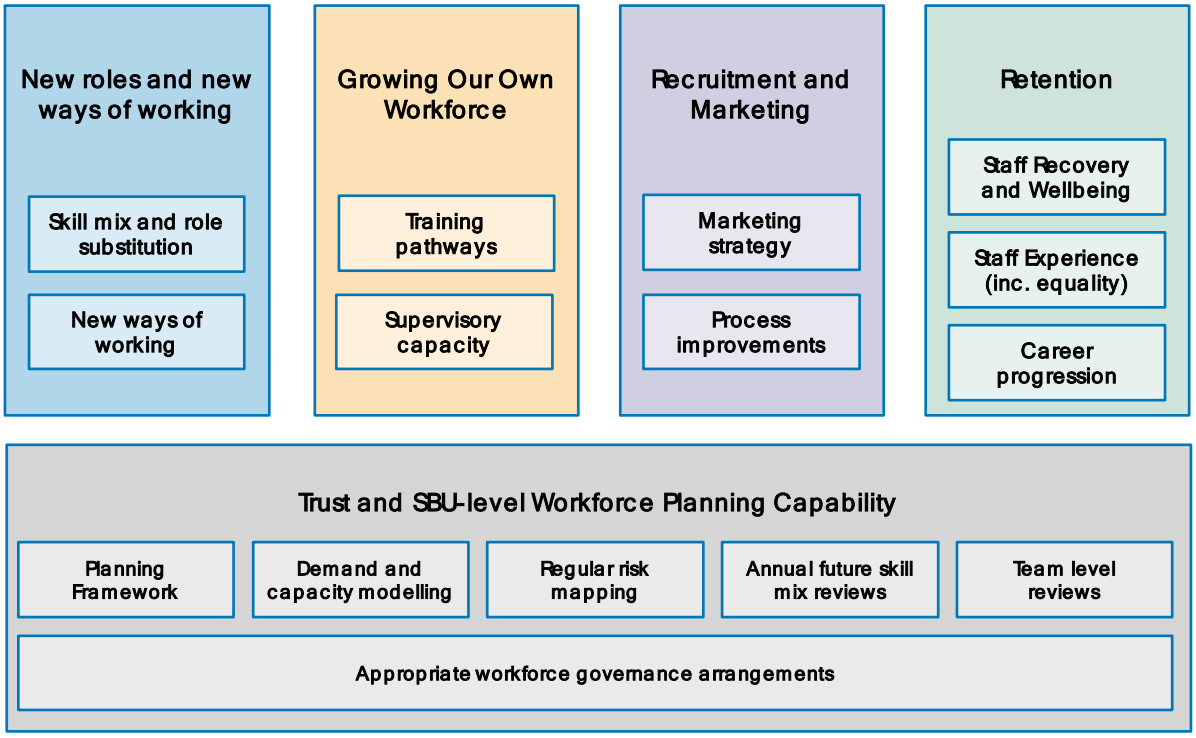
5.1 Junior Doctor Rotations

Preparation work for the August rotation has been completed to streamline the junior doctor starter process, ensuring that the 52 new doctors have all the relevant IT access, ID Badges, scrubs and laptops on their first day. There is still work to be done to streamline the transfer of Statutory and Mandatory training information for the Foundation doctors and GP trainees joining HPFT from West Herts and East & North Trusts.

Work has been carried out with the workforce information team to help improve the quality of trainee data and ESR positions ready for the August rotations. This will enable a successful go live of the ESR Person Updates capability in August and support the national implementation of the Streamlined Doctors in Training Interface.

5.2 Workforce Planning

A workforce plan for the Trust was developed during Q1 following a workforce planning audit that took place in December 2020; the overall plan has been approved through PODG and IGC and a summary of the plan on a page is included below:



Work is underway to build SBU level workforce plans for approval and these are expected to be finalised in the coming weeks.

5.3 Health and Wellbeing

Following last year's refresh of the Health and Wellbeing Strategy, the success of the Winter Wellbeing Programme and the highest score in the NHS Staff Survey for supporting Wellbeing to date, in Q1 we have continued to make progress in supporting staff wellbeing. This has included launching a number of new strategic projects and continuing to develop our on the ground support for staff. In line with our People Recovery Plans, over the last quarter we have:

- Introduced a Non-Executive Wellbeing Guardian to HPFT to provide Board level challenge and sponsorship for Health and Wellbeing.
- Introduced twenty new staff Health and Wellbeing Champions across the Trust to champion wellbeing at all levels.
- Launched our programme of work to become one of the UK's first Menopause Friendly Employers.
- Launched Mental Health First Aid Training across Herts and West Essex ICS with availability for all staff.
- Continued to run our Health and Wellbeing monthly programme of events and activities, seeing over 400 staff participate since December 2020.
- Analysed key trends in our People and Organisational Development data to identify areas for development over the next 12 – 18 months.
- Worked closely with our staff networks to identify priorities and support needs for the next 12 -18 months.
- Successfully recruited a Health and Wellbeing Coordinator on a 12 month fixed term contract.
- Successfully completed our internal Health and Wellbeing audit and received the highest rating.
- Worked with the Here for You service to establish support groups on Long-Covid and share information on support webinars with staff.

Health and wellbeing will continue to be a key priority for activity over the remainder of the year.

5.4 Here for You Service

During Q1 we have successfully launched the Here for You service across the ICS. Over this period we have focused on increasing marketing and knowledge of the service and it's offering. We have also worked closely with the Health and Wellbeing Leads group to facilitate and run all staff webinars and support groups to support emerging issues and the development of support as the Covid-19 pandemic continues. We have delivered webinars on Long-Covid, the crisis in India, as well as burnout and fatigue. Referrals continue to rise and we are working with the Health and Wellbeing Lead group to identify new ways to support staff across the ICS.

5.5 Great Teams, Great People

During the course of the pandemic our approach to team development and OD through the Great Teams model has been adapted to flexibly and more quickly respond to teams' needs. The feedback has been that our historic 'one size fits all' approach has reduced engagement and effectiveness. The model took a diagnostic approach, which was very linear and did not encourage ownership of actions. To continually improve and use the feedback from teams the OD team are using a dialogic approach which engages the primary stakeholder to clearly define the issue to be addressed. This methodology recognises the complexity and emergent issues that teams face.

During Q1 we have run sessions with 15 different teams since April (this is a range of activities - Away Days, reflective sessions and team development sessions).

We continue to support leadership development, with regular training and forums moving to an online format. Applications opened for Cohort 11 of HPFT Leadership Academy a robust process is in place to recruit to the programme. Orientation and the first module will commence in Q2. The local Mary Seacole programme has restarted with 2 cohorts running in Q1 and more dates released to the end of the

year.

In addition, we have produced guidance that links to bite-sized video based training resources which managers can access on demand, linked to our values. We continue to work with the ICS to the development of Leadership and Talent offers.

5.6 Engagement

Due to lockdown restrictions, our Inspire Award presentations had to be postponed during most of Q4 20/21 and Q1 21/22. During that period the awards were presented locally by Managing Directors and/or Senior Service Line Leads to winning individuals nominated during December 2020 to February 2021. A 're-launch' of our Inspire Award ceremony took place on 2nd June when we recognised those who had won during the last lockdown period. A second ceremony was held on 23rd June when the March and April winners were recognised and presented with their certificate, voucher and badge.

During late April/early May we ran 3 virtual and 5 face to face Good to Great Roadshows on the theme Supporting You. This was a great opportunity to share with staff the key themes from the national staff survey and our recovery plan. This was to ensure that the 8 key themes were the right areas of focus and to get them involved in co-producing our plans to continuously improve the experience of our people. The themes were also shared with our 7 staff networks and Senior Managers to cascade and share at SBU and Team level. All of the feedback was collected and collated and used to inform our action plan for the year ahead.

Quarter 1 Pulse Survey achieved 651 responses (14%) which is lower than the previous quarter but similar response rate to the same quarter last year. The full results are to be reported but the highlights are as follows:

- 82% recommend HPFT to friends and family if they need care or treatment
- 74% recommend HPFT to friends and family as a place to work
- 60% said it was easy to make improvements at work
- 82% use feedback service users, carers or customers to learn and make improvements
- 88% HPFT takes positive action to support their health and wellbeing
- 71% have opportunities to develop new skills
- There are areas we can approve on and these will be addressed through our action plan:
    - 57% of staff are likely to work additional unpaid hours
    - 11% of staff experienced bullying and harassment
    - 6% of staff experienced violence – all from Service Users/Carer/Public

6. Conclusions

Overall, our people and OD activity is on plan, however given the pressures within services and for staff, there will be a renewed focus on recruitment and retention and health and wellbeing during coming months.

7. Recommendation

The Board is asked to note the Q1 position and the work that is being undertaken to support delivery against the annual plan, HPFT People Priorities and the NHS People Plan as well as the actions being taken to improve the position moving forward.

June 2021 - Based on Q1 2021/2022

HPFT Workforce Information Report Summary

WORKFORCE INFORMATION REPORT SUMMARY

Workforce Report June 2021 (Based on data for Q1 (2021/2022)

Section 1: KPI summary position

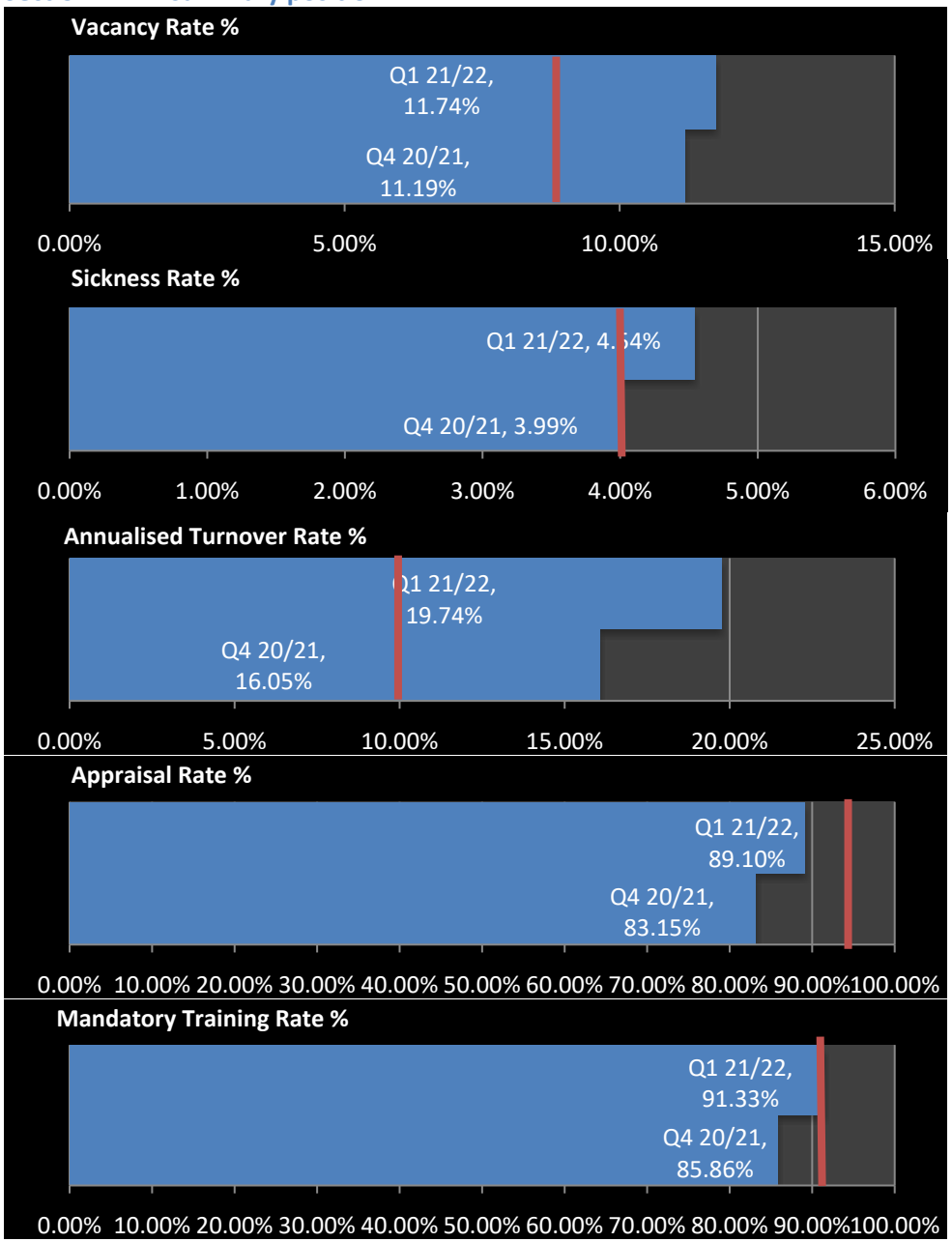
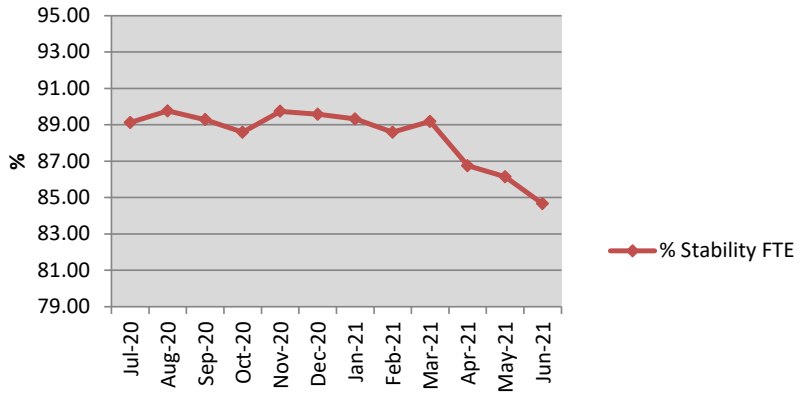


Table 1: Establishment Data

Funded Establishment =	3817.77
Staff in post =	3369.65
Vacant posts =	448.12
% Trust Vacancy rate =	11.74
% Total Turnover rate =	19.74
% Planned Turnover Rate =	9.70
% Unplanned Turnover Rate =	10.04
% Stability rate =	84.66

Graph 1 : % Stability



WORKFORCE INFORMATION REPORT SUMMARY

Section 2: Recruitment

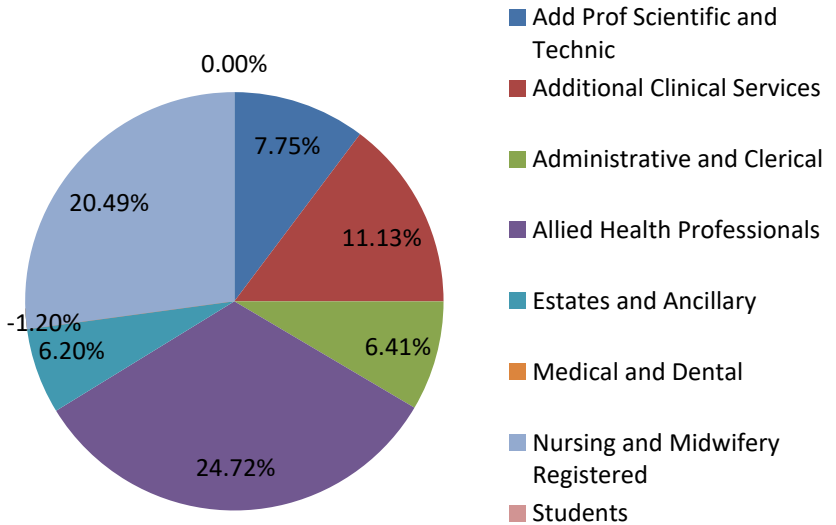
Table 2: Recruitment Summary by SBU

Vacancy Stage	Corporate FTE	SBU Essex & IAPTS	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Authorisation	4.6	13	2.8	4.36	10.56	35.32

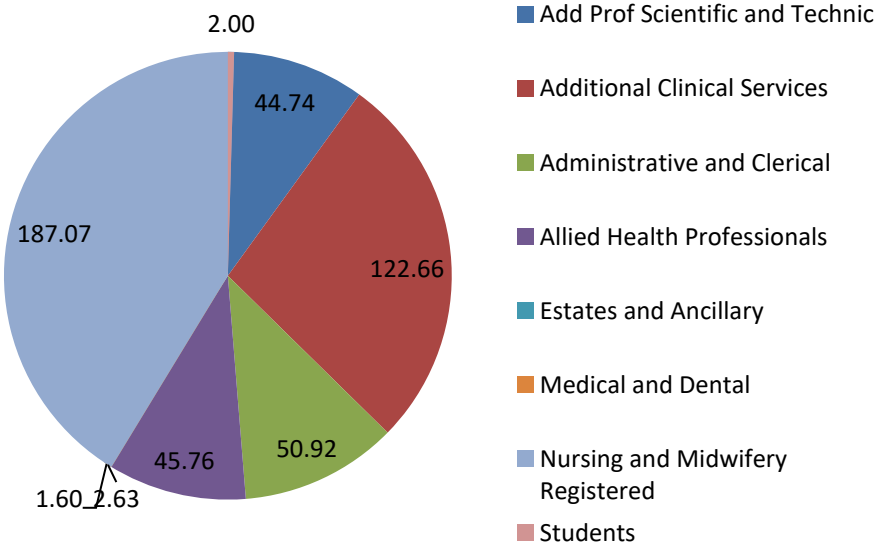
Vacancy Stage	Corporate FTE	SBU Essex & IAPTS	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Longlisting	10	8	19.03	35.01	37.27	109.31
Shortlisting	2	12	12.9	19.2	24.38	70.48
Interview	17.93	13	14.8	44.5	13.9	104.13

Vacancy Stage	Corporate FTE	SBU Essex & IAPTS	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Offer	32.7	28	31.62	66.99	31.5	190.81
Starting	1.8	8.4	9.7	26.33	16.6	62.83

Graph 2: Vacancies (%) by Staff Group



Graph 3: Vacancies (fte) by Staff Group



Section 3: Turnover

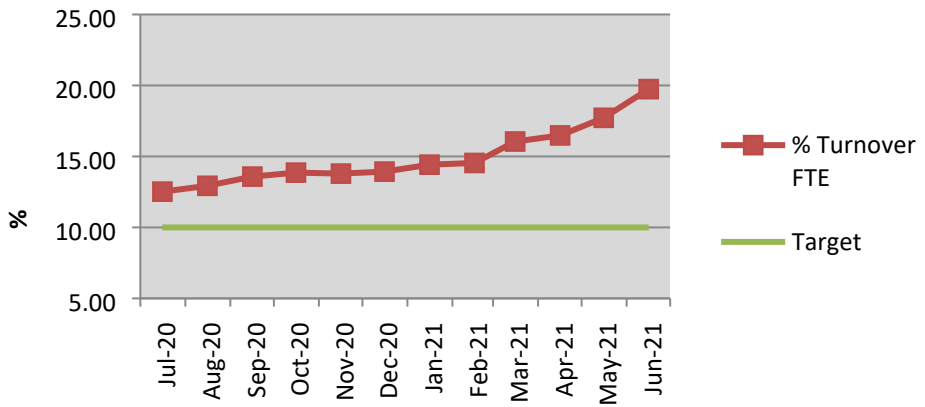
Table 3: Leavers by Leaving Reason

Leaving Reason	Total
Employee Transfer	38
Voluntary Resignation - Relocation	29
Retirement Age	29
Voluntary Resignation - Work Life Balance	18
Voluntary Resignation - Promotion	11
Voluntary Resignation - Other/Not Known	9
Voluntary Resignation - To undertake further education or training	5
Voluntary Resignation - Child Dependants	4
End of Fixed Term Contract	4
Has Not Worked	4
Voluntary Resignation - Better Reward Package	4
Voluntary Resignation - Health	3
Voluntary Resignation - Lack of Opportunities	3
Mutually Agreed Resignation - Local Scheme with Repayment	1
Dismissal - Some Other Substantial Reason	1
End of Fixed Term Contract - Completion of Training Scheme	1
Voluntary Resignation - Incompatible Working Relationships	1
Death in Service	1
Dismissal - Capability	1
Retirement - Ill Health	1
Voluntary Resignation - Adult Dependants	1
Grand Total	**169**

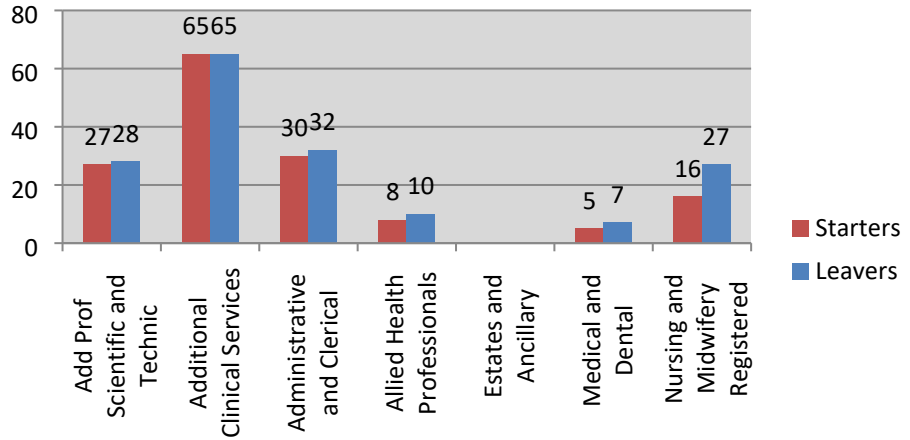
Table 4: Retirement Profile

	Age		
Retirement profile	**55-59**	**60-64**	**65+**
367 Corporate	55	31	16
367 SBU Essex & IAPTS	58	31	16
367 SBU Learning Disability & Forensic	97	59	17
367 SBU MH East & North Herts	131	100	54
367 SBU MH West Herts	123	68	40
Grand Total	**464**	**289**	**143**

Graph 4 : % Turnover



Graph 5: Starters & Leavers by Staff Group



Section 4: Sickness Absence

Table 5: Top 10 Reasons for Sickness Absence

Sickness Absence Reason	Q1 No Of Episodes	Q4 No Of Episodes
S99 Unknown causes / Not specified	196	162
S25 Gastrointestinal problems	167	141
S98 Other known causes - not elsewhere classified	163	187
S13 Cold, Cough, Flu - Influenza	163	180
S16 Headache / migraine	145	134
S10 Anxiety/stress/depression/other psychiatric illnesses	136	137
S12 Other musculoskeletal problems	102	58
S11 Back Problems	74	53
S28 Injury, fracture	37	25
S26 Genitourinary & gynaecological disorders	36	30

Graph 6: % Sickness Absence by Month

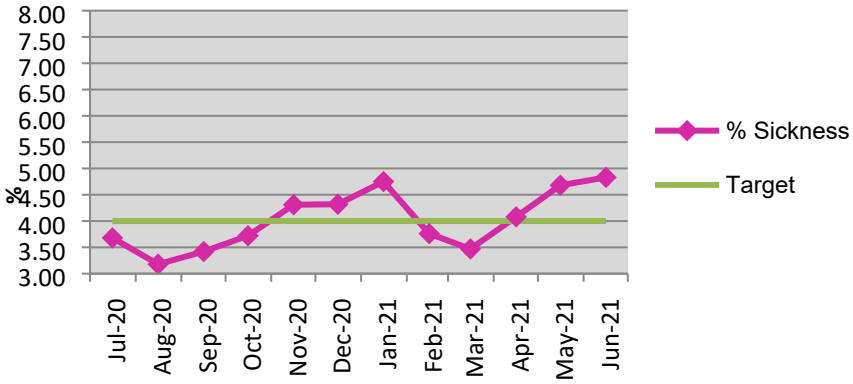
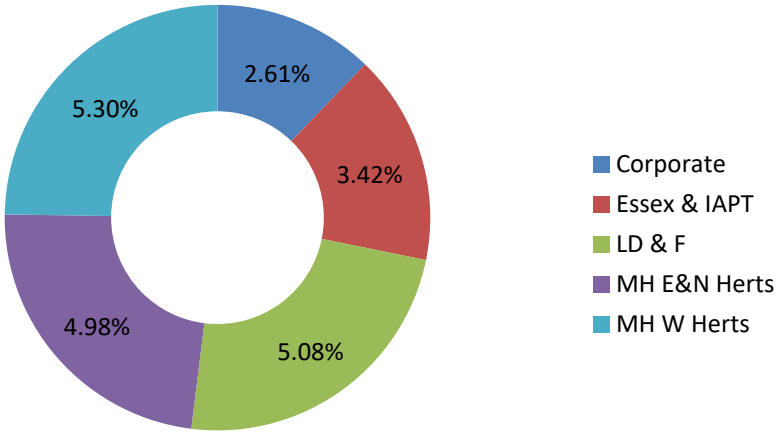


Table 6: Sickness Cost

SBU	Estimated Cost of sickness Q1
Corporate	£115,683
Essex & IAPT	£190,056
LD & F	£249,515
MH E&N Herts	£383,408
MH W Herts	£367,305
Trust	**£1,305,966**

Graph 7: Sickness AbsenceRate by SBU



Section 5: Temporary Staffing

Table 7: Bank, Agency & Substantive Spend

2020-2021				
Total spend	Q1		YTD	
	£	%	£	%
Agency	1,949,710	4.16%	1,949,710	4.16%
Bank	5,362,800	11.44%	5,362,800	11.44%
Substantive	39,566,702	84.40%	39,566,702	84.40%
Total	**46,879,212**		**46,879,212**	

Graph 8: Bank & Agency Spend

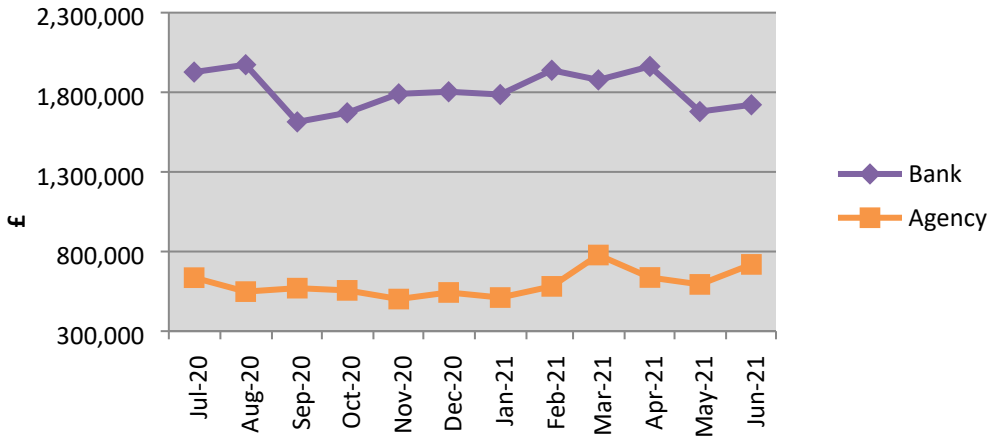
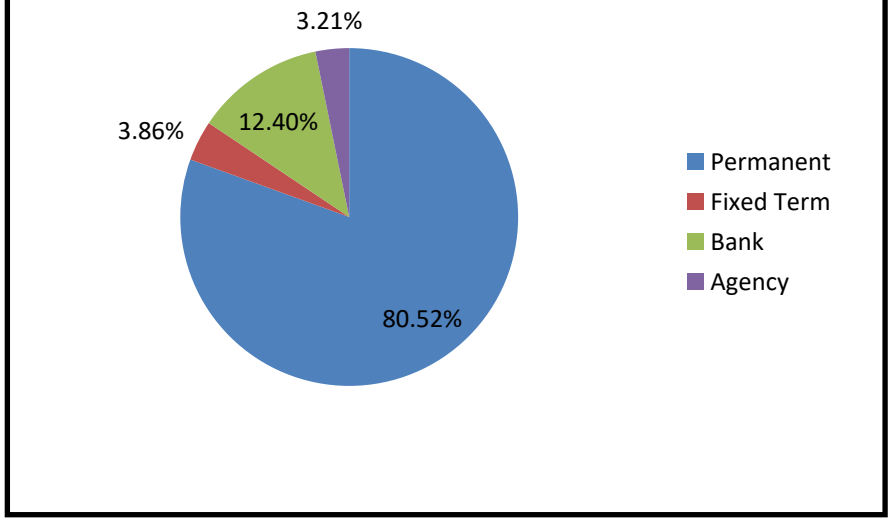


Table 8: Bank and Agency Usage

Staff	Number of Shifts requested minus the cancellations	Number of Bank Shifts Filled	Bank Fill Rate	Number of Agency Shifts Filled	Agency Fill Rate	Total Fill Rate
Nursing Qualified and Unqualified	29,029	20,913	72.04%	5,586	19.24%	**91.28%**
Admin	4,460	4,021	90.16%	318	7.13%	**97.29%**
Social Workers	1,206	946	78.44%	240	19.90%	**98.34%**
OT/AHP	1,409	1,154	81.90%	198	14.05%	**95.95%**
Total	**36,104**	**27,034**	**74.88%**	**6,342**	**17.57%**	**92.44%**

Graph 9: % FTE of Workforce by Assignment Category



Section 6: Employee Relations

Table 9: Live Employee Relations Cases

ER Cases Activity - Jun 21					
SBU	Disciplinary	Grievance	Bullying & Harassment	Capability	Total
SBU East & North	3				3
SBU West	1				1
SBU Essex &IAPTS					0
SBU LD&F					0
SBU Corporate			2		2
Total	4	0	2	0	6

Disciplinary - Length of Process			
	< 9 weeks	9-12 weeks	12 + weeks
SBU East & North	2		1
SBU West			1
SBU Essex &IAPTS			
SBU LD&F			
SBU Corporate			
Total	2	0	2

Capability - Length of Process			
	< 9 weeks	9-12 weeks	12 + weeks
SBU East & North			
SBU West			
SBU Essex &IAPTS			
SBU LD&F			
SBU Corporate			
Total	0	0	0

Grievance - Length of Process			
	< 9 weeks	9-12 weeks	12 + weeks
SBU East & North			
SBU West			
SBU Essex &IAPTS			
SBU LD&F			
SBU Corporate			
Total	0	0	0

Bullying and Harassment - Length of Process			
	< 9 weeks	9-12 weeks	12 + weeks
SBU East & North			
SBU West			
SBU Essex &IAPTS			
SBU LD&F			
SBU Corporate			2
Total	0	0	2

Section 7: Staff Development

Table 10: Appraisal Compliance

SBU	Number of completed appraisals	Number of Staff	PDP Rate %
367 Corporate	260	313	**83%**
367 SBU Essex & IAPTS	499	552	**90%**
367 SBU Learning Disability & Forensic	550	566	**97%**
367 SBU MH East & North Herts	840	887	**95%**
367 SBU MH West Herts	606	774	**78%**
Grand Total	**2755**	**3092**	**89%**

Graph 10: % PDP Compliance

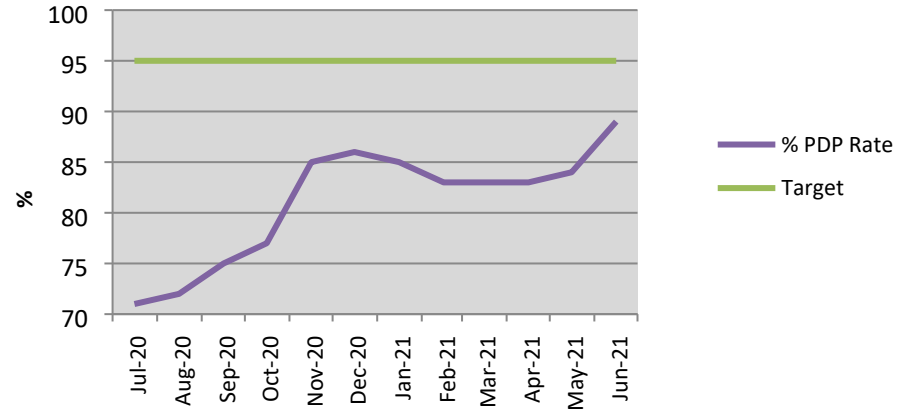
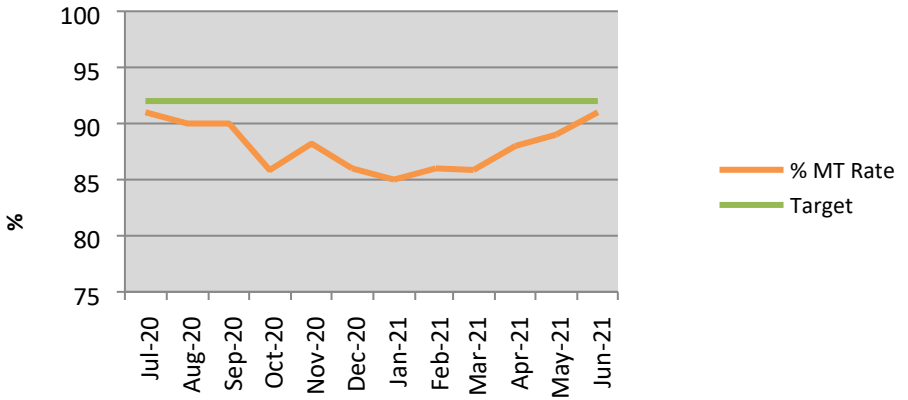


Table 11: Mandatory Training Compliance

SBU	Does not meet requirement	Meets Requirement	% Compliance
367 Corporate	221	3277	**94%**
367 SBU Essex & IAPTS	698	6517	**90%**
367 SBU Learning Disability & Forensic	511	6493	**93%**
367 SBU MH East & North Herts	788	10327	**93%**
367 SBU MH West Herts	1126	8615	**88%**
Grand Total	**3344**	**35229**	**91%**

Graph 11: % Mandatory Training Compliance



Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 14
Subject:	Gender Pay Gap	**For Publication:** Yes
Author:	Maria Gregoriou, Associate Director of People	**Approved by:** Janet Lynch, Interim Director of People and Organisational Development
Presented by:	Janet Lynch, Interim Director of People and Organisational development	

Purpose of the report:

To set out the 31st March 2020 snapshot gender pay gap data, in line with statutory reporting requirements, and to summarise some of the actions which will be developed to address the issues raised.

Action required:

For information.

Summary and recommendations:

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 30 March 2017 requires all employers with 250 or more employees to report annually on their gender pay gap via the government website for gender pay gap reporting and also to report the data and a narrative on public facing websites.

The data is based on pay rates as of 31st March 2020 and bonus payments made during the year 1st April 2019 to 31st March 2020, and shows:

- mean gender pay gap for HPFT - 10.10%
- median gender pay gap for HPFT - 4.11%
- mean gender bonus gap for HPFT - 38.52%
- median gender bonus gap for HPFT - 51.78%

The report provides a range of additional information and sets out that although the Trust's mean gender pay gap is 10.10%, the gap across the Agenda for Change workforce is lower at 5.54%. The Trust gender pay gap may be attributed to Medical staff where the mean gender pay gap is 10.85%, although this has reduced significantly from 12.41% in March 2019. At band 9 the mean gender pay gap is 100% where there are 3 male staff. Staff on spot salaries (mainly as a result of TUPE pay protection rights) have a gender pay gap of -172.57 in favour of women.

There has been a significant reduction in the mean bonus gender pay gap for CEAs from 25.46% in March 2019 to 23.95% in March 2020.

The gender pay gap report has been made available on the Trust's website in line with legal requirements.

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

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 Financial, IT, Staffing & Legal Implications:

Equality & Diversity and Public & Patient Involvement Implications:

Fulfils statutory obligations under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and sets out issues to be addressed.

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

N/A

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

Executive Group June 2021 PODG July 2021 JCNC July 2021

Hertfordshire Partnership University NHS Foundation Trust
Gender Pay Gap Report

1. Introduction

1.1 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31 March 2017 requires all employers with 250 or more employees to report annually on their gender pay gap. This report outlines the Regulations, sets out the data we are legally required to report on, provides an analysis and sets out our next steps as a Trust.

1.2 The gender pay gap is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

1.3 We deliver equal pay through a number of means but primarily through adopting nationally agreed terms and conditions for our workforce which are as follows:

1.3.1 Agenda for Change, which is a national pay system which covers and typically applies to nursing, allied health professionals, and administration and clerical staff which make up the majority of the workforce. Where appropriate, locally agreed policies may supplement Agenda for Change arrangements such as family friendly policies.

1.3.2 Medical and Dental Terms and Conditions of service and pay arrangements are negotiated on behalf of employers by NHS Employers with NHS trade unions and apply to all consultants, medical staff and doctors in training. The Medical and Dental terms and conditions include the following:

- National Junior Doctor contract
- National Consultant contract
- Specialty and Associate Specialist contract (currently under review)

1.4 In addition, Trust contracts are used for Very Senior Managers (VSM), the Trust Chair and Non-Executive Directors (NEDs). As an NHS Foundation Trust, HPFT is free to determine its own rates of pay for its VSMs, Chair and NEDs. The VSMs include the Chief Executive, Executive Directors and other senior managers with board level responsibility.

1.5 The gender profile for HPFT is shown below:

2. Gender Pay Gap Reporting

2.1 The Trust is obliged to publish the following information on our public-facing website and report to government by the 31 March 2021:

- The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the mean gender pay gap');
- The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the median gender pay gap');
- The difference between the mean bonus pay paid to male relevant employees and that of female relevant employees ('the mean gender bonus gap');
- The difference between the median bonus pay paid to male relevant employees and that of female relevant employees ('the median gender bonus gap')

2.2 In addition there is a requirement to publish

- The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay band ('the proportion of men and women in each of four pay quartiles').

2.3 The data is based on pay rates as of 31 March 2020 and bonus payments made during the year 1 April 2019 to 31 March 2020.

2.4 There is a further requirement to report the percentage of male and female staff who received bonus pay which is set out in the table below.

Gender	% of employees who received bonus pay
Female	1.08%
Male	2.90%

3. Gender Pay Gap and Gender Bonus Gap

3.1 The following Gender pay report data is taken as at the snapshot date of 31 March 2020:

1.	The mean gender pay gap for HPFT	10.10%
2.	The median gender pay gap for HPFT	4.11%
3.	The mean gender bonus gap for HPFT	38.52%
4.	The median gender bonus gap for HPFT	51.78%

3.1.1 For the calculation of hourly rate pay, only 'Full Pay Relevant Employees' are to be included. A 'Full Pay Relevant Employee' is any employee who is employed on the snapshot date and who is paid their usual full basic pay (or pay for piecework) during the relevant pay period. This includes:

- Basic Pay
- Paid leave, including annual, sick, maternity, paternity and adoption or parental leave. The exception is where an employee is paid less than usual or is in the nil pay elements of maternity leave.
- Area and other allowances
- Shift premium pay which is defined as the difference between basic pay and any higher rate paid for work during different times of the day or night.
- Bank pay

The calculation for ordinary pay does not include any of the following;

- Remuneration referred to as overtime
- Remuneration referred to as redundancy
- Remuneration in lieu of leave

3.1.2 Within the Gender Pay Gap Regulations, 'bonus pay' means any remuneration that is in the form of money relating to profit sharing, productivity, performance, incentive or commission.

3.1.3 The Clinical Excellence Awards (CEA) scheme is intended to recognise and reward those Consultants who perform 'over and above' the standard expected for their role and therefore for the purpose of Gender Pay Reporting, Clinical Excellence Awards payments are regarded as 'bonus pay'.

3.1.4 At HPFT the mean bonus gender pay gap consists of CEA payments made to consultants, executive bonus payments and refer a friend payments. As at 31 March 2020, 25 male consultants and 20 female consultants were awarded CEAs, 3 female executive and 3 male executives were awarded bonus payments and there were 8 refer a friend payments made to 7 females and 1 male.

4. Pay Quartiles by Gender

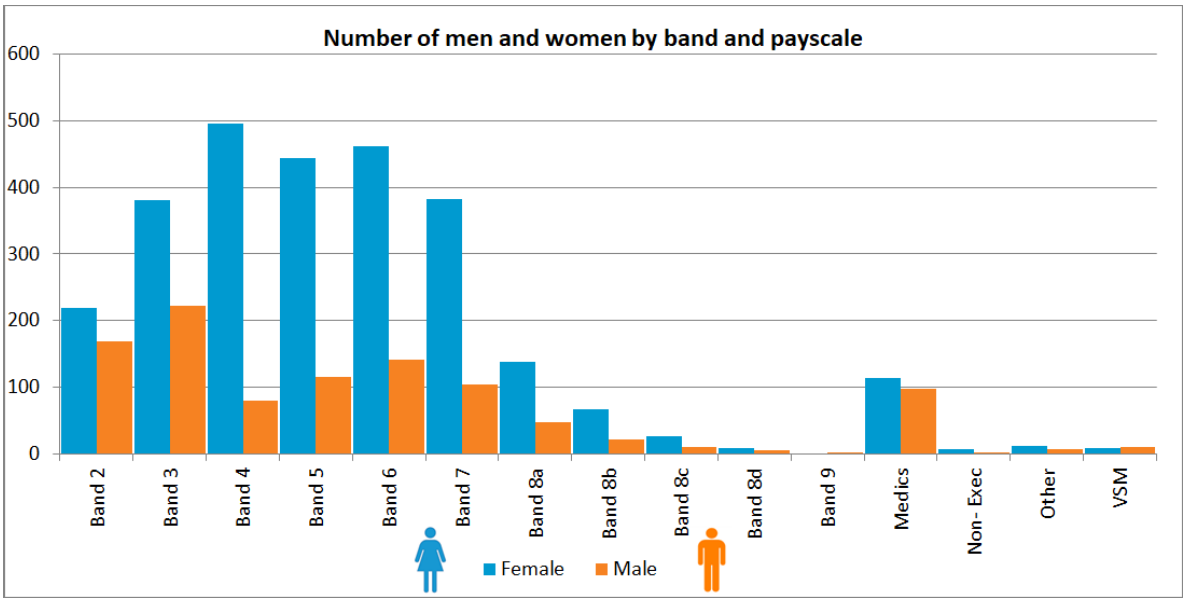
4.1 The pay quartiles shown in the table below are calculated by listing the rates of pay for every employee from lowest to highest, before splitting that list into four equal-sized groups and calculating the percentage of males and females in each.

Quartile	Female Headcount	Male Headcount	Female %	Male %	Description
1 (lowest paid)	716	234	75.37%	24.63%	Includes all employees whose standard hourly rate places them at or below the lower quartile
2	690	261	72.56%	27.44%	Includes all employees whose standard hourly rate places them above the lower quartile but at or below the median
3	722.00	228.00	76.00%	24.00%	Includes all employees whose standard hourly rate places them above the median but at or below the upper quartile
4 (highest paid)	637.00	312.00	67.12%	32.88%	Includes all employees whose standard hourly rate places them above the upper quartile

4.2 It can be seen from this table that the split between male and female employees is reasonably consistent until the 4th quartile (highest paid) where the percentage of female staff in this upper quartile reduces and the percentage of male staff in this quartile increases.

5. Overview of the distribution of gender by band and pay rates

5.1 The following table presents an overview of the breakdown of male and female staff in HPFT by band. This demonstrates that there are more female than male employees in all Agenda for Change pay bands and at Non-Executive and VSM levels except for band 9 and staff who are included in the other category.



5.2 This data can also be presented by gender, band and average hourly rate:

Grade	Male Headcount	Female Headcount	Male Avg. Hourly Rate	Female Avg. Hourly Rate	Difference	Pay Gap %
Band 2	169	219	12.93	12.75	0.18	1.40%
Band 3	222	381	13.00	11.98	1.02	7.83%
Band 4	80	496	12.38	12.18	0.20	1.61%
Band 5	116	444	16.91	15.48	1.43	8.47%
Band 6	141	461	19.62	19.00	0.62	3.17%
Band 7	104	382	22.36	20.97	1.39	6.20%
Band 8a	48	138	25.56	25.07	0.48	1.89%
Band 8b	21	67	30.48	30.20	0.29	0.94%
Band 8c	10	27	36.89	36.24	0.65	1.77%
Band 8d	5	8	44.25	43.07	1.18	2.67%
Band 9	3	0	47.40	0.00	47.40	100.00%
Medics	97	114	40.35	35.97	4.38	10.85%
Non- Exec	1	7	7.78	7.44	0.33	4.29%
Other	7	12	11.57	31.54	-19.97	-172.57%
VSM	11	9	58.45	58.19	0.26	0.44%
Grand Total	**1035**	**2765**	**19.67**	**17.69**	**1.99**	**10.10%**

6. Analysis of Mean Hourly Rate Gap

6.1 As shown previously, across all staff groups male staff earn on average £1.99 per hour more than female staff which leads to a mean gender pay gap of 10.10%. The median gender pay gap across all staff groups is 4.11%.

All Trust Staff – Overall Mean vs Median average hourly rate

Gender	Mean hourly rate	Median hourly rate
Male	£19.67	£16.32
Female	£17.69	£15.65
Difference	£1.99	£0.67
Pay Gap %	10.10%	4.11%

6.2 The majority of the workforce has Agenda for Change terms and conditions and the data shows us that there is a mean gender pay gap in favour of women only in the "other" category. At all other bands the mean gender pay gap is in favour of men. In comparison in 2019 the groups that were in favour or females were Band 2, Band 4, Band 8b, and Non Exec & Other.

6.3 When the mean pay of the agenda for change staff group is calculated alone the result is significantly smaller than the Trust's mean pay gap (see table below).

Agenda for Change Staff – Overall Mean vs Median average hourly rate

Gender	Mean hourly rate	Median hourly rate
Male	£17.70	£15.35
Female	£16.72	£15.24
Difference	£0.98	£0.11
Pay Gap %	5.54%	0.72%

6.4 The mean gender pay gap for staff who are on Agenda for Change pay bands is 5.54% in favour of men with a difference in pay of 0.98 pence between male and female staff. The median gender pay gap is also in favour of males at 0.72%. In comparison to 31 March 2019 there was a mean gender pay gap of 1.29% in favour of men and a median of -0.56%.

6.5 This suggests the Trust's overall gender pay gap is impacted by non-Agenda for Change staff.

6.6 There are a small number of staff employed by HPFT on what have been categorised as Trust Contracts and shown in the category "other". Typically these are substantive members of staff engaged on contracts reflecting the terms and conditions associated with TUPE transfers from non NHS organisations where staff are not on Agenda for Change pay and are paid what is known as a "spot salary" which does not slot into an Agenda for Change salary range. There are 7 male staff in this category and 12 female members of staff. The gender pay gap in this category is -172.57% a pay gap in favour of female members of staff.

6.7 The mean gender pay gap has narrowed at VSM level as at 31 March 2020, there were 11 males and 9 females with a mean gender pay gap of 0.44% and a difference in hourly rate of 0.26 pence. In comparison to 31 March 2019 there were the same number of males and females at VSM level with a mean gender pay gap of 6.33% and a difference in hourly rate of £3.60. This is a positive improvement.

6.8 In the Non-Executive group there is 1 male and 7 female Non-Executive Directors with an average gender pay gap of 4.29% in favour of men. This is a difference in hourly rate of 0.33 pence. In comparison as at 31 March 2020 there were 1 male and 5 female non execs with an average pay gap of -4% in favour of women.

6.9 The medical staff group (including non-consultants, consultants and medical trainees) has a mean gender pay gap of 10.85% for the reporting year 2020 in comparison to 12.41% for 2019, with male medical staff earning on average £4.38 an hour more than female medical staff in comparison to the reporting year 2019 where males were earning £4.98 an hour more than female medical staff. This is a positive improvement.

Medical Staff – Overall Mean vs Median average hourly rate

Gender	Mean hourly rate	Median hourly rate
Male	£40.35	£43.03
Female	£35.97	£37.97
Difference	£4.38	£5.06
Pay Gap %	10.85%	11.76%

7. Analysis of Bonus Payment Gap

7.1 At HPFT the mean bonus gender pay gap consists of clinical excellence award (CEA) payments made to consultants, Executive Director and Chief Executive Officer (CEO) bonus payments and refer a friend payments.

7.2 As at March 2020 25 male consultants and 20 female consultants were awarded CEAs. In comparison at March 2019 there were 29 Male consultants and 20 female consultants awarded CEAs.

7.3 As at March 2020 3 male executives including the Chief Executive Officer and 3 female executives received a bonus. In comparison, as at March 2019 4 male executives including the Chief Executive Officer and 4 female executives received a bonus.

Bonus overall (Clinical Excellence Awards, Executive Director and CEO and Refer a Friend payments) Mean vs Median average payment

Gender	Mean Bonus Pay 2019	Mean Bonus Pay 2020	Median Bonus Pay 2019	Median Bonus Pay 2020
Male	£11,107	£11,413	£8,822	£7,540
Female	£8,479	£7,016	£5,477	£3,636
Difference	£2,627	£4,396	£3,345	£3,904
Pay Gap %	23.66%	38.52%	37.91%	51.78%

7.4 The mean gender bonus gap is 38.52% in favour of males who earn on average £4,396 more than their female colleagues. This equates to a median bonus pay gap of 51.78% In comparison in March 2019 the mean gender bonus gap was 23.66% in favour of males who earned on average £2,627 more in bonus payments than their female colleagues. This equated to a 37.91% median gender bonus pay gap.

Bonus (Clinical Excellence Awards) Mean vs Median average payment

Gender	Mean Bonus Pay 2019	Mean Bonus Pay 2020	Median Bonus Pay 2019	Median Bonus Pay 2020
Male	£11,309	£10,963	£6,421	£6,032
Female	£8,430	£8,337	£3,769	£5,378
Difference	£2,879	£2,626	£2,651	£654
Pay Gap %	25.46%	23.95%	41.29%	10.85%

7.5 The mean gender bonus gap for medical staffing, Clinical Excellence Awards is 23.95% in favour of male consultants who earn on average £2,626 more than their female consultant colleagues. This equates to a median bonus pay gap of 10.85%. In comparison in March 2019 the mean gender bonus gap was 25.46% in favour of male consultants who earned on average £2,879 more than their female consultant colleagues in bonus payments. This equated to a 41.29% median bonus pay gap. This shows a significant reduction in our mean and median gender pay gap for Clinical Excellence Awards.

Bonus (Executive Directors and CEO) Mean vs Median average payment

Gender	Mean Bonus Pay 2019	Mean Bonus Pay 2020	Median Bonus Pay 2019	Median Bonus Pay 2020
Male	£9,637	£19,030	£10,612	£18,927
Female	£8,726	£13,830	£9,310	£18,653
Difference	£911	£5,200	£1,303	£274
Pay Gap %	9.50%	27.32%	12.30%	1.45%

7.6 The mean gender bonus gap for executive directors including the Chief Executive Officer is 27.32% in favour of males who earn £5,200 more in bonus payments than their female executive colleagues. This equates to a median bonus pay gap of 1.45%. In March 2019 the mean gender bonus gap was 9.50% in favour of male executive directors who earned £911 more than their female executive director colleagues.

8. Conclusion

8.1 HPFT has a mean gender pay gap of 10.10%; however the gender pay gap across the Agenda for Change workforce is only 5.54%.

8.2 Analysis of the other staff groups indicates that the Trust gender pay gap may be attributed to Medical staff where the mean gender pay gap is 10.85% this has reduced significantly from March 2019 when it was 12.41%. At band 9 the mean gender pay gap is 100% where there are 3 male staff. Staff on spot salaries (mainly as a result of staff who have TUPE pay protection rights) have a gender pay gap of -172.57 in favour of women.

8.3 There has been a significant reduction in the mean bonus gender pay gap for CEAs from 25.46% in March 2019 to 23.95% in March 2020.

9. Next Steps

9.1 COVID has impacted the progression of planned work on the Gender Pay Gap which was paused. This work will resume with a review and update of the Gender Pay Gap action plan, which includes:

- Introducing more controls in the use of spot salaries throughout the Trust for staff on Agenda for Change contracts, where senior approval will be required for a spot salary to be awarded.
- Further embed family friendly processes and flexible working policies.
- Explore how we can promote senior level vacancies to women and explore how we can better support female talent.
- Within the medical workforce, continue to apply rigor in the negotiations of starting salaries, and afford greater flexibility for part time workers to progress.
- With regards Clinical Excellence Awards changes, continue with the updated process to ensure more female medical staff are encouraged to apply for awards.

9.2 We will regularly review the Gender Pay Gap action plan and evaluation of the impact of actions throughout 2021/2022 via the People and OD Group.

Maria Gregoriou
Associate Director of People
June 2021

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 15
Subject:	Mental Health & Learning Disabilities – Impact of Covid and strategic response	**For Publication:** Yes
Author:	Karen Taylor, Deputy CEO/ Executive Director, Strategy & Integration	**Approved by:** Karen Taylor, Deputy CEO/ Executive Director, Strategy & Integration
Presented by:	Karen Taylor, Deputy CEO/ Executive Director, Strategy & Integration	

Purpose of the report:

To present the key findings and recommendations arising from the Hertfordshire and West Essex Integrated Care System Mental Health & Learning Disability Covid Recovery Plan

Action required:

To receive the report

Summary and recommendations to the Board:

Hertfordshire and West Essex ICS Mental Health Covid Recovery Plan (PDF attached as appendix) reviews the impact of the covid pandemic on mental health and learning disabilities, looking at the impact on the population's need and anticipated demand on services. It identifies short, medium and longer term considerations, together with high level mitigating actions which have been presented to the ICS Partnership Board in July. The attached presentation provides a high level overview of the key findings.

Work to develop this plan, led by Niche who were commissioned by the ICS to undertake this review, has involved engagement with a wide range of stakeholders – providers, commissioners, partner organisations, carers and service user groups. It is anticipated this plan will sit alongside other work being taken forward across the ICS to provide a coherent recovery plan across services, organisations and the ICS. A more detailed plan and response, with investment proposals will be developed and it is anticipated this will be reviewed by the ICS Partnership Board in the early Autumn. HPFT, as a major contributor to this work, will be part of this work through both the Hertfordshire MH & LD Collaborative and the wider ICS MHLD leadership team.

Summary of Report

Three sources of data have been considered in estimating the potential changes in demand for mental health and learning disability services across Hertfordshire and West Essex ICS:

1. The long-term trend – how demand was changing prior to the pandemic
2. Suppressed demand – referrals which might have been expected during the pandemic period, but which were not in fact seen

3. New demand – mental health problems which have been caused directly or indirectly by the pandemic, and which could lead to additional referrals to services

Against a pre-Covid pattern of around 75,000 referrals per year across Hertfordshire and West Essex ICS, over 25% of demand has been supressed over the last 12 months c20,000 referrals. The modelling undertaken, using national models and reviewing the evidence, indicates the HWE system could see as many as 89,000 new referrals per annum, *in addition* to the existing 75,000 per annum.

The review indicates the scale of the potential risk, as being both considerable and material. It stresses the importance of plans being put in place to mitigate this risk. It also indicates the almost certain impossibility of those mitigations being based on incremental changes to existing services. The form of response will need to be quite different and will include investment into the full spectrum of services – public health through to specialist provision.

Niche recommendations have been organised into short- and longer-term priorities. These are assessed as:

- Short-term: needs to start as soon as possible; could taper off after around a year. Initiatives in this category are intended to have a short-term impact, and to be temporary in their delivery.
- Medium-term: needs to start within the coming year and could continue to be required for a planning horizon of 3-5 years. Initiatives in this category are intended to have a short-to-medium term impact (as their delivery is expected to take longer to organise), and could prove temporary or permanent, depending on their impact when reviewed
- Long-term: could be required recurrently, and indefinitely. Initiatives in this category are expected to have a longer-term impact, as many will take some time to fully implement. They are expected to contribute to a permanent change in the way services function.

It is important to note that Niche were not commissioned to provide a fully costed plan. They were asked not to constrain thinking by the question of finances; However, the plan does include some general sense of potential financial scale.

The very clear message from the review, considering the scale of impact and future demand, is that only a broad based plan can realistically respond to and mitigate the scale of anticipated need and respond to that need in a way which is genuinely recovery-focussed – working to maximise the wellbeing of the whole community, and enabling specialist services to focus on those with the most severe needs. Niche note that all organisations will need to consider their role and be willing to work flexibly to provide the best pragmatic overall response.

Conclusion
This review will inform the future development of the HWE ICS response to covid; and will inform planning for MH & LD services in the future. HPFT will continue to support the development of this plan; both for specialist services and also working across the whole system to support a multi-agency, pathway and population health response to the anticipated increased need and demand across the population of Herts & West Essex.

Recommendations to the Trust Board
The Board is asked:

- To receive and note the report
- To review and consider the recommendations
- To note next steps and HPFT's role in development and shaping of response / plans working with partners across the ICS and the MHLD Collaborative.

Relationship with the Business Plan & Assurance Framework:

Aligns with future planning for HPFT

Summary of Implications for:

Paper outlines potential impact of covid on future MH & LD demand

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

N/A

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

N/A

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

Executive Committee and Trust Board received updates on the Demand Modelling and the full Niche report was circulated in July

Hertfordshire and West Essex
Integrated Care System

Essex County Council

Hertfordshire

NHS

Mental Health and Learning Disabilities

Covid Pandemic - Strategic Response

Karen Taylor, Deputy Chief Executive, HPFT and MH / LD SRO
Simon Pattison, Head of Integrated Health and Care Commissioning

Background

- National picture
- Local demand

- Nationally, modelling undertaken by Centre Mental Health (CMH) suggests the pandemic will have **significant impact people's mental health and demand over the forthcoming years**

- Locally, **demand pressures across entire system hitting now**
  - > people needing support & higher levels of acuity
  - Eating disorder services, adult – community, crisis and inpatients
  - Primary care mental health activity

- Niche consultancy have
  - Reviewed research & evidence
  - Consulted local stakeholders on local experience and views
  - Analysed suppressed demand during the peak of the pandemic
  - Estimated the impact of the pandemic
  - Proposed actions/mitigations to take as a system

Demand

- Pre-covid pattern c75,000 referrals p.a
- Supressed demand c20,000 during covid
- Additional demand c89,000 p.a referrals

"Almost certain impossibility of risk mitigations being based on incremental changes to existing services"

Group	CMH forecast annual additional demand - Herts / West Essex ICS
Anxiety and depression amongst people with existing mental health problems	45,900
Anxiety and depression – new cases	22,100
Children and young people (all presentations)	13,300
Survivors of Covid – mental health effects	900
Post critical care PTSD	120
Staff of health and social care – depression, anxiety, PTSD linked to Covid	6,200
Bereavement	450
Carers	200
Total	***89,170**

A Healthier Future
Improving health and care in Herts and west Essex

*growth of this scale likely over 3 year period

Key areas of impact

- Anxiety/ depression
- Children/ Young People
- Eating disorders
- Crisis presentations
- Surge in demand

	Risk	Likelihood	Impact	Summary
1	Up to 22,100 new cases per year of mental health problems in the wider community	High	High	
2	Up to 45,900 additional cases per year of anxiety and depression in people with existing mental health problems; and up to 6,200 additional cases amongst staff of health and social care services.	High	High	
3	An increase of up to 13,300 children per year with mental health problems, an increase of 143%	High	High	
4	Increased frailty in older people presenting to services	High	High	
5	Continuing increase in young people presenting in crisis	Medium	High	
6	Capacity constraints in services as a result of problems with recruitment and retention	Medium	High	
7	Increase in long term mental health problems amongst survivors of severe Covid. This increase could be up to 1020 cases per year.	High	Medium	
8	Very high increases in eating disorders	High	Medium	
9	Continuing pressure on waiting lists for children with autistic spectrum disorder	High	Medium	
10	Continuing high use of out-of-area inpatient beds	Medium	Medium	
11	Significant numbers of known service users re-presenting in crisis	Medium	Medium	
12	Surge demand for people with a learning disability, as they re-engage with services	Medium	Medium	

Discussion

- Any reflections on the future demand/risk profile?
- Does this resonate with what we are seeing in our system / our organisations?
- Are there any areas that are not highlighted in the report that we may have expected?

Proposed Actions/ solutions

Based on principles of creating resilience & good health

This reflects the majority of new demand to relate to mental wellbeing and mild/moderate mental illness

- Promoting Wellbeing and earlier intervention in mental illness
- Building resilience in disadvantaged communities
- Developing specialist services
- Enabling recovery / encouraging engagement with services

Promoting wellbeing & earlier intervention in mental illness

1. Substantially increase the investment in and prominence of early intervention and resilience support for children and young people
2. Implement an at-scale programme to engage with employers about employee wellbeing
3. Develop a programme of training and development intended to ensure that all staff across statutory services are able to offer simple practical advice about mental wellbeing
4. Implement a health surveillance programme, designed to draw data from all partner agencies

Building resilience in disadvantaged communities

5. Implement an at-scale small grants programme, focussing on locally-generated programmes to promote community cohesion and wellbeing	6. Invest in programmes to support people who are financially vulnerable, based on practical financial and debt management advice and support, but including emotional support where necessary	7. Increase the direct support offered to carers and families of all needs groups.

Develop specialist services

8. Develop a full 24/7 offer for children and young people with either a mental health problem or a learning disability

9. Improve the coordination of complex frailty services

10. Ensure crisis services for adults are focussed as exclusively as possible on people at risk of hospital admission

11. Expand access to therapies suitable for supporting people with post-traumatic stress

12. Widen the pool of people able to offer support to people with an eating disorder

13. Rebalance IAPT service towards more severe problems, within the safe and realistic scope of IAPT staff's skills

14. Ensure people with a learning disability have access to services able to meet their physical health needs.

Enabling Recovery

Encouraging engagement with services

Communications

15. Maximise use of online computer-led alternatives to direct face-to-face therapy, for both children and adults
16. Rebalance services for older people, for adults with serious mental health problems, and for people with a learning disability back towards a primarily in-person offer
17. Actively seek to re-engage people known to be at risk, but who have “fallen off the radar” – both people with a mental health problem, and people with a learning disability
18. Re-establish a full autism diagnosis service. This is relevant for both children and adults
19. Develop a coherent media campaign, across local print, broadcast and social media

Discussion

- Overall reflections?
- What should our ICS response be?
- What would our priorities be?
- Next steps?

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 16
Subject:	EoE Provider Collaborative – Update	**For Publication:** Yes
Author:	Andrew Godfrey, Managing Director Learning Disabilities and Forensics SBU	**Approved by:** Sandra Brookes, Executive Director of Service Delivery and Experience
Presented by:	Sandra Brookes, Executive Director of Service Delivery and Experience	

Purpose of the report:

To provide an update for the Trust Board on the implementation of the Provider Collaborative arrangements effective from 1 July 2021.

The report provides an update to Board on the progress of the translation of both operation and financial aspects of the negotiated agreements reached in the establishment of the East of England Provider Collaborative. The report identifies the good progress made to date and the further work being completed over the next weeks to ensure there are robust systems in place sufficient to meet the needs of the Trust in fully participating in the Collaborative.

Action required:

The Board is requested to:-

- note the progress made by the Provider Collaborative;
- seek any additional information required;

Summary and recommendations

Six NHS Mental Health Trusts, service users and carers have been working together as the East of England Provider Collaborative to transform local specialist mental health services.

The initial focus is on transformation of:

- Secure/Forensic Services (both mental health & learning disabilities)
- Child & Adolescent Tier 4 Services
- Adult Eating Disorders

A paper was brought to June's Trust Board to seek approval to implement the Provider Collaborative. That paper outlined the key elements of the proposal, including:

- Purpose
- Scope & scale
- Benefits
- Financial evaluation & due diligence
- Risks & mitigations
- Governance arrangements – partnership agreement, contractual arrangements and risk share

The Provider Collaborative, consists of the six mental health organisations acting in accordance with the MH Provider Partnership Agreement. Following the June Board approval to implement the Provider Collaborative, it formally went live on 1 July 2021.

This paper provides a brief update on the progress to date and outstanding issues for resolution. It

outlines HPFT's role and responsibilities within the collaborative, which can be broadly broken down into three key areas:

1. Lead provider for Child & Adolescent Tier 4 Services
2. Host of the Patient Flow Hub (bed management) for all service lines
3. As a provider of Secure/Forensic, CAMHS and Adult Eating Disorder services.

Additionally, it provides an update on the finance, contracting and governance arrangements.

There has been good progress around the development of the individual transformation schemes, including successful submission for Accelerated Schemes. This includes the potential for £700k pump priming investment in community LD forensic services in Norfolk.

However, there are also emerging risks in the delivery of the required transformational change in CAMHS given the national and regional demand and capacity issues. At the time of writing there are 43 closed CAMHS beds in the region with a large number of children and young people in the community requiring hospital level care.

Board is requested to note the progress of the Provider Collaborative to date. Board to also note the continued commitment and work which will be required between HPFT, the other providers and the TACT team in the coming months .

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:

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

Background

The NHS Long Term Plan set an ambition that *'Provider Collaboratives will cover 100% of the country by 2023/24, covering all appropriate specialised mental health services, and learning disability and autism services, to be managed through NHS-led provider collaboratives'*.

Six NHS Mental Health Trusts, service users and carers have been working together as the East of England Provider Collaborative to transform local specialist mental health services.

The Trusts are:-

- Cambridge and Peterborough NHS Foundation Trust (CPFT)
- Central and North West London NHS Foundation Trust (CNWL)
- East London NHS Foundation Trust (ELFT)
- Essex Partnership University NHS Foundation Trust (EPUT)
- Hertfordshire Partnership University NHS Foundation Trust (HPFT)
- Norfolk and Suffolk NHS Foundation Trust (NSFT)

The initial focus as the East of England Provider Collaborative is on transformation of:

- Secure/Forensic Services (both mental health & learning disabilities)
- Child & Adolescent Tier 4 Services
- Adult Eating Disorders

The common benefits in all areas include:

- A focus on repatriation and reducing length of stay
- A single point of access
- Effective bed management including regular case management of every service user placed outside of the region
- Reinvesting any financial surplus in service development and transformation including bed management and alternatives to admission.

The East of England Provider Collaborative successfully went live on 1 July 2021.

Hertfordshire Partnership Foundation NHS Trust

HPFT was previously commissioned directly by NHSE to provide these services. In 2018, this was extended to cover the new care model for CAMHS T4 with its core of community Home Treatment Team and DBT services supported where required by additional specialist beds. The income level for 2020/21, which operated under the interim financial framework is set out below.

Service	£k	What it covered
Forensic	£13,849	Broadland Clinic, Beech Ward, Warren Court & 4 Bowlers Green
CAMHs T4 block	£2,923	Block sum for operation of Forest House as 16 bed unit.
CAMHs other	£4,684	Operation of HTT Commissioning of beds in private sector for services not provided at Forest House or any inpatient need above FH capacity
Other services	2,202	Severe OCD and Body Dysmorphic disorder and Perinatal services at Thumbs wood
Total	£23,658	

Within the new arrangements, HPFT's role and responsibilities within the collaborative can be broadly broken down into three key areas:

1. Lead provider for Child & Adolescent Tier 4 Services
2. Host of the Patient Flow Hub (bed management) for all service lines
3. As a provider of Secure/Forensic, CAMHS and Adult Eating Disorder services.

The most significant area of responsibility and work is our role as Lead Provider for Child & Adolescent Tier 4 Services.

Lead Provider for Child & Adolescent Tier 4 Services

HPFT is the Lead Provider for CAMHS services, reflecting expertise and experience demonstrated through the delegated responsibilities for Tier 4 CAMHS services already held for Hertfordshire.

The Clinical Design Group, which has been led by HPFT, has outlined a clear model for transformation across the region to deliver improved outcomes for service users. The initial focus for accelerated transformation for all providers in the region is the introduction of:

- Home Treatment Team
- Red to Green inpatient flow management
- 72 hour crisis admissions

The CAMHS Clinical Design Group has also been requested to look at evidence-based practice to support development of integrated pathways to support young people with Eating Disorders due to the pressures on services and the need to consider alternative models of care.

Working groups are being established in each provider within the collaborative to deliver this change. Governance arrangements to ensure all providers deliver to the model, within expected timescales are being developed.

Following the Board's approval to "go live on the East of England Provider Collaborative from 1 July 2021 the Trust has now signed its lead provider contract for specialist inpatient CAMHS. Under these arrangements the role of NHSE is significantly reduced with the majority of its previous responsibilities transferring to the Lead Providers.

The contract is for £42,879,435 (for the full year 2021-22) and has a term of two year and nine months, this reflects the current funding settlement associated with the NHS

Long Term Plan that ends at the end of 2023-24. The contract provides for a review of this contract at the end of the current financial year in the light of a better understanding of the demand for these services.

As the Lead Provider we now need to enter into sub contracts with other organisations that provide specialist inpatient care for children and young people from the East of England. This is a total of seventeen contracts three of which are with other members of the Collaborative. This work, which is being undertaken by TACT on our behalf, is to be completed under the terms of the lead provider contract by 1 October 2021. HPFT will work closely with TACT on both the contracting and performance management arrangements within this area.

There are currently risks around the delivery of transformational change across CAMHS given the current national challenges with increased demand and the temporary closure of CAMHS beds due to either regulatory or local action. At the time of writing there were 43 closed CAMHS beds in the region.

Whilst financial risks remain, much of this is mitigated by the risk share arrangements as outlined below.

Host of the Patient Flow Hub

HPFT will host the patient flow hub on behalf of the Provider Collaborative for all service lines. This will provide the bed management function for all the inpatient beds within the Provider Collaborative. HPFT will work closely with the TACT team in the development and delivery of the bed management function.

There is a two phase process in developing the Hub. The first phase will focus on the smooth transition of responsibilities to the Provider Collaborative and the scoping of the longer term model. Phase 2, which is expected to be delivered from April 2022 will implement the longer term model.

In regards to phase 1, the TACT team are providing support from 1 July whilst recruitment is underway. A number of posts have been recruited by HPFT with individuals expected into post in the next 2 months. It is expected that HPFT will pick up full responsibility in Q3.

A scoping exercise is underway around a bed management system with a basic specification having been shared with the Clinical Design Groups. This will be refined and confirmed as part of the scoping works for Phase 2.

The priorities for the hub at present are:

- Access to timely data and information with a resilient bed management system
- Resourcing the hub in the short term and longer term to realise scalable benefits.
- Clarification of roles and responsibilities across the providers, Lead Providers and TACT team

Patient Flow Hub is an essential function of the Provider Collaborative to ensure it delivers its objectives. There are risks around recruitment and the resourcing to be able to deliver against the expectations. There are also significant risks around ensuring access to and management of critical data on a day to day basis.

Provider role

The trust provides significant services in both CAMHS and secure services. Whilst the trust also have leadership roles within CAMHS and LD secure services, we also have responsibilities as providers to implement the transformation as outlined by the relevant Clinical Design Groups. Local transformation groups have been established to implement these changes.

An Accelerated Scheme business case to expand Norfolk Community LD Forensic Services has been developed and is expected to be agreed by the Provider Collaborative Board in July. This will see an investment of £700k in Norfolk services to allow for more timely discharges and preventions of admissions.

The Trust will be subcontracted for secure (including LD forensic services) and Adult Eating Disorder services. It is expected that financial arrangements will be contracted on a 'steady state' basis in the initial period which will provide some level of certainty.

Financial considerations

The overarching recurrent baseline budget for the collaborative is £129.29m. The breakdown of the financial offers for each service line is as follows:

	Recurrent £m	Non-Recurrent £m	Total £m
CAMHS	44.53	0.31	44.84
AED	10.52	0.05	10.57
SECURE	73.21	0.67	73.88
TOTAL	**128.26**	**1.03**	**129.29**

Additionally, a further £4.7m of non-recurrent pump priming investment has been made available by NHSE to support Accelerated Schemes across the three service lines. This funding will be used to accelerate transformation in 2020/21 and 2021/22.

An initial assessment in relation to the HPFT finance position is as follows. This excludes any allocation of the £4.7m;

Service	£k	Comment
Forensic	£13,647	The contracting party will be with EPUT. Also in terms of this service more income will flow from commissioners outside of the regional collaborative and be paid on contract rate basis. There will be an interim period whereby some funding will derive from NHSE and the majority from the Provider Collaborative. This portion is currently being worked through with TACT. The management of this is with EPUT £202k less than previously per annum at moment
Eating disorders	£0k	no changes as HPFT do not currently access Adult ED beds. HPFT are exploring the possibility of split funded placements and therefore the possibility of securing additional income
CAMHs T4 Forest House	£2,949	Figure being finalised but will be broadly in line with current
CAMHS other	£29,812	See detail below
Total	**£46,408**	

The forecast reductions in the contract values on Forensic and Forest House reflect changed in the bed occupancy level compared to previously negotiated contracts. This will be continuously reviewed with the Provider Collaborative under the new arrangement.

In relation to the CAMHS service line the income and related cost position for HPFT is estimated as follows. Within this there is circa £5m of additional cost allocation in the line Private Sector Providers against the 20/21 actual costs which will provide headroom against any activity variation in 21/22.

	£K	comment
Income	£32,761	This is based upon the 18/19 cost to NHSE for these services.
Cost		
To HPFT	£2,949	This is the amount for the running of FH it is the FY21 amount uplifted. HPFT will continue to carry the provider financial risk on this as now
Other collab members	£11,683	Similar to HPFT. These are block amounts predetermined based upon historic
Other NHS providers	£1,167	
Private sector providers	£16,797	This is the main area of risk as these are activity based tariff contracts. Additional demand or pricing pressures will see this cost rise with a reduction in placements reducing cost and generating surplus for reinvestment
Other Costs	£166	Contingency
Net position	£0	This amount will be subject to netting if in surplus and risk share if a deficit

Risk share arrangements

New arrangements around risk share have been introduced alongside the go-live of the Provider Collaborative. The proposed financial risk share is summarised in the table below:

Trust	AED	CAMHS	Secure
Central and North West London	X	X	
Cambridgeshire and Peterborough	X	X	X
East London	X	X	X
Essex Partnership	X	X	X
Hertfordshire Partnership	X	X	X
Norfolk and Suffolk	X	X	X

Whilst some of the details of the risk share mechanism are still being finalised, there is a commitment across the partners to these principles:

- Where any service line has a deficit then this will be offset against those service lines in surplus
- Where there is a surplus then this will remain in the service line generating the surplus
- Where there is a deficit then this will be risk shared across the members of the service line generating the deficit in equal shares.

Governance

Detailed governance arrangements in the Provider Collaborative are in place with the structure outlined in Appendix A.

Following the launch of the collaborative, it is expected there will be some changes to the delivery and transformation functions as the service lines move into the delivery of their transformation change.

Internal governance arrangements within HPFT have also been reviewed. A New Care Models Steering Group has been established with key senior membership from across the organisation. This meets fortnightly and is chaired by the Executive Director of Service Delivery and Experience. This group will drive change internally and ensure issues are identified and resolved in a timely manner across all of HPFT's functions. The Steering Group reports into the Trust Executive and Finance and Investment Committee.

Additionally a Lead Managing Director has been identified to provide oversight and support on a day to day basis.

Key Risks & Mitigations

There are a number of key risks which have been identified as part of the development of the Provider Collaborative. A number of these are outlined in the table below. Whilst these risks remain, there is a clear mitigation and risk management strategy in place. Actions are in place to either resolve these risks entirely or mitigate them sufficiently to avoid significant issue.

Key risks and mitigations are summarised as:-

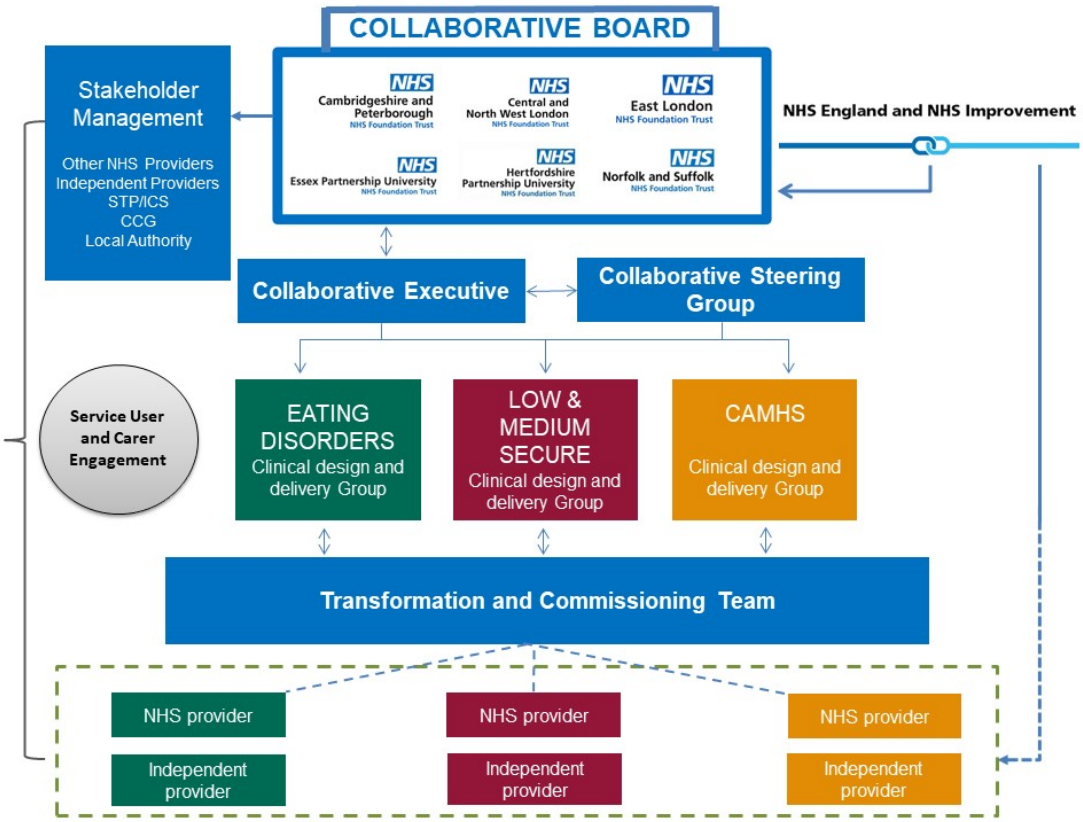
Risks	Mitigations
Risk that service users (CAMHS and AED) remain in hospital treatment outside of their local area	Transformation plans in place to offer alternatives to admission delivered locally. Effective controls will also be in place through single point of access, effective bed management, clinical scrutiny of admissions and a focus on repatriation
Activity growth above long term planning assumptions	'Hard' review of activity and associated funding with NHSEI at end of year
Ability to recruit Workforce to achieve the pace of transformation that is required	The collaborative is working with HEE as well as together across partners to develop innovative workforce solutions
Investment in New Care Model unaffordable due to delayed transformation delivery	c. £4.7m non-recurrent funding from NHSEI for 21/22 to pump-prime community team development
Transformation Schemes deliver efficiencies below plan	Transformation schemes are based on an evidenced approach and have been discounted in part either by an efficacy factor or prudently profiled
Quality risk arising from activity growth above funded levels e.g. COVID impact where appropriate settings, particularly inpatient admission, are temporarily unavailable due to demand.	Effective mitigations are through investment in Patient Flow Management, clinical scrutiny and the planned development of viable alternatives to admission.

Conclusions

Significant progress has been made in establishing the Provider Collaborative and identifying the key priorities and areas of work. The collaborative launched on schedule on 1 July and the Lead Providers are beginning to implement their transformation agendas.

As expected, at this early point, there remain a number of challenges and issues to resolve over the coming months regarding the contracting and implementation. However, there is a strong governance process in place, both within HPFT and within the Provider Collaborative to ensure these issues are resolved in a timely and satisfactory manner and that the progress of the change in pathways and practices is taken forward at the required pace.

Appendix A


COLLABORATIVE BOARD
Stakeholder Management
Other NHS Providers
Independent Providers
STP/ICS
CCG
Local Authority
Cambridgeshire and Peterborough NHS Foundation Trust
Central and North West London NHS Foundation Trust
East London NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
NHS England and NHS Improvement
Collaborative Executive
Collaborative Steering Group
Service User and Carer Engagement
EATING DISORDERS
Clinical design and delivery Group
LOW & MEDIUM SECURE
Clinical design and delivery Group
CAMHS
Clinical design and delivery Group
Transformation and Commissioning Team
NHS provider
Independent provider
NHS provider
Independent provider
NHS provider
Independent provider

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 17
Subject:	Report of the Audit Committee held 19 July 2021	**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 19 July 2021.

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 the meeting was in a workshop style with four deep dives into: Operations; People; Digital and Finance. This format provided an opportunity for detailed discussion on issues raised over the past year and provided an opportunity for assurance to be taken.

The Committee also agreed for the Trust to undertake the procurement of internal audit and counter fraud services, with the new contract starring April 2022.

Matters of Escalation

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

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

None

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

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

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

Seen by the following committee(s) on date:

Finance & Investment / Integrated Governance / Executive / Remuneration /Board / Audit

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Audit Committee held on 19 July 2021

1. Introduction

1.1 The Audit Committee was held on the 19 July 2021 in accordance with its terms of reference and was quorate.

1.2 The Chair of the Committee set out that this was an additional meeting, set up to provide an opportunity to have a more in depth discussion and consideration of issues that have been reported to the Committee in the previous year. It was noted that feedback on the Committee feedback was sought and would be reflected on.

1.3 In line with the different approach the Committee did not receive any formal reports and the usual cycle of follow up work and in year work by internal audit to give external assurance will continue in the normal way and report to a subsequent Committee meeting.

2. Matters Arising

2.1 The Committee was updated with regard to a data breach relating to information being published on public website as part of the papers for Public Board papers. It was reported that the ICO had concluded their review and had closed the case with no further action required by the Trust. It was noted that there was litigation with regard to this case which was subject to discussion with NHS Resolution.

3. Deep Dive Presentation – Operations

Service User Property

The Committee received a comprehensive presentation that set out the work underway to improve the process for safeguarding service user's property. The Committee heard about the annual number of claims but also the impact on service users and their families and staff having to undertake investigations.

The Committee were updated on the work of the cross SBU task and finish group, which involved service user and carers and was taking a CQI approach.

The Committee noted the progress to date including use of a focus group and local review which had identified areas for improvement. The task and finish group have commissioned spot checks to track improvements and help with engagement from services.

The Committee welcomed the engagement of Experts by Experience thereby making sure the Trust had a clear sense of what is it like for SU's who are admitted and how they feel property is managed. The session had proved invaluable and helped identify a new approach with regard to which items of clothing needed to be logged.

It was noted that a culture shift is needed in inpatient services to move from logging all items to logging valuables/items of sentimental or financial value. It was highlighted to ensure this change happens clear links with work underway through Acute Flow Group are being made, as well as crib sheets and reminders for staff as well as information leaflets. The next phase will be to consider digital options for sharing the forms with service users.

The Committee heard that for the new system to be successful there is a need for it to be embedded and aim to do this by using the Plan Do Study Act (PDSA) cycle as well as training and education for staff.

The Committee were updated on the next steps, including a PDSA cycle; Communications strategy and focus on discharge processes and unclaimed property.

In response to Catherine Dugmore's question it was identified that success measures for the project would include positive results from local audits as well as speedy resolution of disputes. It was noted that disputes related to both the presence and condition of property. Internal Audit added that in their experience the use of photography could help with record keeping. The need to continue to explore digital solutions was emphasised. It was agreed that the service would consider when it would be helpful for internal audit to undertake an audit in this area.

Safe Staffing

The Committee was updated on the processes in place to manage Safe Staffing, to ensure the more appropriate safe staffing levels are in place. It was emphasised that the underlying principle was safety first, followed by the scrutiny of the use of staff and the resources this committed.

The Committee received an update on the work underway to embed the recommendations from the advisory internal audit report on pay costs and eroster. It was noted that the need for safe and supportive observations was often the reason for the need to increase staffing. It was reported that the CQI project was underway regarding safe and supportive observations.

The Committee was taken through the progress to date to address the recommendations made. In particular the approval of additional bank shifts now involved the Modern Matrons/Team Leaders and Out of Hours Clinical Leads. This was also supported by the review of tolerance levels and establishments. It was noted there was planned for an increased involvement of finance in the approval process and the setting up of regular reporting to PODG on the use of bank and agency staff. Progress has also been made with regard to record keeping and developing a more robust approach to pay cost forecasting.

Janet Lynch welcomed the reporting of bank and agency costs to PODG as this would help triangulate with workforce metrics linked with retention and recruitment.

In response to Catherine Dugmore's question is was reported that the remaining challenges related to the fact that currently only nursing staff were on eroster. The Committee noted that a proposal was being worked up for the extension of eroster to include other disciplines.

4. Deep Dive Presentation - People

The Committee received a comprehensive presentation that updated them on the NHS People Plan and People Promise, developments on the ICS system workforce improvement model and the headlines form the workforce metrics for the first quarter for 2021/22.

The Committee also received an update on the progress with implementing the management actions from the people audits undertaken since 2017. The Committee heard that all actions from all but two audits had been completed and closed. The actions from the two audits, appraisal and proactive counter fraud work were scheduled to be closed in the coming months. The Committee considered the themes from the audit noting the importance of taking the learning from them forward.

The Committee were pleased to not the progress with the workforce planning audit actions and that this work as well as the work of PODG had been considered at the IGC meeting in July, where no issues had been raised. The Committee also noted that the recent internal audit on staff wellbeing had provided substantial assurance.

With regard to the themes from past audits the progress that has been made in relation to the review of strategies, embedding of processes and compliance with system was noted. It was also noted that the Trust was working with RSM to consider how can provide further assurance on the themes identified.

Liz Wright welcomed the approach being taken and the importance of the recognition of the importance of embedding practice in all parts of the organisation. Janet Lynch added that she was working with the team to ensure that all that was being done by the People team was visible and that did not wait for an audit to identify areas for improvement.

In response to Tim Bryson's question Janet Lynch confirmed that the People team did analyse the reasons recorded for learning the Trust and that the teams were drilling down into the hotspots relating to retention and recruitment.

5. Deep Dive - Digital

The Committee received an update on three elements relating to digital. First of which was the Digital Security and Protection Toolkit (DSPT). It was noted that The DSPT is an annual, mandatory self-assessment of the Trust's cyber and IG governance, with the emphasis on cyber. It is a key indicator for commissioners, information sharing partners and the CQC and there is a requirement that the Trust submission independently audited.

It was reported that the Data Security and Protection Toolkit was submitted in June 2021, with all mandatory evidence items complete, which meant the Trust is now published as "Standards Met", an improvement on the previous year. It was noted that there were four outstanding actions from the internal audit all of which are complete or superseded (with the submission of the 20/21 toolkit).

The Committee noted the continued work to support access to information from different systems to support the recommendations from the safeguarding internal audit. It reported that the current system was fit for purpose and that Trust would look to benefit from wider piece of ICS system work to integrate systems. It was noted that the current approach of the Trust was to bring the information together through SPIKE2.

The Committee considered and supported the Trust's approach to cyber security. It received feedback on the Trusts' response to a recent cyber attack and the benefits of early reporting and responding to local and national intelligence. It was noted that the Trust had high levels of reporting of possible cyber incidents through the Datix system.

It was agreed to look at the systems in place through our shared services for finance, payroll and procurement to protect against the cyber security.

6. Deep Dive - Finance

The Committee received a detailed presentation on the financial control systems in place for 2020/21 and the recommendaitons from recent internal and external audits of financial systems and the end of year accounts. The themes of: review of outsourced work; ensuring availability of evidence; systems and recording; governance and clarity were dicussed in relation to the specifc managmenet actions. The Committee also considered and welcomed the proposed approach with regard to preparing for 2021/22 year end.

The need for close engagment with the ICS was emphasised to help with the likely increase of income coming from that source. External Audit also provided some advice with regard to IFRS15. It was agreed that the December Committee meeting would receive an update on the progress with the actions identified.

It was noted that there would be early dialogue with external audit with regard to the handling of income and resources relating to the East of England Provider Collaborative and what is would mean for 2021/22 year end.

7. Internal Audit and Counter Fraud Procurement

The Committee considered and approved the proposal to undertake a procuremet of Internal Audit and Counter Fraud Services to the Trust, as the current contract was due to end March 2022.

It was noted that the ICS system had made no firm decision regarding system wide procurement of Internal Audit and Counter Fraud services and that currently the contracts for providers and CCGs have different breaks or end points. It was proposed to ensure a level of flexibility that would support a system wide procurement, should it be an option at a future that that the contract is for two years with an option to extend by a further two (one plus one).

It was proposed to procure internal audit and counter fraud services under one contract. The Committee considered and approved the proposed timetable that would see the awarding of the contract by early October thereby providing sufficient time for a mobilisation of the new to contract.

It was agreed that to meet the timescale Trust managers would work with Audit Committee members outside of the committee meetings to meet the agreed timetable.

8. Any Other Business

The Committee formally thanks Dr Jane Padmore for all her contributions to the Committee and wished her well in her new post.

NHS
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Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 18
Subject:	Trust Risk Register June 2021	**For Publication:** Yes
Author:	Nick Egginton, Compliance and Risk Manager	**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:

For the Board of Directors to consider and review the risks presented, the mitigating actions and resultant risk scores on the Trust Risk Register (TRR).

Action required:

To receive the Trust Risk Register for assurance.

Summary and recommendations:

This paper is the Trust Risk Register and contains the current position, scores and mitigation.

Changes made to the Trust Risk Register since it was reported to the Board of Directors on 25th March 2021:

The following risks have been approved and added

- Quality and safety: CAMHS Eating Disorders Team demand exceeds capacity.
- Quality and safety: National Shortage of specialist CAMHS beds impacting the capacity with FHAU and a risk that service users are not placed in the most appropriate environment.
- Quality and safety: Reduced provision of face to face mandatory training and the impact on staff compliance and consequently impact on staff and service user safety.

The following risks have reduced in score following approval by Tactical and Strategic Command

- Workforce: The Trust is unable to maintain staff wellbeing and staff morale during the pressures of COVID19, with increased demand now and during the recovery phase.
- Quality and Safety: The Trust may not be able to sustain core operational services and maintain service user and staff safety during the continued COVID19 pandemic.

The following risks have been identified and will be considered for inclusion in the next reporting period:

- The preparation for winter.
- The increased acuity in community services

The following has been approved the removal of the following risk from the Trust Risk register and for the constituent parts to be managed in the local risk registers:

- Implications for the Trust of unforeseen consequences arising from the end of the EU Exit transition period on the 31st December 2020 at which point the UK and EU's relationship will be governed by what is agreed in the future relationship agreement

The Board is asked to:

- Consider the current risks and whether they reflect the current risks for the Trust.
- Consider the risk scoring and whether they are appropriate.
- Consider whether the mitigation and actions are robust enough, offering constructive challenge to the team to ensure the risks are managed and mitigated.

- Note the three new risks that have been added since the last report relating to CAMHS beds and CAMHS eating disorder services.
- Note the two risks that will be considered in the next reporting period.
- Note the removal of the EU exit risk from the Trust risk register and for the constituent parts to be managed in local risk registers.

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

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

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

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

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

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

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

Health and Social Care Act 2008 (Regulated Activities) Regulations

Regulation 12: Safe care and treatment

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

Regulation 17: Good Governance

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

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

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

Exec 07.07.2021; IGC 15.07.21

Hertfordshire Partnership University NHS Foundation Trust

Trust Risk Register Executive Summary June 2021

1. Introduction

1.1. The purpose of this executive summary is to present an overview of the recent updates to the Trust Risk Register (TRR), for discussion. Consideration should be given to the current situation and the mitigations that have been put in place. The TRR identifies the high level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them.

1.2. Each Director has reviewed the risks that they are Senior Responsible Officer for and the current position and mitigation has been updated. The preparation for winter will be considered prior to the next version of the Trust Risk register being brought to board.

1.3. IGC are asked to:

- Consider the current risks and whether they reflect the current risks for the Trust.
- Consider the risk scoring and whether they are appropriate.
- Consider whether the mitigation and actions are robust enough, offering constructive challenge to the team to ensure the risks are managed and mitigated.
- Note the three new risks that have been added since the last report relating to CAMHS beds and CAMHS eating disorder services.
- Note the two risks that will be considered in the next reporting period.
- Note the removal of the EU exit risk from the Trust risk register and for the constituent parts to be managed in local risk registers.

2. Summary

2.1. The Trust currently has 13 risks on the TRR, grouped into the following themes:

- Quality and Safety (5)
- Finance (2)
- Workforce (2)
- External landscape (1)
- Operational (1)
- EU Exit (1)
- Information Management and Technology (1).

2.2. Since the TRR was last presented to the Board of Directors, two risks have been added relating to quality and safety:

- CAMHS Eating Disorders Team demand exceeds capacity
- National Shortage of specialist CAMHS beds impacting the capacity with FHAU and a risk that service users are not placed in the most appropriate environment.

2.3. Three risks have had their scores reduced following review, one relating to quality and safety and the other to the workforce:

- Workforce: The Trust is unable to maintain staff wellbeing and staff morale during the pressures of COVID19, with increased demand now and during the recovery phase.
- Quality and Safety: The Trust may not be able to sustain core operational services and maintain service user and staff safety during the continued COVID19 pandemic.
- Reduced provision of face to face mandatory training and the impact on staff compliance and consequently impact on staff and service user safety

2.4. It is proposed that the EU exit risk is removed from the Trust Risk register and the consistent parts are managed through the appropropriate risk registers:

- Implications for the Trust of unforeseen consequences arising from the end of the EU Exit transition period on the 31st December 2020 at which point the UK and EU's relationship will be governed by what is agreed in the future relationship agreement

2.5. Over the next reporting period two new risks will be considered:

- Preparation for winter.
- Increased acuity in community services.

3. Current position

3.1. Quality and Safety

- *COVID pandemic* – The likelihood of the risk occurring has been reduced to unlikely. This is the Trust maintaining core operational services and service user and staff safety within its remit during the most recent COVID wave and continues to have sufficient controls and mitigation in place, such as good IPC compliance, a robust vaccination programme and the use of LFTs.
- *CAMHS Eating Disorders* – This has been escalated to the Trust Risk Register due to the likelihood of this risk occurring. The current mitigation plan in place is managing and prioritising work but further work is being prioritised to reduce the risk further.
- *National Shortage of specialist Child and Adolescent Mental Health Services (CAMHS) beds impacting the capacity with Forest House Adolescent Unit (FHAU) and a risk that service users are not placed in the most appropriate environment* – This risk has been escalated to the Trust Risk Register due to the likelihood of it occurring increasing. The actions and mitigation relating to this risk are reviewed regularly at meetings with NHS England (NHSE) and daily reviews of all young people waiting for specialist beds.
- *Unlawful detention in the Places of Safety* – Daily demand and capacity meetings discuss all service users detailed under Section 136 (S136). An escalation process is in place to identify potential breaches and a patient flow project will support the movement of service users from the section 136 suite into a treatment bed when required. The S136 Operational Group are currently focusing on a number of areas including:
    - Identifying what can be done differently to ascertain the individual service user's care needs at the point of Street Triage involvement
    - Identifying ways to increase Street Triage involvement
    - Identifying ways to reduce S136 detentions by increasing diversion to the Crisis Recovery Home Treatment Team (CRHTT), adult community services and CGL
    - Sharing information with the police to assist them with assessing the risk
    - Developing procedures around the use of video technology to enable Approved Mental Health Practitioners (AMHP) to complete initial pre-screen assessment
    - Developing online training sessions for police officers on care planning, the Street Triage services and other mental health services the police access.
- *Reduced provision of face to face mandatory training* – This risk has been escalated to the Trust risk register from the COVID19 risk register on the basis of the increasing risk it represents to the safety of staff and service users within the context of the challenges in recovery. Of particular concern are Respect, moving and handling and resuscitation training:
    - Respect: Non-medical Education Training (NMET) funding approved to second 3 additional Respect train the trainers. Additional venues and increased trainee capacity also actioned to increase compliance rates and weekly monitoring of the trajectory provides oversight.
    - Moving & Handling (basic and advanced patient handling): Train the trainer held with 8 delegates, currently awaiting results from the external training provider and to then commission additional training.
    - Resuscitation: additional sessions commissioned to support the recovery plan for Basic, Intermediate and Paediatric Life Support. Additional train the trainer providing Basic Life Support sessions in the service areas, with an additional one currently being trained for life support and also moving and handling.

3.2. Finance

- *Short term* – The Trust has a robust delivering value programme managed through the Delivering Value Management group, which will provide mitigations to the effects of higher efficiency that may be required in H2.
  Robust financial management systems in place, monitored through the Finance and Investment committee, allows for earlier identification of potential financial risk which can be managed in a timely manner. Currently there are temporary financial arrangements which see a payment based upon 19/20 contract values. This is then topped up based upon recent spend to cover existing costs. Details of the proposed new financial structure are not expected until September 2021. The Trust will continue to work actively as part of the ICS to ensure these arrangements provide a fair settlement for MH & LD services.
  Levels of Income assumed in the 21/22 financial plan has been confirmed until end of Q2, any changes to income levels will only impact on half 2. Additional Mental Health funding has been confirmed for the whole year, which brings certainty of income and allows for transformation work to be planned and delivered.
- *Long Term*- NHSE has proposed to implement a regional Provider Collaborative from October 2022 covering CAMHs Forensic and ED services currently provided through NHSE. Work continues on each work stream to implement the clinical redesign, agree the resource allocations and implement the governance and risk share structures.
  The Trust has been given organisational control totals up to 2024, however, following the change to a system control total in 20/21, there are signals that this and other changes to the financial arrangements will be made for future periods which will likely change the financial metrics for individual organisations. At the moment this has been substituted with temporary arrangements which see a payment based upon 19/20 contract values which is then topped up based upon current spend to cover existing costs. Details of the proposed further changes in the financial structure are not expected until May/June 2021. The Trust will continue to work actively as part of the ICS to ensure these arrangements provide a fair settlement for MH & LD services.
  The Trust has set an initial Delivering Value target of £7m and is continuing to develop plans to meet this. The Trust is also developing its next 3 year capital plan with a core element being the completion of the OBC and planning application for the investment in a new inpatient unit to provide for the eastern County.

3.3. Workforce

- *Insufficient Workforce to deliver long term plan*- The Recruitment and Retention Strategy is being refreshed. A Trust-wide workforce plan and SBU level workforce plans are being implemented during quarter 2. HCSW vacancy rate reduced following recruitment campaign. Establishing an international recruitment programme for Registered Nurses, with a consistent high volume of people in the recruitment pipeline each month and 79 newly registered nurses to join in September.
- *Staff wellbeing and morale during COVID19 and recovery phase* – Engagement through *Good to Great* roadshows, staff network conversations and team/SBU conversations continue to discuss the staff survey results and the People Recovery plan. The feedback received is informing the plans and being implemented, focusing on improving staff experience in relation to equality, diversity and inclusion, violence and bullying, harassment and abuse.

3.4. External landscape

- *The changing external landscape* - The Health & Care Bill was published on 6 July, and it builds on proposals for legislative change set out in the NHS long Term Plan, and sets out the biggest reforms to the NHS in a decade. Although the majority changes are well rehearsed, the Bill and its potential impact for HPFT in context system changes is under review. The Hertfordshire Mental Health and Learning Disability Collaborative is established, with the Partnership Board in place and overseeing system transformation. Sgnificant funding secured under the mental health investment standards and spending review to support delivery Long Term Plan, MHLD Collaborative moving into a key stage of

development including defining scope and commissioning approach, The East of England Provider Collaborative has gone live in July 2021.

3.5. Operational

- *Risk that the sustainability of the Specialist Residential Services (SRS) becomes unviable following the reduction and changing needs of service users leading to an impact on quality and finance -* There is a programme of work being undertaken around the future provision of SRS, led by the Trust with the Steering Group being led by commissioners. Co-production was launched in September 2020 with all stakeholders and was completed in November 2020. The second stage of coproduction ran May to June 2021 and is being used to plan the next stages. Commissioners have agreed to extend the current shortfall arrangements until the end of the consultation in 2021/22.

3.6. EU Exit

- *Implications for the Trust of unforeseen consequences arising from the end of the EU Exit transition period on the 31st December 2020 at which point the UK and EU's relationship will be governed by what is agreed in the future relationship agreement* –The risk relating to medicines management following leaving the EU has not materialised. Since the creation of the Settlement Scheme, the Trust has encouraged non-British EU staff to apply for settled status. All EU employees (173 staff) were written to in January 2020, again in October 2020 and in February 2021 to remind them of the process, the support available, how they are valued by the Trust and to ask them to keep us apprised of their situation and any ways in which we might be able to help and support them. Of the 173 EU staff, 113 (65%) have made successful applications to the scheme. Staff had until 30 June 2021 to apply for pre-Settled Status or Settled Status. The Trust worked with staff to ensure they were supported to do this and to minimise the risk to services.
    - It is proposed that this risk is moved down to the appropriate risk registers.

3.7. Information Management and Technology

- *Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability* - Cyber security remains in a controlled state and continues to be monitored due to the potential likelihood. The NHS has agreed extended support arrangements for Windows 7 until January 2022. Windows 10 upgrades, which were paused during the COVID pandemic, will be completed by the end of quarter 2 2021/22. Further mitigation and assurance actions continue into quarter 2:
    - New Cyber Risk Management Framework
    - Gartner IT Score for Security and Risk Management
    - Start implementing Single Sign On
    - Penetration Testing
    - Cyber Essentials Plus Assessment
    - Start migration to N365, latest Microsoft office package
    - Targeted phishing campaign with training
    - End Point Security systems on Trust devices to identify and quarantine malware and suspicious files
    - Regular updates and patches to systems to address known vulnerabilities
    - Annual Penetration Testing to identify and address vulnerabilities.

4. Conclusion

4.1. This executive summary provides an overview of the Trust risk register and asked the IGC is asked to:

- Consider the current risks and whether they reflect the current risks for the Trust.
- Consider the risk scoring and whether they are appropriate.
- Consider whether the mitigation and actions are robust enough, offering constructive challenge to the team to ensure the risks are managed and mitigated.
- Note the three new risks that have been added since the last report relating to CAMHS beds and CAMHS eating disorder services.
- Note the two risks that will be considered in the next reporting period.

- Note the removal of the EU exit risk from the Trust risk register and for the constituent parts to be managed in local risk registers.

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

	Opened	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Key Mitigations	Executive Lead
1	25.03.2021	1370	**Quality and safety:** National Shortage of specialist CAMHS beds impacting the capacity with FHAU and a risk that service users are not placed in the most appropriate environment.	16 (4x4)	20 (Almost Certain 5 x consequence 4)	4 (1x4)	We will provide safe services, so that people feel safe and are protected from avoidable harm	Reduction of beds when escalation in presentation Daily reviews of the YP awaiting specialist beds	Sandra Brookes (Executive Director Service Delivery & Service User Experience)
2	25.03.2021	1300	**Quality and safety:** CAMHS Eating Disorders Team demand exceeds capacity	12 (4x3)	16 (Likely 4 x Major 4)	4 (1x4)	We will provide safe services, so that people feel safe and are protected from avoidable harm	Waiting list system Review clinic to manage the waiting list and prioritisation Additional funding for bank and agency posts Business case for additional permanent staff	Sandra Brookes (Executive Director Service Delivery & Service User Experience)
3	01.06.2020	1284	**Quality and safety:** Reduced provision of face to face mandatory training and the impact on staff compliance and consequently staff and service user	16 (4x4)	16 (Likely 4 x Major 4)	4 (1x4)	We will provide safe services, so that people feel safe and are protected from avoidable harm	Trajectories for each face to face training course Commissioned additional sessions for Moving & Handling to support the recovery plan A Train the Trainer programme for Moving & Handling. NMET approval to second 3 internal train the trainers into the RESPECT team Increased maximum numbers of delegates from 6 to 8	Janet Lynch (Interim Executive Director of People & Organisational Development)
4	27.12.2017	882	**Quality and safety:** S136: Unlawful detention of service users under S136 breaching beyond 24hrs which has legal implications and an impact on service user care, treatment and experience	16 (4x4)	15 (Almost certain 5x Moderate 3)	3 (1x3)	We will provide safe services, so that people feel safe and are protected from avoidable harm	Availability of Street Triage 7 days a week, in order for Police to consult Dedicated Section 136 team to monitor progress against 24 hour timeframe and co-ordinate assessing clinicians Protocol for escalation of service users detained under Section 136 Interagency S136 meetings S136 Operational Group	Sandra Brookes (Executive Director Service Delivery & Service User Experience)
5	08.10.2020	1321	**Workforce:** The Trust is unable to maintain staff wellbeing and staff morale during the pressures of COVID19, with increased demand now and during the recovery phase.	12 (4x3)	12 (Possible 3 x Major 4)	4 (1x4)	We will attract, retain and develop people with the right skills and values to deliver	'Here For You' support service Staff COVID risk assessments Employee Assistance Programme Staff networks Good to Great Roadshows	Janet Lynch (Interim Executive Director of People &

							consistently great care, support 6and treatment	Catch up with the Execs Health and Wellbeing Activities	Organisational Development)
6	16.10.2018	1001	**Finance:** The Trust may not have sufficient resources to ensure long term financial sustainability	12 (3x4)	12 (Likely 4 x 3 Moderate)	6 (2x3)	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	Secure a fair share of the ICS revenue allocations including Income allocated to MH Investment standard and LTP. Effective grip on resource use with appropriate cost controls Robust Delivering Value programme Effective Service Transformation programme Effective use of capital spending Supporting innovation	Paul Ronald (Director Operational Finance)
7	08.10.2020	1320	**Workforce:** Insufficient workforce to meet predicted increased demand and deliver commitments in Long Term Plan	12 (4x3)	12 (Likely 4 x Moderate 3)	6 (2x3)	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	Recruitment, Retention and Reward plan HCSW mass recruitment campaign Trust Workforce plan and action plan	Janet Lynch (Interim Executive Director of People & Organisational Development)
8	02.02.2019	749	**External landscape:** The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health and learning disability services provided by HPFT	20 (4x5)	12 (Possible 3 x Major 4)	8 (2x4)	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	Active Engagement across the system Inc. ICS & Geographical ICP and partner organisations Robust Stakeholder & Communications plan & Narrative Development of MH ICP Positive Relationship with Regional office and other regulators Focus on MH Investment Standard and LTP plan requirements	Karen Taylor (Deputy Chief Executive and Director of Strategy and Integration)
9	14.10.2020	1323	**Operational:** Risk that the sustainability of SRS becomes unviable following the reduction and changing needs of service users leading to an impact on quality and finance.	16 (4x4)	12 (Possible 3 x Major 4)	4 (1x4)	We will improve the health of our service users through the delivery of effective, evidence based practice	Commissioners have agreed to extend the current funding shortfall arrangements until the end of the consultation in 21/22. There is a wider programme of work being undertaken around the future provision of SRS. The second stage of coproduction is being launched at the end of May 2021 and will be completed by end of June 2021.	Sandra Brookes (Executive Director Service Delivery & Service User Experience)
10	10.07.2020	1301	**Finance:** The Trust is unable to ensure short term financial performance in current financial year 2021/2022	12 (3x4)	12 (Possible 3 x Major 4)	4 (1x4)	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	Current arrangements re COVID costs extended to September 2021 at the same levels as H2 2020/21.	Paul Ronald (Director Operational Finance)

								Additional £500m MH/LD investment announced in the November spending 11review has been confirmed. Draft Financial Plan developed for 2021/2022	
11	17.02.2020	1253	**Quality and Safety:** The Trust may not be able to sustain core operational services and maintain service user and staff safety during the continued COVID19 pandemic	25 (5x5)	10 (Unlikely 2 x Catastrophic 5)	5 (1x5)	We will provide safe services, so that people feel safe and are protected from avoidable harm	IPC procedures in place. Staff COVID risk assessments undertaken. Appropriate PPE and supply in place. Safe staffing levels reviewed and monitored. Current arrangements re COVID costs extended Lateral flow home testing for all service user-facing staff and non-service user facing as required. Staff vaccination	Dr Jane Padmore (Executive Director of Quality and Safety (Chief Nurse))
12	07.10.2020	1319	**EU Exit:** Implications for the Trust of unforeseen consequences arising from the end of the EU exit transition period on the 31 December 2020 at which point the UK and EU's relationship will be governed by what is agreed in the future relationship agreement	12 (3x4)	8 (Unlikely 2 x Major 4)	4 (1x4)	All strategic objectives	Internal EU Exit cell within incident command structure if required Monitoring and implementing guidance from NHSEI Encourage non-British EU staff to apply for settled status Action plan for identification and implementation of contingencies arising New trade agreement with EU that reduces the impact on supply chain, finance and data flow related risks	Maria Wheeler (Executive Director of Finance, Performance and Improvement)
13	30.01.2017	747	**Information Management and Technology** : Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability	12 (3x4)	8 (Unlikely 2 x Major 4)	4 (1x4)	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	Application of cyber security patches Offsite Data Centres Windows 10 upgrades Digital strategy work stream active to deliver extended Wi Fi and new SD WAN network in 21/22 Advanced Threat Protection (ATP) gives better cyber security protection New Cyber Risk Management Framework Start implementing Single Sign On Cyber Essentials Plus Assessment Start migration to N365, latest Microsoft office package Targeted phishing campaign with training	Maria Wheeler (Executive Director of Finance, Performance and Improvement)

Hertfordshire Partnership University NHS Foundation Trust

Trust Risk Register
June 2021

To be reviewed by:

Integrated Governance Committee

Trust Board

Audit Committee

Risk Bubble Matrix

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Sandra Brookes (Executive Director Service Delivery & Service User Experience) **Last Review Date** 15.06.2021 **Current Position:**
1370	National Shortage of specialist CAMHS beds impacting the capacity with FHAU and a risk that service users are not placed in the most appropriate environment.	There is a risk due to a shortage of specialist beds available nationally resulting in: - YP being admitted and or remaining at FHAU when their presentation is no longer appropriate for the unit. - increased waiting times for PICU and Low Secure Unit beds which is impacting on the service. -Young people are remaining in the Acute Trusts for long periods of time due to no access to specialist beds	16 (4 x4)	NHSE meetings are arranged regularly and in place to monitor availability. Local steps being taken; the reduction in beds when there is an escalation in presentation. MH and LD collaborative leading on a number of system – wide actions to support young people awaiting for specialist ED beds in Acute trusts and to improve pathways and reduce need for admission; -Establish a paediatric liaison service - Review of service user journey before admission to identify gaps in service -Explore option to cohort current young people in acute trusts and	20 (5x4)	4 (1x4)	Increase in YP being detained in acute trust waiting to be admitted due to closure of beds. Management of increase acuity in community teams. Reduced staff morale due to increase in use of restrictive practice and LTS. Increased injuries for staff and increase in having to manage more self-injury/harm behaviours by YP.	National shortage of beds resulting in service users remaining on wards in acute hospital waiting for beds. As at 10/06/21 there are 6 service users waiting in acute for Tier 4 bed detained under MHA and 11 service users in community waiting for a Tier 4 bed. FHAU increased eating disorder beds from 3 to 7. There is an indirect impact that the CAMHS S136 is being use permanently to manage one of these YP meaning CAMHS S136 admissions are now via the main Kingfisher Court S136 suites. Daily reviews taking place of the presentation of the YP waiting for specialist beds, to identify if it is clinically safe to admit into available beds. A learning lessons review meeting has taken place involving national and regional representation looking at learning lessons from an incident which occurred in January 2021 linked to this risk.

				provide integrated approach -Explore establishing an integrated pathway – paediatrician, dietetic and mental health support				

	Title	**Description**	**Rating (initial)**	**Controls in place**	**Rating (current)**	**Rating (Target)**	**Early warning indicators**	**Executive Lead:** Sandra Brookes (Executive Director Service Delivery & Service User Experience) **Last Review Date** 15.06.2021 **Current Position:**
1300	CAMHS Eating Disorders Team demand exceeds capacity	The CAMHS Eating Disorders team are at capacity with the referral rate having increased dramatically. There is a risk the team will be unable to meet the waiting times standards impacting access to services and the quality of care provided. Prior to COVID the team were already working above capacity and seeing more referrals than agreed in the contract. There is a risk the situation will escalate due to an increase of referrals due to	12 (4 x 3)	Additional funding for bank and or agency posts agreed by CCG. However, appropriate candidates are not always available and vacancies remain. The team now have 2 local GP's offering sessional support with medical monitoring, working with the team at Forest Lane. Urgent referrals can be booked into the medical monitoring clinic for physical assessment and advice prior to a full assessment to help manage the risk.	16 (4 x4)	4 (1x4)	Manager is monitoring daily and weekly in her discussions with the team so will be aware if the risk is increasing further. Recruitment is being completed but this will take some time so this risk is going to be present for a number of months. Manager is also working with the team to ensure inappropriate referrals are passed to appropriate services	Referrals have continued to increase beyond an additional 50% and as a result the team have moved into Business Continuity. A waiting list system is in place for new referrals – there are 80+ young people currently waiting for treatment. The team had already set up an assessment clinic/review clinic to manage the excessive referral rate. Letters are being sent to families on the waiting list. Team Manager working with GPs on a system and a plan to stratify the risks of those on the waiting list. Prioritising highest risk YP based on the referral information. The team are providing information packs to both GP's, families and YP to support medical monitoring to be carried out by the GP's in the local surgery. Plans for further discussion with GP leads and HPFT Medical Director and Medical Leads for CAMHS as to what more can be done. Additional business case completed with E&N Business Manager has been submitted to request additional permanent funding for new staff, including providing more intensive support as alternative to admission

		COVID-19 and those already in the service deteriorating.		Capacity and referrals are discussed in the daily team meeting and weekly MDT meeting so team can ensure the risk is being managed.				

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Janet Lynch (Interim Executive Director of People & Organisational Development) **Last Review Date** 14.06.2021 (via Tactical Command) **Current Position:**
1284	Reduced provision of face to face mandatory training and the impact on staff compliance and consequently staff and service user safety	During COVID19 and as a result of social distancing the provision of staff face to face training has ceased impacting staff compliance and consequently service user safety, namely Basic Life Support, Intermediate Life Support, Moving and Handling and RESPECT Training. deteriorating.	16 (4 x 4)	Restarting of classroom based training with limited numbers in line with IPC. Increased Train the Trainers.	16 (4 x4)	4 (1x4)	Mandatory Training Compliance Reports	The following courses were paused for three months during the height of the COVID19 pandemic and moving and handling and BLS/ILS was paused over the 20/21 Christmas period and into the new year : • Basic Life Support (BLS) • Intermediate Life Support (ILS) • Moving and Handling (Hoist) • RESPECT Training Trajectories of each face to face training course have been scoped which are based upon the current non-compliance of our substantive staff and the planned training courses which are taking place now and throughout the new 2021/2022 financial year. The trajectories also take into account the need to train our bank staff and offer spaces to these staff as well as new starters joining the Trust and a level of DNA's which we experience frequently. Still adhering to Covid / IPC measures where we have less numbers of delegates attending due to social distancing (maximum of 6 delegates in training rooms at the colonnades, which is a reduction of 50% from 12 delegates which was in place prior to Covid). Following the PODG meeting in March 2021 a Task and Finish Group was set up to focus on face to face training chaired by the Head of Safety and Head of Nursing, Physical Health and Education. Going forward it is proposed this group will focus solely on RESPECT training as the recovery plans for the other face to face training are now in place. Moving & Handling: as the current Moving & Handling Trainer is unable to train currently, we have commissioned ECG to provide Moving & Handling Training as a contingency which has been put in place over the previous few years. The Training provider is also utilised by other NHS

								Trusts including Hertfordshire Community Trust (HCT). We work closely with ECG in carrying out risk assessments to ensure the safety of staff attending the training. We have commissioned additional sessions for Moving & Handling to support the recovery plan. Moving & Handling Basic Patient Handling (BPH) Level 2: May Compliance is at 60% (remains the same compliance from last month). Moving & Handling Advanced Patient Handling (APH) Level 2: May Compliance is at 41% (an increase of 7% in the last month). A Train the Trainer programme for Moving & Handling took place from the 1st June to the 4th June and 8 delegates carried out the course (including the Moving & Handling SME's). A written assessment was carried out at the end of the course and the delegates are awaiting results from the external training provider. Once confirmation of passed delegates has been confirmed we can start commissioning additional training with the internal train the trainers. Resuscitation: We have commissioned additional sessions for Resuscitations courses to support the recovery plan and Trajectories and the compliance is at: • Basic Life Support (BLS): May's compliance is 71% (an increase of 6% in 1 month). • Intermediate Life Support (ILS): May's compliance is 85% (an increase in 5% in 1 month) • Paediatric Basic Life Support (PBLS): May's Compliance is 69% (an increase of 1% in 1 month). We only have 11 staff who are currently non-compliant and we have commissioned additionally sessions to increase compliance in June and July 2021 against the recovery plan and trajectory. In addition we have a train the trainer who has been released from the SBU for 2 months carrying out local Basic Life Support (BLS) sessions at units to support the recovery plan and increase compliance. Therefore we propose a further increase in June's compliance reports. The further release for the train the trainer for a further month has been granted by the SBU to support our recovery plan. A NMET form has been approved to support the funding of a Resuscitation train the trainer being seconded into the Resus team for a fixed period of 12 months to support our recovery plan and to continue to increase compliance. The train the trainer is additionally completing the ILS and PBLS course in June and July 2021 and will be completing the Moving & Handling Train the Trainer course.

								Respect: We have received NMET approval to second 3 internal train the trainers into the RESPECT team to deliver training. Discussions are taking place with regards to the timeframe of releasing the staff from clinical services as soon as possible. • Relating to People Mod 3b – May's compliance is 27% (an increase of 4% in 1 month) • Relating to People Mod 4 – May's compliance is 20% (an increase of 2% in 1 month) • Relating to People Mod 4/5 (Norfolk Staff only) – May's compliance is 89% (an increase of 4% in 1 month) • Relating to People Mod 5 – May's compliance is 46% (an increase of 1% in 1 month) A decision has been made to increase maximum numbers of delegates from 6 to 8 with immediate effect. Changes have been on Discovery to allow staff to book onto the additional spaces available. Two of the three of the train the trainers have accepted the Secondment for an initial period of 12 months to be a Respect Trainer. Plans are in place to release the staff from w/c 14th June 2021 to provide Respect Training. Trajectory modelling of having additional trainers in place has been carried out to show the increase in compliance and the recovery plan. Weekly reporting has been requested by the Exec Team. Monitoring of Compliance: • Statutory & Essential Training is monitored monthly by the Exec team where they receive a monthly People & OD Flash report. Statutory & Essential Mandatory Training Reports have also been taken to People & Organisational Development Group (PODG) meeting which is chaired by a member of the Exec team.

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Sandra Brookes (Executive Director Service Delivery & Service User Experience) **Last Review Date** 17.06.2021 **Current Position:**
882	S136: Unlawful detention of service users under S136 breaching beyond 24hrs which has legal implications and an impact on service user care, treatment and experience	From 11th December 2017, changes to Section 136 of the Mental Health Act came into force as a result of the Police and Crime Act. These changes have an impact on the Trust's responsibility to make available a qualified clinician for the Police to consult with prior to using Section 136, and for Section 136 detentions to last no longer than 24 hours (unless there are circumstances that warrant an extension of up to 12 hours). The risk, therefore, is in relation to availability of a bed to admit someone into, should this be the outcome of the S136 assessment; or the lack of	16 (4x4)	Availability of Street Triage 9am - 4am 7 days a week, in order for Police to consult regarding anyone over 16. Crisis Resolution Home Treatment Team available 24/7. Forest House Adolescent Unit to provide a clinician for consultation with Police regarding use of Section 136 at all times for anyone under 16. There is a dedicated 136 Suite for CYP in operation. Dedicated Section 136 team to monitor progress against 24 hour timeframe and co-ordinate assessing clinicians; Section 136 team to monitor and note where an extension to the	15 (5x3)	3 (1x3)	Lack of Street Triage involvement in Police decision to detain Use of Section 136 by Police to manage risk as a result of intoxication, rather than use of public order offence or return to home Lack of availability of AMHP's out of hours to undertake assessment Lack of availability of S12 approved Dr's to support AMHP if detention necessary Numbers of people discharged from Section 136 with no evidence of mental disorder or no further action required either continues at current rate or increases Lack of availability of S136 suites and Police waiting due	S136 admissions continue to cluster together, demand is difficult to anticipate and manage. Longer lengths of stay in acute pathway impacting on bed availability delaying S136 admissions. S136 impacted in the short term of around 6 weeks whilst dedicated CAMHS S136 was being used as a permanent room for a service user. Hertfordshire Mental Health Crisis Care Concordat being reenergised. Interagency meeting continue to work to reduce S136 detentions. Failure of police to liaise with Mental Health professionals prior to S136 admission still having an impact. Excluding those who are not fit to be assessed (intoxicated), individuals remain in the place of safety(POS) longer than the 24hr period for two main reasons: • Delays in the actual assessment taking place because the necessary staffs (AMHP, Crisis Team or Doctor) are not available. • The service user has been assessed as requiring an inpatient bed and the current bed capacity does not allow this to take place. The following actions are anticipated to make further progress in reducing, with the aim of eliminating, the number of unlawful detentions in the Section 136 suite: • Consistency in the recording of unlawful detentions using Datix, and weekly review of these between Matron, Team Leader and Service Line Lead to agree learning and take forward with the team • Weekly review of data from Section 136 Suite to continue as part of acute oversight meeting and learning of factors that contribute to extended detention, such as unstable housing or frequent crisis presentation • Consistency in the use of the escalation procedure for Section 136 detentions, where there is concern about the likelihood of breaching 24 hours, including out of hours. Draft Escalation Protocol now in place.

		availability of clinicians to carry out triage and assessment in a timely way i.e. discharge from S136 within 24 hours. Since implementation of the legislation, there has been an increase in incidents of illegal detentions. Analysis of these incidents has identified the following themes as factors driving this increase: - Delays due to AMHP availability out of hours - The individual being too intoxicated to assess - Complex social issues such as homelessness or vulnerability, or waiting for transfer back to home area for treatment. A particularly challenge has been the presentation of children and adolescents, who are unable to		detention can be authorised. Between 9 - 5, Monday to Friday, AMHP Service prioritise Section 136 assessments in order to meet timescales Presence of CRHTT staff in Kingfisher Court overnight, increasing availability for assessment. Interagency meetings and governance arrangements in place to monitor implementation of the Police and Crime Act changes to Section 136, reporting to Hertfordshire's Crisis Care Concordat Group Escalation process in place for SU approaching 24 hours in order to prevent unlawful detentions Weekly Report from S136 Matron and discussion, review and actions with Senior Managers of			to inability to move patients through - Lack of bed capacity in HPFT, as identified through OPEL status of 3/4 - Bed closure due to damage or fault, impacting on capacity Non medical 136 service users being taken to acute hospital ED due to capacity issues of HPFT 136 suite	• Senior Service Line Lead to establish relationship and escalation processes with equivalents in key London Trusts, with the aim of avoiding delays due to disputes • Agree communication, monitoring and escalation processes with key partners for those detained outside of a HPFT Section 136 Suite, in order to ensure that individuals do not breach timescales elsewhere in the system. Protocol for escalation of service users detained under Section 136 of the Mental Health Act 1983 drafted. When individual service users remain in the POS at 6 hours following point of entry the escalation process will commence. Letter before action received 26th June 2020 following the detention of a service user in the S136 suite on Oak ward on 22nd October 2019 for longer than 24hrs. The Trust has admitted that he was detained for over 24 hours but that the delay was because of trying to find an available bed for the service user. The claim is brought under for unlawful detention/imprisonment and under the HRA 1995 (breach of Article 5 ECHR). The Trust has denied false imprisonment and is a awaiting a further response from the claimants solicitor. The Trust is continuing to defend the claim at this stage, and may look to get a contribution from Barnet, Enfield and Haringey Mental Health Trust if the claim is in time and the Trust decides to make an admission (the service user was out of county and the delay was due to their delay in making a bed available for us to transfer the service user out of our s136 place of safety) Escalation process is in place. Patient Flow Project will support the movement of Service Users from the section 136 suite into a treatment bed when required. Daily Demand and Capacity at midday will discuss 136 cases. The latest S136 Audit Jan – Mar 2021 identified: • 154 S136 detentions • 67 (44%) detentions exceeded 24 hrs. 50 (75%) of these due to bed availability . Compared with 74 (37%) previous audit. • 17% (26) of detentions exceeded 36hrs. • An extension form is required to be completed by a registered medical practitioner to extend the detention from 24hrs up to 36hrs in exceptional circumstances. Only 6 extension forms were received. • Of the 6 appropriately extended, 3 detentions exceeded 36hrs, and therefore became unlawful detentions.

		return to their home Of these, only intoxication is an accepted reason for extension of the 24 hour deadline. The risk is both of unlawful deprivation of liberty for which the legal proceedings could be brought against the Trust by an individual, however, there is also the significant impact on an individual's privacy, dignity and mental well-being of remaining in a 136 suite for longer than necessary.		previous weeks unlawful detentions				The S136 Operational Group are currently focusing on the following areas: • Identifying what can be done differently to ascertain the care need of the service user at the point of Street Triage involvement. • Identifying ways to increase Street Triage involvement • Identifying ways to reduce S136 detentions by increasing diversion to CATT, CMHT, Home Treatment team and CGL. • Sharing information with the police to assist police making risk assessments e.g care plans for people who have multiple detentions • Developing procedures around the use of video technology to enable AMHP's to complete initial pre-screen assessment • Developing online training sessions for Police Officers to focus on care plan training, street triage services and other mental health services the police can access

	Title	**Description**	**Rating (initial)**	**Controls in place**	**Rating (current)**	**Rating (Target)**	**Early warning indicators**	**Executive Lead:** Janet Lynch (Interim Executive Director of People & Organisational Development) **Last Review Date:** 14.06.2021 (via Tactical Command) **Current Position:**
1321	The Trust is unable to maintain staff wellbeing and staff morale during the pressures of COVID19, with	The Trust is unable to support and protect the well-being of its staff -Short Term Impact of COVID on staff - Staff Anxiety about COVID	12 (4x3)	Staff Annual Appraisal / PDP Staff Inspire Awards Annual HPFT 'Stars' Staff Awards	12 (3x4)	4 (1x4)	High turnover rates Negative NHS Staff Survey Results	The Trust has put systems and processes in place to deal with the immediate and long term impact of COVID on staff: Staff Support • COVID19 Workforce Wellbeing Strategy details the support we are offering to both teams and individuals. • We have launched a staff hardship fund to provide emergency financial relief to any staff in need.

	increased demand now and during the recovery phase.	-Long term impact of COVID19 on staff There is a risk that a higher number of existing staff choose to exit the organisation due to high workloads, working requirements and experience and a perceived lack of career pathways leading to increased and unplanned vacancies and a drain of knowledge and experience from the organisation.		Big Listen events Tom's Q&A sessions Staff Support Staff Network Groups Health and Wellbeing Strategy Inclusion Strategy Recovery Strategy Good to Great Roadshows			Negative Staff PULSE Survey results WDES / WRES indicate difference in experience according to protected characteristic	• Staff Resilience Hub 'Here for You' operational • Supporting you bulletins setting out EAP, OH plus Trust and national wellbeing resources incorporated into HPFT News weekly. • People recovery strategy developed which flows from the regional strategy with 5 pillars: Paying Witness; Rest and Recuperation; Health and Wellbeing; Keeping Our People; and Reward and Recognition. • Engagement through Good to Great roadshows, staff network conversations and team/SBU conversations to discuss the staff survey results and people recovery plan. Feedback used to finalise our plans which are now being implemented. • Launched new Board level Wellbeing Guardian, recruited Wellbeing Champions and the new Mental Health First Aid Training has launched. • The following remain in place - Catch up with the Execs - Health and Wellbeing Activities – Here for You webinars and workshops. BAME • The BAME staff network is flourishing with virtual meetings taking place frequently, to enable staff to share experiences and concerns and ensure support is put in place. • Work is underway to strengthen the BAME staff recruitment panellist system to give greater confidence in the fairness of recruitment. Individual Staff Risk Assessment • The Trust developed an individual risk assessment to help understand staffs individual needs so that the Trust could support staff and keep staff safe at work. The Trust prioritised those with risk factors (including BAME staff) for completion. 100% completion achieved and managers and staff are now reviewing the risk assessments regularly directly on SPIKE2 therefore removing the reliance on paper processes and creating a shortened process with less steps. Any risk assessments which have resulted in an outcome of purple, amber and red need to be reviewed on a monthly basis and any risk assessments in blue and green need to be reviewed every 3 months. • All managers and staff are automatically notified via SPIKE when a staff COVID risk assessment is due for review. Staff Vaccination and Testing

								• Introduced of lateral flow home testing kits for all service user facing and non-service user facing staff in line with national guidance. • 85% of staff have been vaccinated with their first dose, 68% of staff have received their 2nd dose. 2020 Annual Staff Survey Results/Pulse Survey • Health and wellbeing. Under the theme of health and wellbeing, the Trust scored higher than national average (6.6 compared to a national average of 6.4). Our score on this theme was also statistically significantly improved since 2019. • Morale. Under the theme of morale, the Trust scored higher than national average (7.4 compared to a national average of 7.3). 76% recommend us as a place to work and 76% would be happy with the standard of our care for their own family/friends. • Staff engagement. The Trust scored higher than national average (7.3 compared to 6.9 nationally) in relation to staff engagement. This score is fifth best nationally, compared to the national best of 7.5. • Whilst we will celebrate the overwhelmingly positive staff survey results, our action plans focus on improving staff experience in relation to equality, diversity and inclusion, violence and bullying, harassment and abuse. • Our Q4 pulse survey was similarly positive and engagement with staff confirmed the key areas of focus for our action plans <u>Appraisals</u> Our appraisal rates have increased significantly but the changing nature of the pandemic had an impact on achieving full compliance, both in relation to appraisal and mandatory training compliance. We have launched a new strengths based appraisal conversation approach.

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Paul Ronald (Director Operational Finance) **Last Review Date** 20.06.2021 **Current Position:**
1001	The Trust may not have sufficient resources to ensure long term financial sustainability	Failure to maintain long term financial sustainability specifically: 1) Potential risk to future income levels with change to system allocations directed through the ICS meaning that the allocation of resources to the MH/LD ICP organisations is not sufficient 2)Failure to address underlying demand and/or cost pressures and/or to deliver required efficiency savings. 3) Significant unidentified QIPP requirements across the ICS that are allocated across provider organisations without due evaluation of the individual organisations underlying position.	12 (3x4)	For 21/22 H1 temporary national rules in place for health and social care contracts for Q1 rolling over from PY. Relationship management with commissioners and partners to support fair resource allocation based upon detailed analysis of likely demand/capacity and outcomes Regular financial Reports and forecasts are made to the Trust Board, Finance & Investment Committee, Executive Team and Trust Management Group. The transformation boards oversight of the transformation program and its link to delivering value.	12 (4x3)	6 (2x3)	Level of income tariff uplifts and national efficiency requirement set for H2. Negotiations with commissioners ICS regarding 21/22 amounts and level of related resource commitments Self-assessment of likely DV achievement. Level of external bed use and forecast over next period	Hertfordshire - A five year contract with an option to extend for a further two years is in place. Included in the contract are agreements in relation to access target thresholds for CAMHS and Adult services. Additionally, funding meets the Mental Health Investment Standard and allows us to meet the commitments made within the Five Year Forward View for Mental Health. Uncertainty is whether as a result of current response to pandemic there will be changes to existing commitments or an escalation in costs. NHSE- implement of regional Provider Collaborative from July 2021 covering CAMHs Forensic and ED services currently provided through NHSE. Work being finalised on each work stream to implement the clinical redesign, agree the resource allocations and implement the governance and risk share structures. Currently there are temporary financial arrangements which see a payment based upon 19/20 contract values which is then topped up based upon recent spend to cover existing costs. Details of the proposed new financial structure are not expected until September 2021. The Trust will continue to work actively as part of the ICS to ensure these arrangements provide a fair settlement for MH & LD services. Levels of Income assumed in the 21/22 financial plan has been confirmed until end of Q2, any changes to income levels will only impact on half 2. Additional Mental Health funding has been confirmed for the whole year, which brings certainty of income and allows for transformation work to be planned and delivered. The Trust has a robust delivering value programme managed through the Delivering Value Management group, which will provide mitigations to the effects of higher efficiency that may be required in H2. Robust financial management systems in place, monitored through the Finance and Investment committee, allows for earlier identification of potential financial risk which can be managed in a timely manner.

		4) availability of capital funding to provide fit for purpose infrastructure to support services and staff		The implementation of the Trust workforce plan to ensure a capable motivated workforce with the required skills and capacity. Regular Placement Panel with cross-SBU coordination of placements pathway Ongoing Delivery Value Program including range of actions to support effective resource use; Model hospital champions promoting the use of benchmarking. Use of CQI to support process review and implementing best practice Corporate service redesign. Three year rolling capital program developed with partners				

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Janet Lynch (Interim Executive Director of People & Organisational Development) **Last Review Date** 19.05.2021 **Current Position:**
1320	Insufficient workforce to meet predicted increased demand and deliver commitments in Long Term Plan	There is a risk that the organisation is not able to recruit and retain the best staff and that timely recruitment to vacancies does not occur leading to increased operational pressures and a reduction in quality of care	12 (4x3)	Recruitment reporting through the recruitment and retention group is escalated to Exec and Board level. Emerging system, regional and national workforce planning requirements. Recruitment, Retention and Reward Plan.	12 (4x3)	6 (2x3)	Long standing number of vacancies and hotspots Increased bank /agency costs Lack of clarity to plan recruitment campaigns Increasing turnover and a falling stability index Increasing Short Term sickness absence Lack of skills and capability to manage services differently Failure to attract people with the right experience	Our recruitment and retention strategy is currently being refreshed. We have developed a Trustwide workforce plan and are developing SBU level workforce plans during Q2. The recruitment process has continued throughout the pandemic with the impact that the Trust vacancy rate was 11% at the end of March 2021, this has reduced to 10.75% in May. Our voluntary turnover rate is 9.41%, close to our target of 9%. Our stability rate was just below target at 86.14% and our absence rate was just over target at 4.68%. We have utilised remote working technology to enable interviews and selection processes to continue throughout all phases of the pandemic. This has also enabled remote checking of ID documents. A mass recruitment campaign resulted in recruitment of 94 new HCSWs who started in April 2021. HCSW vacancy rate is now 10.83%, down 7% from a year ago. We are also establishing an international recruitment programme for registered nurses. We are consistently seeing high volumes of people in the recruitment pipeline each month and 79 newly qualified nurses wish to join us in September. The actions agreed at Safer Staffing Group meetings continue and have been reinforced at both the Trust's Recruitment and Retention Group meeting and the Trust Management Group. These include: • 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. Our Bank use during 20/21 increased as a result of the pressures arising from the pandemic, however, our fill rates remained high and our agency use remained at a consistently far lower level. Bank/agency costs fell during May 2021. 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 employer, and enabling a smooth transition from student to RN, with the Trust being their employment area of choice. 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. The Health and Care Academy engaged with a large number of young people, encouraging them into health-related careers, supporting the pipeline of individuals joining the NHS. The Academy concept allowed 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. We are engaging with people to develop a comprehensive plan for supporting our people over the next year. This will include reward, recognition, wellbeing, retention and continuously improving staff experience

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Karen Taylor (Deputy Chief Executive and Director of Strategy and Integration) **Last Review Date** 01.03.2021 **Current Position:**
749	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health and Learning Disability.	The rapidly changing health and social care landscape nationally and locally creates a potential risk to the sustainability of high quality service provision for people with a mental illness or learning disability due to: • Dilution of a strong mental health and learning disability voice and presence within new models of care and systems or structures that are focused on reducing activity within general acute hospital settings • Increased sharing of risks and financial pressures across the system resulting in shifting of resources away from mental health and learning disability services	20 (4x5)	Active engagement with the system about MH & LD by HPFT leaders; together with leading the development of a Herts MH & LD ICP Regular review of position by the Executive and Board Active monitoring and support by Council of Governors Strong leadership roles for key staff within local ICS On-going regular dialogue with commissioners ICS Mental Health & LD workstream chaired by HPFT National LTP commitments for MH documented within ICS LTP	12 (3x4)	8 (2x4)	Commissioning intentions demonstrate reduced funding/intention Parity of esteem agenda not honoured within contract negotiations or lack of commitment Lack of discussion about Mental Health & LD priorities across ICS, within developing geographical ICPs and in Local Delivery Boards No demography increase and / or usual commitments aren't delivered by CCG's. Insufficient attention to the recovery of mental health services from the Covid incident	MH Long Term Plan provides a roadmap for further investment and priorities and is reflected within the ICS LTP submission. MH investment standards and LT plan commitment remains. Anticipate planning guidance early / mid-March. NHSE transformation • Funding secured for community (Adult & Older People) and Crisis, service design commenced; confirmed for 2020/21. • Funding secured for 2021/22. Funding secured for Suicide Prevention. HPFT CEO/directors involved in key ICS decision making forums and groups. E&N ICP and West Herts ICP developing at pace; with HPFT well represented and supporting/shaping development, including MH & LD priorities within the ICPs. ICS wide MH & LD group in place, overseeing MH investment and developments across the ICS – chaired by Dir. Strategy. The development/collation of an ICS MH & LD strategic response to Covid Pandemic – commissioned report due back early May. Herts MH & LD ICP Partnership Board is firmly established, developing well with a strong partnership in place, priorities identified and being implemented with focus on Community and Primary Care Network. EOE Provider Collaborative continues to develop with go live date July 2021reflecting the impact of the pandemic. Business case being finalised with underpinning activity and financial modelling. Negotiations with NHSE/I re financial settlement ongoing. Norfolk Commissioners have supported the development of a Multi-Speciality Community Provider (MCP) model for LD services across Norfolk and a Partnership across NSFT, NCHC & HPFT is under development. The Trust responded to the consultation on the resulting white paper Integration and innovation: working together to improve health and social care for all', published February 2021 which describes the way the ICS will develop, the impact for HPFT is being considered.

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Sandra Brookes (Executive Director Service Delivery & Service User Experience) **Last Review Date** 17.06.2021 **Current Position:**
1323	Risk that the sustainability of SRS becomes unviable following the reduction and changing needs of service users leading to an impact on quality and finance.	Specialist Residential Services is home to 25 individuals with severe learning disabilities and autism; most of whom have spent their entire lives in hospital in Hertfordshire. Due to previous legal proceedings, the service is in a unique position nationally, which has meant discharges from the service have effectively been unable to happen since 2010. The service does not take new admissions, therefore, there is a significant income risk as service users are either discharged or pass away. There is a risks of a short-medium term financial gap in 2020/21 and	16 (4x4)	Financial and operational plans developed. Conversations commenced with commissioners. Co-production commenced with stakeholders. Bank Shifts covered by unit staff, ex unit staff and external bank staff. Expansion of band 4 associate practitioner role planned. Secondments from Dove ward to support practice.	12 (3x4)	4 (1x4)	Increasing vacancies linked to retirement. Increase in incident reports of adverse physical health outcomes.	<u>Future provision of SRS</u> There is a wider programme of work being undertaken around the future provision of SRS. This has been led by HPFT up until recently with the Steering Group now being led by commissioners. The co-production work regarding the long term provision of SRS started in the third week of September 2021. It is proposed that if consultation regarding consolidation is required, that the two processes take place at the same time as they will involve the same stakeholders. It is not expected there will be any significant change in service provision for a further 12-24 months. Co-production was launched in September 2020 with all stakeholders and was completed in November 2020. The second stage of coproduction is being launched at the end of May 2021 and will be completed by end of June 2021. Following these key options will be identified to be formally consulted on. <u>Staffing</u> Current vacancies for SRS are 32% vacancies unqualified and 40% qualified. On-going recruitment efforts have not been successful and the service is seeing a significant increase in use of bank staff. <u>Financial</u> Some immediate, low risk actions can be taken to reduce costs which will reduce potential in-year shortfall to £300k in 2020/21 and £509k in 2021/22 involving revised staffing subject to safer staffing. However, more significant action will be required to maintain 1. Consolidate bungalows down to five a. Close 1FL, create mixed sex ward b. Create an extra bedroom on 4FL. Close 3FL. c. Move a male into 1FL Annex. Close 3FL d. Creation of mixed sex frailty unit. Close 1FL 2. Request further investment from commissioners to cover shortfall 3. Combination of 1 and 2.

		2021/22. Without mitigation the shortfall will be £430k in 2020/21, growing to £732k in 2021/22. There is a risk that difficulties with ongoing recruitment to vacant posts will leave the service heavily reliant on bank staff. There is a risk that the changing physical health / declining physical health of the service users increases the need for additional staff training and additional changes to the environment, nationally this cohort is within the age range of people with learning disabilities who are at a higher risk of premature death from both expected and unexpected causes.						The preferred option, which would be least disruptive to service users, is option 2. Commissioners would need to pay an additional £12k for each remaining service user in 2020/21 and £20.4k in 2021/22 to meet the shortfall. However, it is likely to be challenging to get all 8 commissioners to agree to increase funding in the medium term and therefore this option is potentially the most financially risky. This option would allow us to maintain the status quo (including single sex units) and avoid the need for multiple moves which could arise following the co-production process. The second preference is 1d – creation of mixed sex frailty unit. Close 1FL. This would have a positive impact on quality whilst also delivering the necessary savings - £547k-£774k FYE. Whilst HPFT would be required to consult with stakeholders on implementing this change, it's a process and change that would be within our control to implement and is therefore less financially risky. This option would involve creating a mixed sex unit but the challenges of this are outweighed by the benefits of cohorting the most frail service users together. Discussed 2 options with commissioners (create a frailty unit by consolidating the bungalows / commissioners fund short term) Commissioners agreed to fund the shortfall in 2020/21. Commissioners have also agreed to extend the current shortfall arrangements until the end of the consultation in 21/22. <u>Physical Health</u> The Service has managed well over the covid period but this has led to some delays in the development of the frailty pathway work. However some progress has been made with multi factorial falls assessments and prescription of VitD. Sadly, three service users have passed away unexpectedly in SRS in recent months (June – August 2020)

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Paul Ronald (Director Operational Finance) **Last Review Date** 15.06.2021 **Current Position:**
1301	The Trust is unable to ensure short term financial performance in current financial year 2021/2022	This year has seen a continuation for the first 6 months of the arrangements introduced in FY2021 regarding funding during the COVID response The contract process for 2020/21 was suspended. Trusts are paid income based upon -an historic assessment of contract revenues, adjusted by NHS through a "top up" -Additional COVID costs are funded through a fixed sum based upon M1-3 costs in FY2021. -There are further income sums from the ICS for growth and income loss. In addition as a MH Trust there is income from MHIS SDF and from the SR which will support both the extra costs and variation currently being incurred and	12 (3x4)	Continuing discussions with commissioners and the ICS to ensure a full allocation of the FY21 income allocation. These discussions are supported by the work on demand, on bed provision and workforce modelling Continuing development of a full DV program at £7m target. Detailed budgeting process to reset number of cost centre budgets to reflect current fair resource allocation. Revision to the controls over E Roster and safer staffing to ensure correct oversight over variations to agreed rosters Development of joint ICS procurement function which can improve PO controls and leverage further procurement efficiencies	12 (3x4)	4 (1x4)	There is weekly monitoring of key indicators which is discussed at the weekly meeting of senior operational leadership. Monthly flash report provided to ET first meeting of the month. End of year forecast provided in the monthly finance report from Q2 Regular attendance and scrutiny from finance team of; -E roster meetings -Joint operational meetings with HR -budget reviews with SBUs and corporate heads - Meetings with commissioners on contract performance and any issues of risk	For FY2122 the Trust has set a plan of (£1m) deficit for full year with B/E in H1 and deficit in H2 as COVID income is withdrawn and some of the costs continue. The Plan will be reviewed for H2 when the detail of the settlement for the second half of year is agreed. To support the achievement of the financial control total this year requires a continuing focus on; • Continuing to ensure the key controls on pay including efficient rostering are applied consistently • Managing out of area beds back towards budgeted levels • Managing down Covid-19 related costs where no longer necessary • Renewed focus on the Delivering Value Programme including for Support Services. • Utilisation of discretionary funds to pump prime service developments and support invest to save schemes • Review of discretionary expenditure ensuring this is utilised effectively and focussed on priorities

		funds service development		Ensure prudent approach in both the costing of new service specifications recognising the costs risks on staffing and non-pay costs given current environment. Maintaining regular oversight of balance sheet and cash flow ensuring appropriate provisions and accruals and the correct matching of income				

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Dr Jane Padmore **Last Review Date** 14.06.2021 (via Tactical Command) **Current Position:**
1253	The Trust may not be able to sustain core operational services and maintain service user and staff safety during the continued COVID19 pandemic	There is a significant risk that the Trust is unable to sustain operational services and maintain service user and staff safety during the COVID19 outbreak, combined with winter pressures, following the outbreak being declared a Public Health Emergency of International Concern on the 30th January 2020 by the World Health Organisation (WHO). The risk specifically covers: - Service user and staff death - Unable to sustain core services - Unable to sustain safe staffing and the wellbeing of staff - Unable to meet the legal and regulatory requirements	25 (5x5)	Staff have been advised to follow the Public Health England guidance regarding the risks associated with the virus. Public Health England posters have been sent out to display in the entrance to HPFT locations. PPE supply and distribution process in place. Incident Command implemented in line with Business Continuity Plan to manage and oversee the Trusts preparedness and incident management. Emergency/Contingency plan in place. Detailed winter plan in place. Environments Covid Secure and IPC procedures in place Staff risk assessments, appropriate PPE , enhanced technology Safe staffing levels reviewed & monitored daily	10 (2x5)	5 (1x5)	Increase in UK confirmed cases of COVID19 and deaths attributed to COVID19 Increase in confirmed cases of COVID19 within Hertfordshire, Buckinghamshire, Essex and Norfolk. Increase in staff self-isolating at home if they have a high temperature, a new continuous cough or less of sense of taste/smell. Increase in demand arising from impact of winter season.	Unable to maintain and work within the financial envelope • Contingency of £1m within provisions. • The contractual process is again suspended from April for at least Quarter 1 2021/22, and most likely Quarter 2, with cash payments remaining at the same level as 20/21. This ensure that the Trust has most of its expected income. • There is a twice weekly KPI report on various finance indicators including COVID-19 spend and invoices outstanding to suppliers. • Specific COVID-19 income to cover this expenditure is being received regularly as in 20/21, and is expected for at least Quarter 1. It is expected that COVID-19 income will fall in the 2nd half of 21/22 and therefore this may give rise to some cost pressures at that stage. Reduced provision of face to face mandatory training and the impact on staff compliance and consequently staff and service user safety Respect: • We have received NMET approval to second 3 internal train the trainers into the RESPECT team to deliver training. Discussions are taking place with regards to the timeframe of releasing the staff from clinical services as soon as possible. • Relating to People Mod 3b – May's compliance is 27% (an increase of 4% in 1 month) • Relating to People Mod 4 – May's compliance is 20% (an increase of 2% in 1 month) • Relating to People Mod 4/5 (Norfolk Staff only) – May's compliance is 89% (an increase of 4% in 1 month) • Relating to People Mod 5 – May's compliance is 46% (an increase of 1% in 1 month) • A decision has been made to increase maximum numbers of delegates from 6 to 8 with immediate effect. Changes have been on Discovery to allow staff to book onto the additional spaces available. • Two of the three of the train the trainers have accepted the Secondment for an initial period of 12 months to be a Respect Trainer. Plans are in place to release the staff from w/c 14th June 2021 to provide Respect Training. • Trajectory modelling of having additional trainers in place has been carried out to show the increase in compliance and the recovery plan. Weekly reporting has been requested by the Exec Team. Moving & Handling: • Moving & Handling Basic Patient Handling (BPH) Level 2: May Compliance is at 60% (remains the same compliance from last month).

		- Unable to maintain and work within the financial envelope - Unable to provide the equipment required						• Moving & Handling Advanced Patient Handling (APH) Level 2: May Compliance is at 41% (an increase of 7% in the last month). • A Train the Trainer programme for Moving & Handling took place from the 1st June to the 4th June and 8 delegates carried out the course (including the Moving & Handling SME's). A written assessment was carried out at the end of the course and the delegates are awaiting results from the external training provider. Once confirmation of passed delegates has been confirmed we can start commissioning additional training with the internal train the trainers. Resuscitation: • We have commissioned additional sessions for Resuscitations courses to support the recovery plan and Trajectories and the compliance is at: • Basic Life Support (BLS): May's compliance is 71% (an increase of 6% in 1 month). • Intermediate Life Support (ILS): May's compliance is 85% (an increase in 5% in 1 month) • Paediatric Basic Life Support (PBLS): May's Compliance is 69% (an increase of 1% in 1 month). We only have 11 staff who are currently non-compliant and we have commissioned additionally sessions to increase compliance in June and July 2021 against the recovery plan and trajectory. • In addition we have a train the trainer who has been released from the SBU for 2 months carrying out local Basic Life Support (BLS) sessions at units to support the recovery plan and increase compliance. Therefore we propose a further increase in June's compliance reports. The further release for the train the trainer for a further month has been granted by the SBU to support our recovery plan. A NMET form has been approved to support the funding of a Resuscitation train the trainer being seconded into the Resus team for a fixed period of 12 months to support our recovery plan and to continue to increase compliance. The train the trainer is additionally completing the ILS and PBLS course in June and July 2021 and will be completing the Moving & Handling Train the Trainer course. Service user and staff COVID19 related deaths as a result of Trust actions and/or failure to act • The Clinical Professional Advisory Committee (CPAC) continues to review advice and update clinical guidelines during the pandemic to ensure service user and staff safety. • FFP3 re-fit testing almost complete • LFT Home testing kit Trust wide email reminders for staff to take the tests and submit results. Text message reminders being considered. • Staff recording an LFT test twice weekly - performance remains low • No outbreaks

								• Full guidance on staying (working) at home and social distancing has been provided by the Trust following national guidance. Including those staff with high risk underlying health conditions. This message has been reinforced following the 3rd national lockdown. Following CEV ending staff being encouraged to return to work with guidance for staff and managers. • The CPAC committee support the temporary pause of community face to face groups in favour of remote option. However, if there is an acute risk of deterioration of their mental health which may result in an inpatient admission. CPAC agree that the option of face to face contact should always be available. The RAG rating system should still be used when considering face to face appointments. • The Trust has implemented testing of all service users on admission to inpatient services and 72 hours prior to discharge. On admission servicers are asked to self-isolate in en-suite bedrooms prior to knowing the test results. Most service users adhere to this request with a small minority refusing and presenting with behaviours that challenge. • Each SBU has developed cohorting and isolation plans around what to do when they admit patients with known or unknown COVID status taking into account capacity and compliance to adhere to self-isolation. • COVID19 situation reports - This enables Tactical and subsequently Operational Commands to monitor the high risk locations specifically in relation to COVID19 confirmed cases to put in place any mitigating action to prevent future COVID19 transmission. • At the beginning of the COVID-19 pandemic all the teams were asked to RAG rate their service users to enable the allocation of care and treatment based on vulnerabilities, risk and need. This was recorded in the service user risk assessments and individual team spreadsheets. The Trust has now created a COVID Rag Rating Case Note on PARIS which enables staff to record the RAG Rating in a specific case note. The service users RAG rating will then show on their front page on PARIS. This will also enable the RAG rating for teams to be viewed on SPIKE2 to enable monitoring and to prioritise resources. RAG ratings continue to be reviewed. • The Trust needs to ensure it reduces the potential risk of transmission between members of staff. In consideration of the new government guidelines the Trust has revised restrictions and following a recent issue of revised IPC guidance, the Trust has made the decision that with effect from Thursday 23 September 2020 all staff must wear a facemask (fluid repellent, not just a face covering) at all times whilst on Trust premises. This extended use of facemasks is for all staff (both clinical and non-clinical) and includes staff only areas. Clear guidance has also been issued on staff eating and drinking. • COVID Early Response Team (CERT) is now operational from Monday to Friday 9 – 5. CERT are available to provide virtual physical health advice

								and support to staff caring for service users with COVID-19. Care of service user with COVID-19 teaching can be arranged over MS Teams with supporting resources available on The Hive. • 84% of all staff have been vaccinated with their first dose, 67% of all staff have received their 2nd dose. • Service user vaccinations continue for new admissions with a drop in clinic every Tuesday at Kingfisher Court. Vaccinations extend to Norfolk service users within Broadland Clinic and Astley Court as we have vaccinators there. They have a small stock of vaccines in Norfolk. At Lexden, if a service user needed the vaccine then the Trust would try to arrange this locally, however if not possible someone would go over there to undertake the vaccination. • Staff are supporting individuals living in the community with a learning disability or severe mental illness to access the Covid-19 vaccination. Increased harm or death of service users due to mental health related illness • Whilst impact of the pandemic such as general concerns about the situation, isolation, finances, domestic abuse, access to support have been identified as stressors in some of the self-harm and suspected suicide deaths reported as SI's it is too simplistic to say this was a contributory factor or root cause. • NCISH reports o Pandemic has had significant impact on mental health o This has not translated into a national rise in suicide/self-harm but serious risks remain in 2021 o Young people and service users in contact with mental health services remain key groups for prevention o Addressing isolation, economic protections and maintaining mental health care are important suicide prevention measures o Recovery from pandemic means also addressing pre-COVID risk o In HPFT the past year saw a significant increase in deaths overall, largely due to deaths of people with COVID -19, but a reduction in deaths thought to be through suicide. The Trust is unable to manage subsequent COVID19 Waves The Trust has successfully implemented and now has established processes for flexibly managing surges and providing additional resources as required. Within the trust it is proposed that we would continue to closely monitor the impact of COVID on our staff, service users and on bed / ward closure which we have used in the COVID OPEL approach. It is proposed that we will continue to use these parameters as triggers for escalation and to support decision making about when we might need to consider stepping up the incident command approach – whenever the next surge becomes apparent.

								Unable to maintain core services Adult Mental Health Community Services • The Infection Prevention and Control measures, the need to limit staffing numbers in buildings/teams, the ability to remain COVID secure and the new ways of working during COVID are now having a detrimental impact on the functioning and service provision in West SBU Adult Community Mental Health. • Adult Community teams cannot accommodate sufficient face to face meetings with service users for those with increased acuity or complexity, and the demand to undertake face to face assessments is beyond the capacity to do so under the current COVID secure guidelines. • Continuing to see/assess service users via virtual assessments longer term has the potential to reduce the quality of care and treatment provided and impact the ability to manage risk. • The teams have been working under these arrangements for over 12 months and the loss of the support network of working within a team is now being felt by staff. • Psychological intervention waiting times continue to increase as these interventions are reliant on face to face appointments. • There is a concern that whilst the Trust offers virtual appointments service users are more inclined to ask for telephone appointments, there are some potential limitations, especially with regards to a service users Mental State Examination and the ability to identify the signs that a service users current mental state may be deteriorating based on their appearance and behaviour. • Increased home visits or the hiring of other spaces is being utilised to reduce the impact of limited face to face appointments on HPFT sites. • Both SBU's reported an impact on new starters and the ability to induct and fully integrate new starters into the team with the restricted site numbers. Single Point of Access • Increase in CAMHS referrals into SPA remains challenging with regards to meeting the 5 day target, significant increase in referrals being managed by the existing number of staff. • Increased demand on GP hotline. • Increase in the number of referrals for the PATH service. Forest House Adolescent Unit • National Shortage of specialist CAMHS beds impacting the capacity with FHAU and a risk that service users are not placed in the most appropriate environment.

								• This risk has been escalated from the East and North SBU Risk Register to the Trust Risk Register as a standalone risk. CAMHS Eating Disorder Service • Referrals have continued to increase beyond an additional 50% and as a result the team have moved into Business Continuity. • A waiting list system is in place for new referrals – there are 58 young people currently waiting for treatment. • The team had already set up an assessment clinic/review clinic to manage the excessive referral rate. • This risk has been escalated from the East and North SBU Risk Register to the Trust Risk Register as a standalone risk. Deterioration in core performance • Weekly performance KPI report control measure Unable to sustain safe staffing during COVID19 • Minimal impact from COVID19 on staffing numbers, BAU challenges remain. Unable to maintain the wellbeing of staff during COVID19 • Q4 pulse survey results are positive with 77% recommending us as a place to work. In addition, the national WRES data was recently published and shows that we are performing the same or better across all the metrics. • COVID19 Workforce Wellbeing Strategy details the support we are offering to both teams and individuals. • We have launched a staff hardship fund to provide emergency financial relief to any staff in need. • Staff Resilience Hub 'Here for You' operational • Supporting you bulletins setting out EAP, OH plus Trust and national wellbeing resources continue. • Development a people recovery strategy which flows from the regional strategy with 5 pillars: Paying Witness; Rest and Recuperation; Health and Wellbeing; Keeping Our People; and Reward and Recognition. • Recruiting Wellbeing Champions has commenced and the new Mental Health First Aid Training has launched. • Launched the "Paying Witness" work and we are engaging with our people to co-design the full plan on how we support our people over the next year. • The following remain in place - Good to Great Roadshows - Catch up with the Execs - Health and Wellbeing Activities. Unable to sustain the necessary support across the range of Trust infrastructure

								• Laptop pressures easing, only 1 escalation received in the last 3 or 4 weeks • Estates produced a building options appraisal for possible capacity increases. SBU's are currently completing their reviews of their occupied space and working up their individual agile working plans. No further actions for estates at this time but we will support any decisions made by SLL's • The second phase of changing facilities - cabins delivery will commence w/c 14th June. Inability to provide essential clinical equipment • PPE Push Stock will now continue until at least March 2022. • FFP3 Fit Testing summary - over 2.2k people have now been fit tested on the new range of masks, with an excellent 91% pass rate. • LFT Home testing kits - 3rd batch of new LFT kits have been distributed to all staff whose kits will run out before the end of May, these had to be sourced via mutual aid from West Herts NHS Trust and East and North NHS Trust who had unused stock. • Both service user and non-service user facing staff have been issued with LFTs. • LFT text reminders to staff is being considered by Strategic.

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Maria Wheeler (Executive Director of Finance, Performance and Improvement) **Last Review Date** 16.06.2021 **Current Position:**
1319	Implications for the Trust of unforeseen consequences arising from the end of the EU exit transition period on the 31 December 2020 at which point the UK and EU's relationship will be governed by what is agreed in the future relationship agreement.	If agreement on the terms of the future relationship with the EU are not resolved then it is likely that the Trust will need to undertake preparations for potential no-deal style disruption. There is a risk that some or all of the agreements required will not be reached. Supply of medicines and medical technologies – New border arrangements and requirements on goods, as well as regulatory barriers, could cause delays in release of supplies / increased costs onto the UK market. The health and care workforce – In addition to the changes that a new future relationship will bring, from	12 (3x4)	Guidance on plans / preparedness from the NHS confederation / Department of Health and Social Care. The Trust's CIO, Hakan Akozek, will act as the EU Exit SRO and the preparation activities will be managed through the existing incident management structures for COVID-19, in line with the national direction. Automated system to monitor minimum medication stock levels and order as appropriate.	8 (2x4)	4 (1x4)	Increase difficulty or delay in sourcing sufficient quantities of medication or equipment. Increased staff turnover of EU registered staff	The Trade agreement reached with EU has significantly reduced the impact to the Trust, particularly around supply chain, finance and data flow risks. However as the impact of the changes for EU national workforce will not come into effect until 1st July 2021, workforce related risks to the Trust and other independent provides involved in care delivery remain unchanged. <u>Actions completed</u> • Monitor, advise and implement guidance from NHSEI as appropriate • Review and advise on briefings from NHS Providers and NHS Confederation • Encourage non-British EU staff to apply for settled status • Revisit the DHSC developed mandatory Self-Assessment Methodology for NHS Trusts to use to review contracts that may be impacted by a 'no deal' EU exit. • Review our information flow to re-assess potential risk • Identify and finalise key risks • Develop action plan for identification and implementation of contingencies arising <u>Medicines Management</u> MHRA guidance published 1 September 2020 for pharmaceutical industry and organisations on how to operate from 1 January 2021, including on licensing of medicines and devices, clinical trials, importing and exporting medicinal products, pharmacovigilance procedures and new IT systems. On the 3rd August 2020 the Department of Health and Social Care wrote to medicine suppliers and the wider supply chain advising medicine suppliers to stockpile six weeks' worth of drugs to guard against disruption at the end of the Brexit transition period and to make boosting reserves a priority. The medicines management team have an automated system to monitor minimum stock levels and order as appropriate, DHSC monitor any changes in ordering patterns.

		January 2021 the UK will have a new immigration system, which will affect international recruitment for the health and care services. There is a risk if Care Homes are more heavily reliant on EU staff with a smaller staff pool then this might impact their capacity and ability to take admissions from HPFT.						The chief pharmacist has advised that the risk around medicines management following the EU has not materialised. <u>EU Staff</u> Since the creation of the Settlement Scheme the Trust has encoraged non-British EU staff to apply for settled status. All EU employees (180 staff) were written to in January 2020, again in October 2020 and in February 2021 to remind them of the process, the support available, how they are valued by the Trust and to ask them to keep us apprised of their situation and any ways in which we might be able to help and support them. Of our 173 EU staff, 113 (65%) have made successful applications to the scheme. We have continued to follow up our advice with staff via our Business Partner Team and via direct emails and telephone follow ups to offer our support and to request the settled status and pre settled status code which will enable us to verify their status. Staff have until 30 June 2021 to apply, By this date, all eligible applicants are supposed to have applied for pre-Settled Status or Settled Status. Failure to make an application by the deadline will result in the person becoming unlawfully resident in the UK. The following steps will be taken to mitigate against the risks; • A further letter will be sent to the remaining 60 staff who have yet to let us know about their intentions to apply to the settlement scheme or if they have done so the outcome of their applications. • One to one calls have already been made to them and the Information Team will continue to do so until the 30 June 2021 • Contact with their line managers will be made to ensure that they can be further supported to make their applications. • Member of the Business Partner Team have raised this matter at core management meetings and will work with managers and staff to support in this area of work

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Maria Wheeler (Executive Director of Finance, Performance and Improvement) **Last Review Date** 17.06.2021 **Current Position:**
747	Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability	Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability, together with a negative impact on organisational reputation and potential financial legislative penalties. Our IT infrastructure contains some vulnerability and there are some insecure working practices which are contributing to our exposure to Cyber risk.	12 (3x4)	Cyber security audits undertaken within HBL ICT. IT Security Policy in place. Email and Internet Policy in place. Mobile Device Policy in place. Intrusion Prevention Sensors on all 'internet' connections Regular/periodic messaging to staff regarding potential issues, vigilance, expected behaviours and appropriate responses. Information Governance mandatory training. Move to NHSmail	8 (2x4)	4 (1x4)	Increase in cyber security related or suspected related issues/calls logged on Service Now Advice from HBL ICT, NHS Digital or other key organisations Cyber-attacks on other HBL ICT organisations, other NHS organisations and/or wider organisations	The Trust remains up to date in applying critical cyber security patches. The Trust has, with HBLICT, invested in two Data Centre's in the past two years, including firewall upgrades. The Trust will continues to review the benefits from the NHS Secure Boundaries initiative as it develops further. The NHS has agreed extended support arrangements for Windows 7 until January 2022. The upgrading of IT equipment to Windows 10 was paused owing to COVID related activities which saw the need to urgently deploy large numbers of laptops to support remote working. Windows 10 upgrades will now be completed by end of Q2 21/22. CareNotes support arrangements still need to be resolved. HPFT secured 420k support from NHS Digital for further cyber security, work including new network routers and network switches to upgrade any of the existing kit which are end of life or potentially vulnerable to minimise chance of cyber issues. Digital strategy work stream active to deliver extended Wi Fi and new SD WAN network in 21/22. COVID19 has resulted in the rapid implementation of a number of projects and software solutions to support remote working. To support this, a shortened data protection impact assessment has been developed. The intention is to capture any immediate risks and propose practical mitigations. Zoom paid for license now in place and operational which includes security updates. Advanced Threat Protection (ATP) gives better cyber security protection. It is also linked to the Data Security Centre (DSC), which improves cyber security protection for local health and care communities, and the NHS as a whole. ATP monitors and identifies any indicators of cyber security comprise or attack, it can then take immediate action to address the problem before it spreads. It also alerts local system managers and the DSC. A deep dive on Cybersecurity was presented and discussed at the Audit Committee's December 2020 meeting. Two externally facilitated workshops have been completed in January 2021 which resulted in a more granular vulnerability and risk assessment and an

								associated action plan. These will be managed at departmental level, but will be used to inform the Trust level overall risk. Further mitigation and assurance actions planned: • New Cyber Risk Management Framework (Completed) • Gartner IT Score for Security and Risk Management (need to ask Hakan) • Start implementing Single Sign On (Started but not completed) • Penetration Testing (Completed by HBLICT) • Cyber Essentials Plus Assessment (Ongoing) • Start migration to N365, latest Microsoft office package (has commenced) • Targeted phishing campaign with training (identifying an external supplier) • End Point Security systems on Trust devices to identify and quarantine malware and suspicious files • Regular updates and patches to systems to address known vulnerabilities • Annual Penetration Testing to identify and address vulnerabilities Cyber Security remains on the HBL ICT Risk Register – Cyber security remains in a controlled state and continues to be monitored due to the potential likelihood. This risk continues to be monitored at the Information Management and Governance Sub Committee (IMGS). Risk of cyber-attack is ever present.

Appendix 1 Risk Scoring Matrix (Risk = Likelihood x Consequence)

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

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

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

Step 2 Estimate the likelihood

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

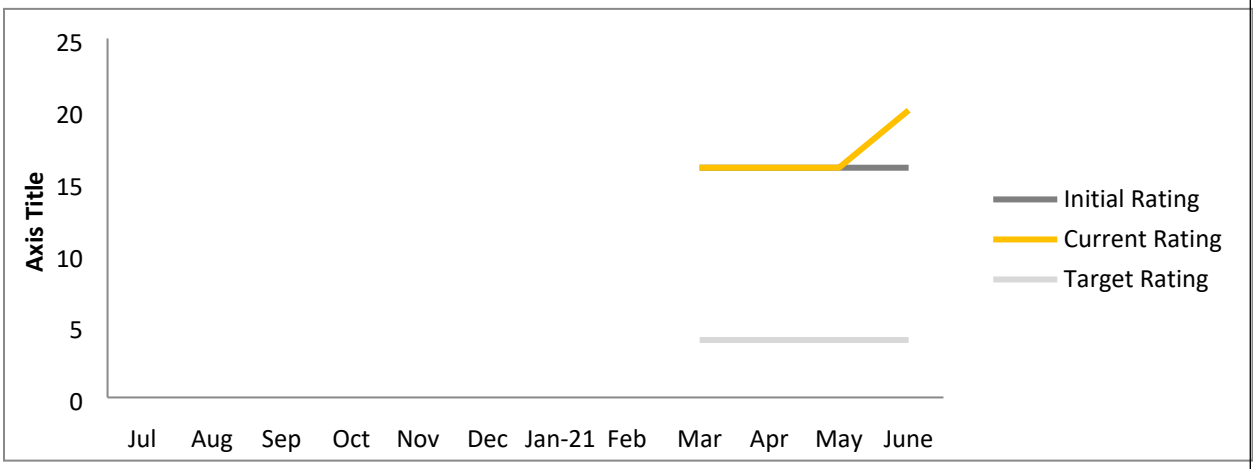
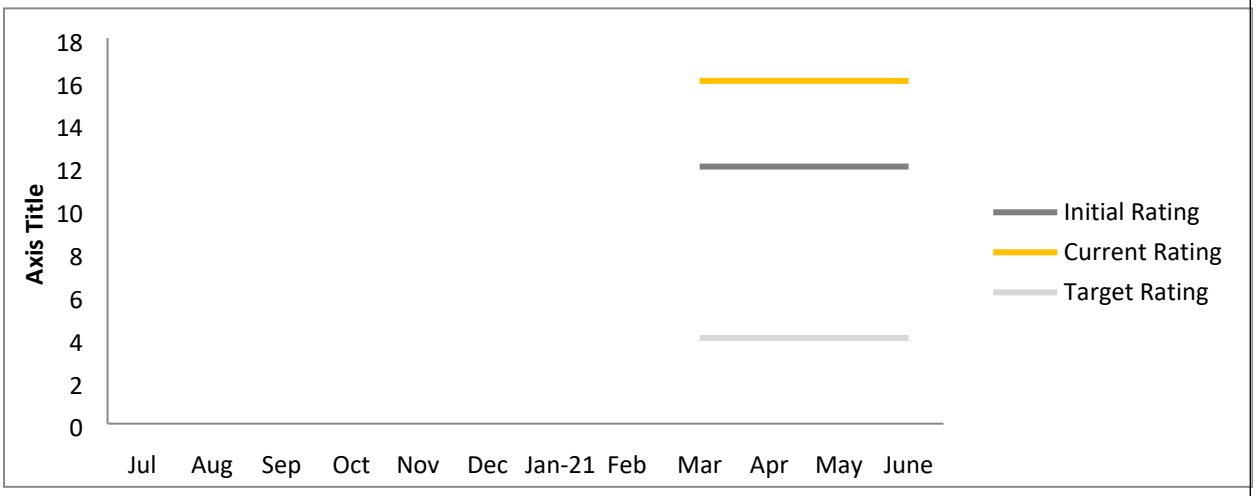
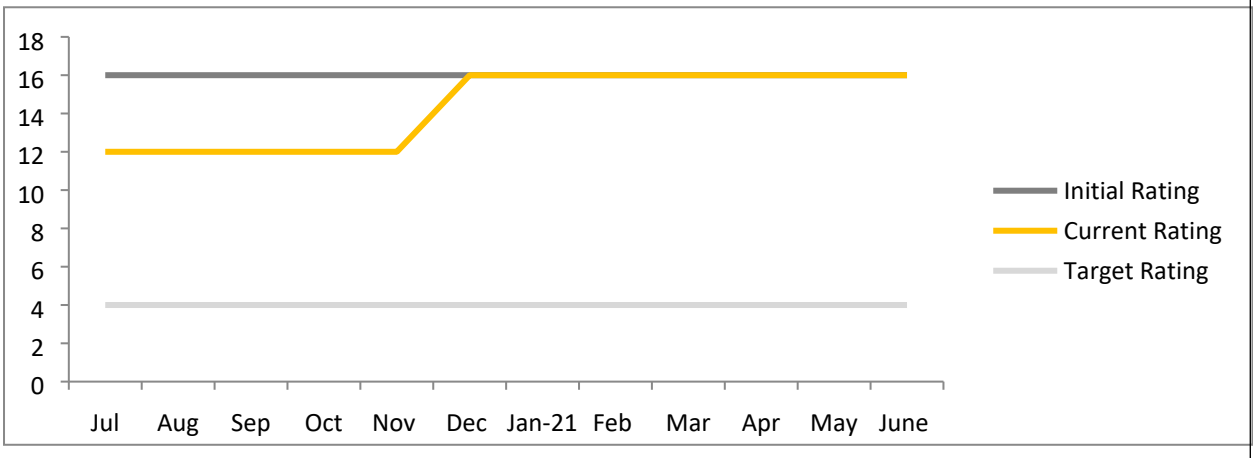
Step 3 Complete the Risk Grading Matrix

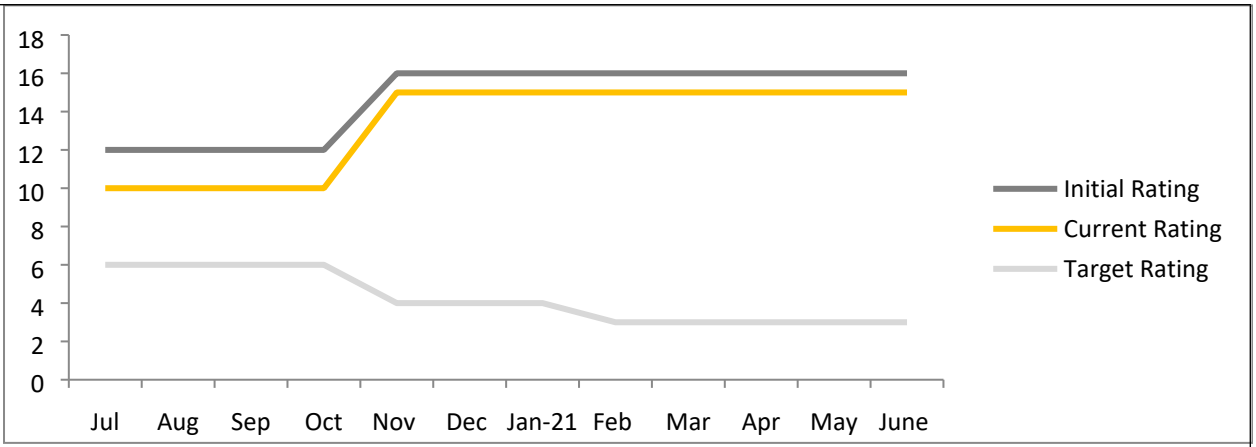
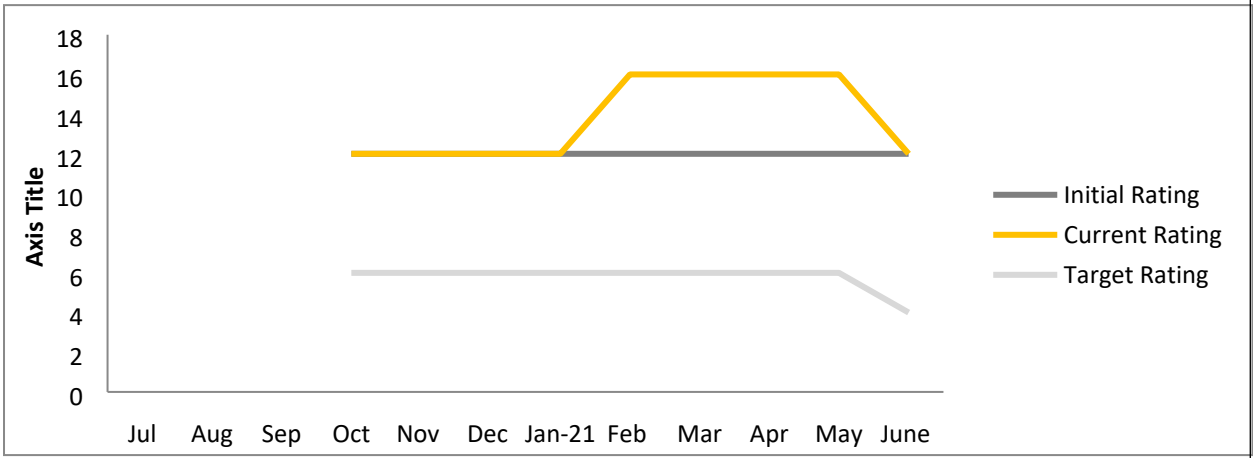
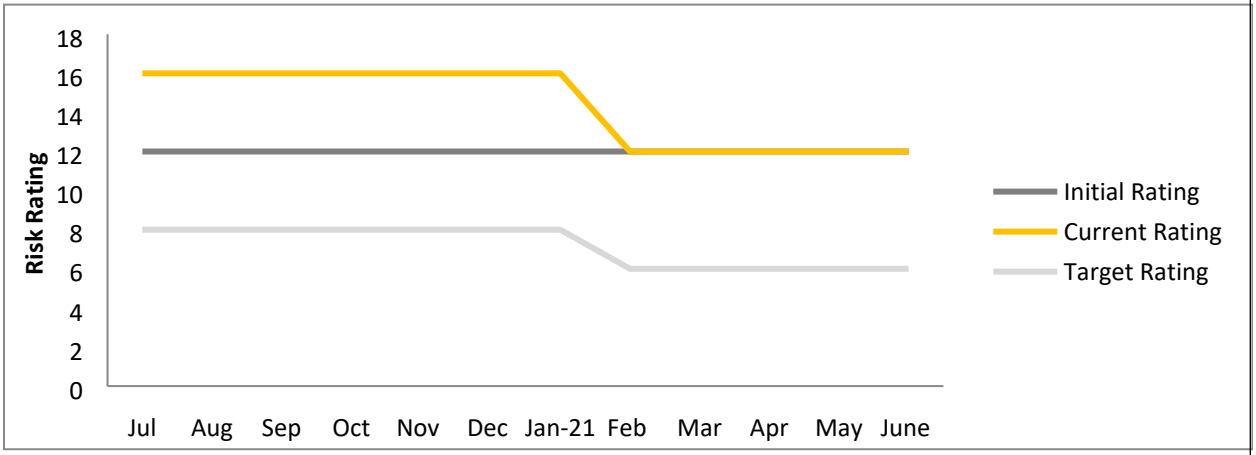
	Consequence				
Likelihood	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 Almost certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

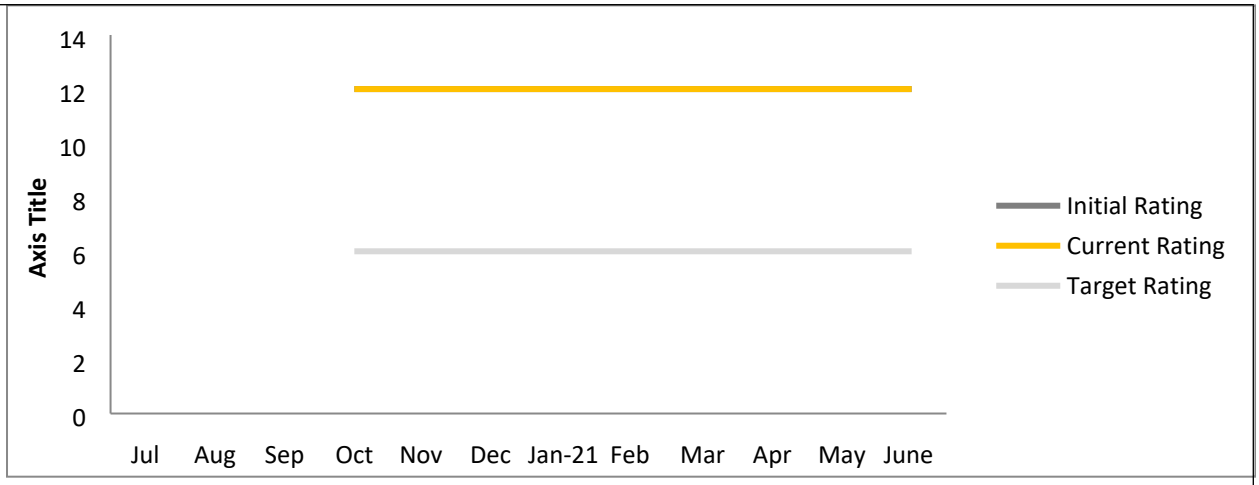
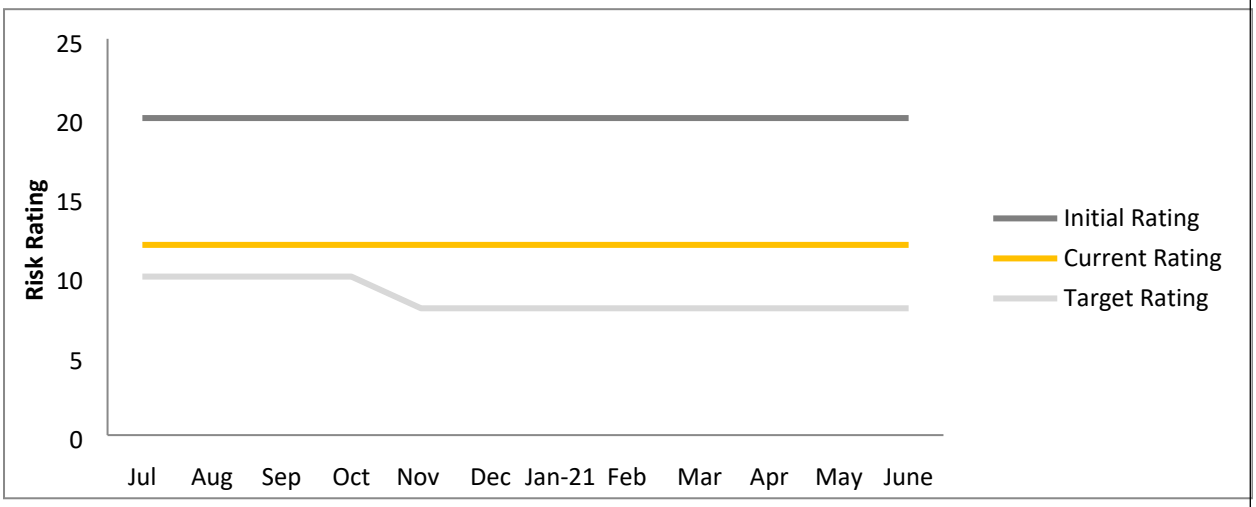
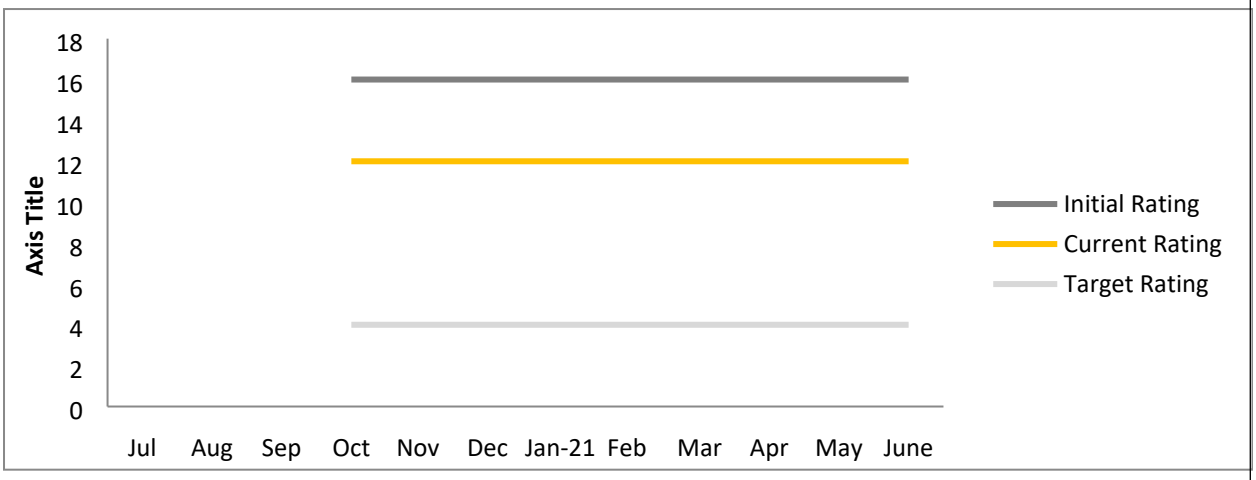
Step 4 Escalation Process

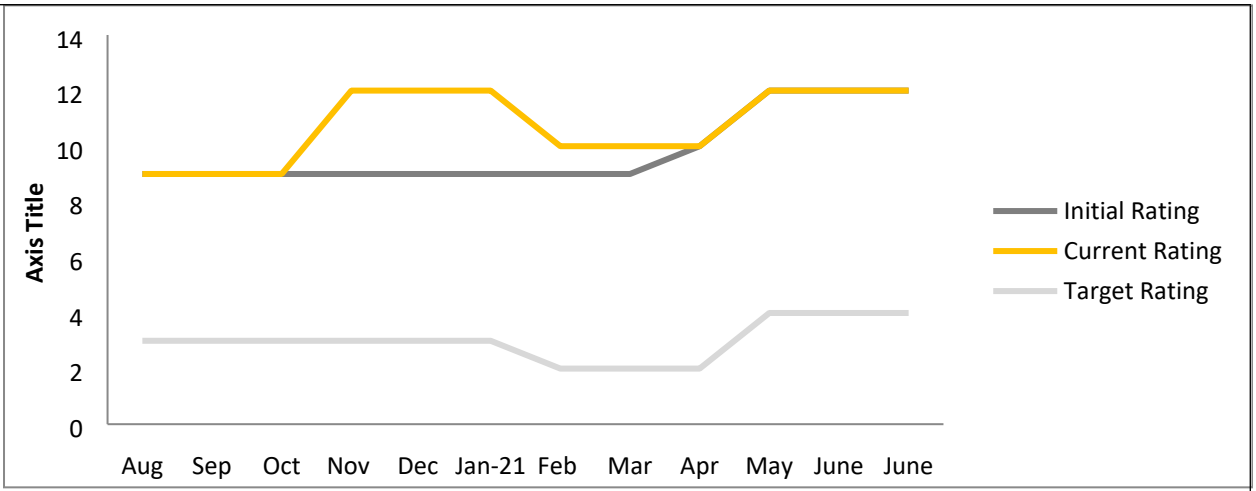
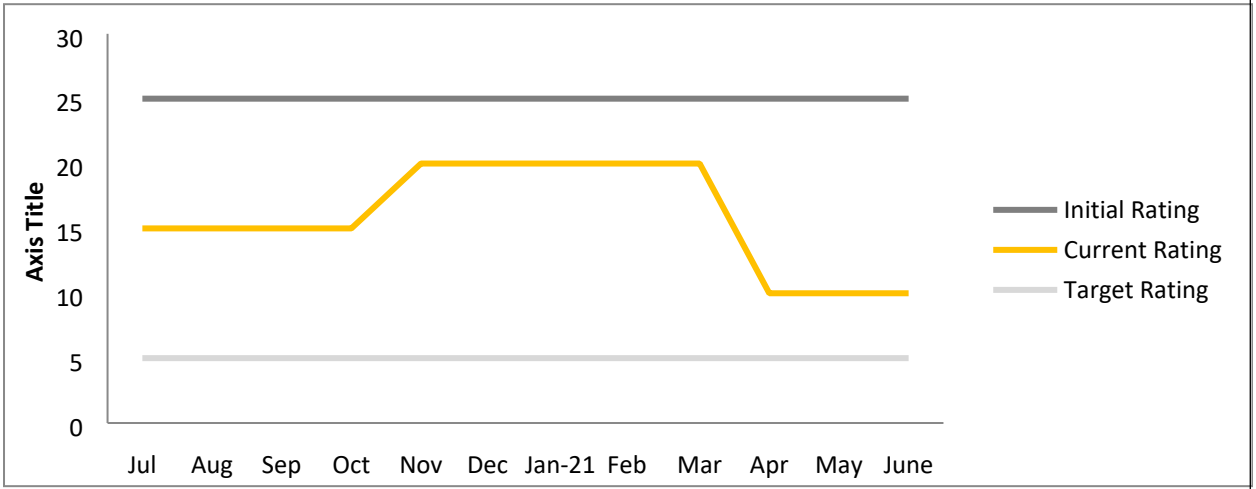
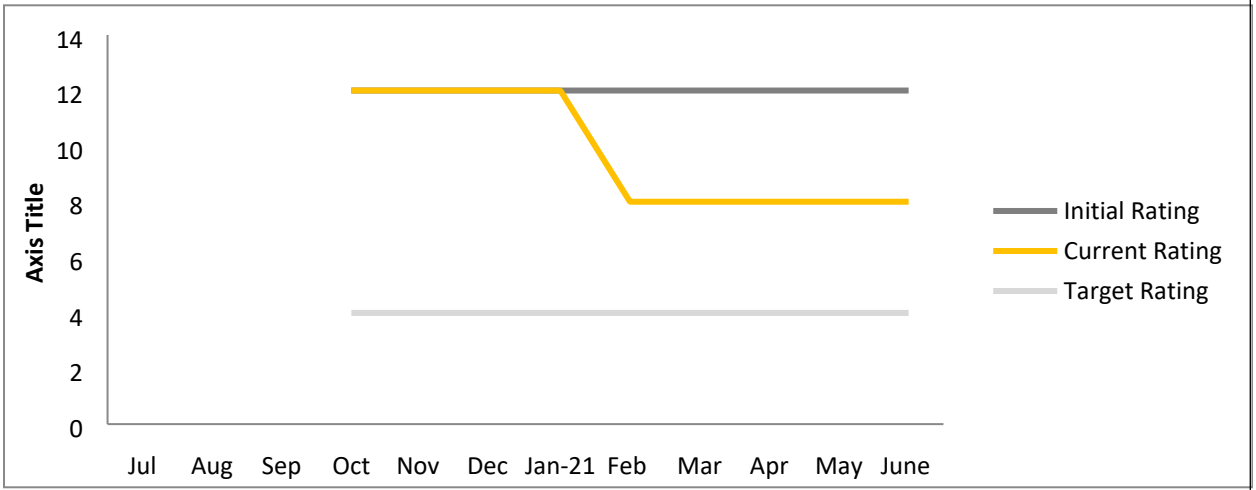
Very Low Risks	Low Risks	Moderate Risks	High Risks
1-3	4-6	8-12	15 - 25
Local Risk Register	Service Line Risk Register	SBU Risk Register	Trust Risk Register

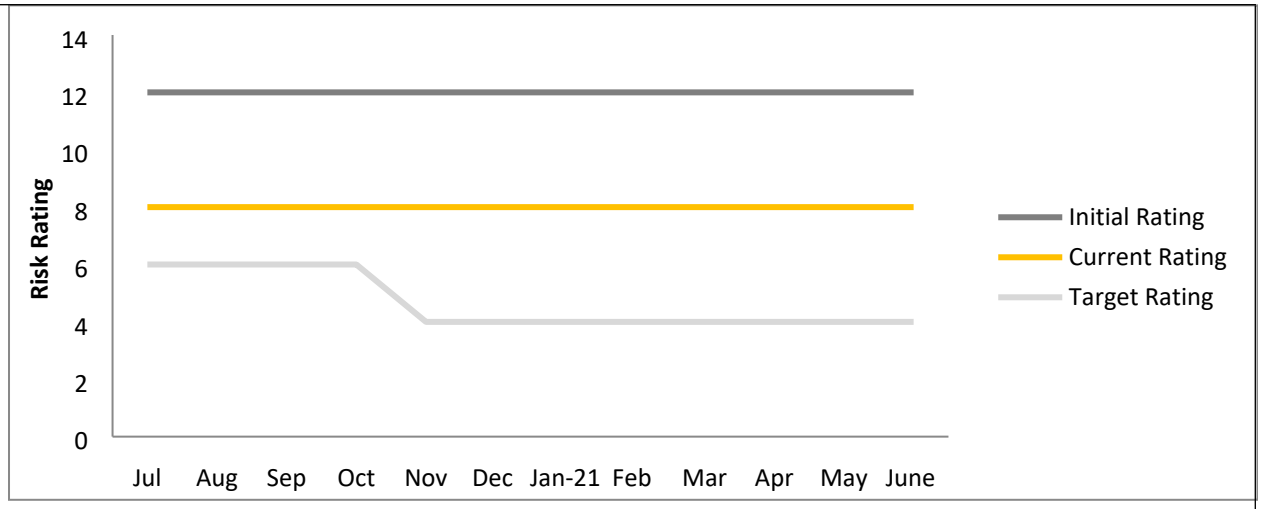
Trend Analysis – 12months

No	Risk	12 month trend analysis
1	1370	**Quality and safety:** National Shortage of specialist CAMHS beds impacting the capacity with FHAU and a risk that service users are not placed in the most appropriate environment. 
2	1300	**Quality and safety:** CAMHS Eating Disorders Team demand exceeds capacity 
3	1284	**Quality and safety:** Reduced provision of face to face mandatory training and the impact on staff compliance and consequently staff and service user 
4	882	**Quality and safety:** S136: Unlawful detention of service users under S136 breaching beyond 24hrs which has legal implications and an impact on service user care, treatment and experience

		
5	1321	**Workforce:** The Trust is unable to maintain staff wellbeing and staff morale during the pressures of COVID19, with increased demand now and during the recovery phase. 
6	1001	**Finance:** The Trust may not have sufficient resources to ensure long term financial sustainability 
7	1320	**Workforce:** Insufficient workforce to meet predicted increased demand and deliver commitments in Long Term Plan

		
8	749	**External landscape:** The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health and learning disability services provided by HPFT. 
9	1323	**Operational:** Risk that the sustainability of SRS becomes unviable following the reduction and changing needs of service users leading to an impact on quality and finance. 
10	1301	**Finance:** The Trust is unable to ensure short term financial performance in current financial year 2021/2022

		
11	1253	**Quality and Safety:** The Trust may not be able to sustain core operational services and maintain service user and staff safety during the continued COVID19 pandemic 
12	1319	**EU Exit:** Implications for the Trust of unforeseen consequences arising from the end of the EU exit transition period on the 31 December 2020 at which point the UK and EU's relationship will be governed by what is agreed in the future relationship agreement 
13	747	**Information Management and Technology:** Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability.


14
12
10
8
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4
2
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Risk Rating
Jul
Aug
Sep
Oct
Nov
Dec
Jan-21
Feb
Mar
Apr
May
June
Initial Rating
Current Rating
Target Rating

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 19
Subject:	Board Assurance Framework	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To provide assurance that the Trust's principal risks have been identified and are being appropriately managed.

Action required:

The Trust Board Committee is asked to:

a) Note the recommendation from the Integrated Governance Committee to the Board to approve the Board Assurance Framework (BAF).
b) Ensure the evidence in the BAF provides assurance that the principal risks have been identified and appropriate controls and assurance are in place.

Summary and recommendations to the Board:

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.

This report provides an update on the latest iteration of the BAF. This version includes updated controls and lines of assurance together with the most recent dates for the assurance evidence. It also reflects the end of the interim governance arrangements in place for part of 2020 and that management of COVID-19 is part of Business As Usual. It was also been updated to recognise the establishment of the East of England Collaborative and Place Based Partnerships.

Appendix 1 details the significant changes to the BAF since it was reviewed at Board in March 2021.

Recommendation:

The Trust Board Committee is asked to:

a) Note the recommendation from the Integrated Governance Committee to the Board to approve the Board Assurance Framework (BAF).
b) Ensure the evidence in the BAF provides assurance that the principal risks have been identified and appropriate controls and assurance are in place.

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 7 July 2021 Integrated Governance Committee 15 July 2021

Please note the BAF has been updated to include most relevant dates for Board, Committees and other groups, these numerous updates are not included in the table below

Appendix 1

Principal Risks and Lead Director/s	BAF Risk No.	Risk Change in period
Strategic Objective 1: We will provide safe services, so that people feel safe and are protected from avoidable harm		
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	1.1	**New Assurance** Addition of Annual Report and Quality Account for 2020/21 **New Actions** Deep Dive into suspected suicides Deep Dive into unexpected deaths of Service Users in Older People's services
Risk that do not deliver restrictive practice in line with best practice, therefore impacting on patient safety and experience	1.2	**New Actions** Relating to participation on CQC pilot of MHA assessments and taking learning forward.

Principal Risks and Lead Director/s	BAF Risk No.	Risk Change in period
Strategic Objective 2: **We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience**		
Service Users unable to access the right services in a timely way, meaning a poor experience and or outcomes for service users.	2.1	**New Assurance** Addition of Annual Report and Quality Account for 2020/21

Strategic Objective 4. **We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment**		
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.	4.1	**New Assurance** Relating to internal audit report **New Action** Relating to the implementation of actions linked with workforce planning internal audit

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**		
Fail to develop and deliver integrated services for CYP across partners, which would provide earlier intervention and suitable treatment options for young people	6.4	**New Action** Lead System actions in relation to pathways and capacity for Children and Young People services

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)**		
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	7.2	**New Action** Update stakeholder map and plan.

Board Assurance Framework (BAF)

July 2021

Reviewed by:

- Integrated Governance Committee
- Board Assurance Committee: Covid19
- Audit Committee
- Trust Board (TB)

Introduction

This Board Assurance Framework brings together the principle 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	**Action** **Deep Dive into suspected suicides** **Deep Dive into unexpected deaths of Service Users in Older People's services**	Director of Quality and Safety [IGC]
		Mortality Governance processes (including LEDER	IGC TB Brd Ass Sub-Cttee Covid		Mortality Governance Reporting Quarterly Integrated Safety Report	Externally Reporting	High	IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB 25.06.20 30.7.20 24.9.20 Assurance Cttee 11.06.20		
		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 20/21 (published) Annual Report 20/21 (externally audited) External audit advisory report	High	Assurance Cttee 09.07.20 IGC 6.4.20 Audit Committee 9.2.21 27.4.21 10.6.21 TB 10.6.21 24.6.21	**Action** **Development of Quality framework to triangulate information from visits.**	
		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 19.08.20 11.11.20 QRM 25/8/20 24/11/20 23/2/21 25/5/21 TB 30.7.20 Assurance Cttee		

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				
								09.07.20		
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 19.08.20 11.11.20 20.2.21 8.3.21 13.5.21 QRMC 14.8.20 10.11.20 24.2.21 30.4.21 2.7.21 TB 30.7.20 26.11.20 25.3.21 20.5.21		
	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 11.11.20 13.5.21 Ass Cttee 11.6.20 TB 26.11.20 20.5.21 QRM 25/8/20 24/11/20 23/2/21 25/5/21	**Action** **Board level self assessment.**	
		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 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB 30.7.20 24.9.20 26.11.20 25.3.21 20/5/21 Ongoing. unannounced & announced	**Action** **Implementation of Strategy** **Action** **Participation in CQC MHA pilot**	

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				
								visits QRM 25/8/20 24/11/20 23/2/21 25/5/21		
	1.3 Failure to implement Infection Prevention and Control policies and behaviours.	Infection Prevention and Control Board Assurance Framework	Infection Prevention & Control Committee IGC	Reports to IGC IPC audits Outbreak management	Annual Infection Prevention & Control Report Reports on emerging issues	CQC external review of IPC Externally commissioned review of IPC BAF	Medium	Assurance Cttee 11.06.20 9.7.20 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB 30.07.20 24.9.20 22.10.20 26.11.20 28.1.21 25.3.21 29.4.21 20.5.21	**Action** **Implement actions to support IPC BAF** **Action** **Implement recommendations of independent external review of IPC BAF**	DIPC [IGC]
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	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 &	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 2020/21	Assurance visits from CQC and CQC MHA team – Provider Action Statements Herts-wide assurance group	High	QRMC 14.8.20 10.11.20 24.2.21 30.4.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 Assurance Cttee 9.7.20 QRM 25/8/20 24/11/20 23/2/21 25/5/21		Director of Quality and Safety [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				
				actions)						
		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	TB 22.10.20 26.11.20 28.1.21 25.3.21 29.4.21 20.5.21 IGC 20.1.21 8.3.21 13.5.21	**Action** **Action plan to ensure Trust meets one partial compliance area of self-assessment**	Director of Service Delivery and Experience [IGC]
		Safeguarding processes and monitoring	Safeguarding Strategic Committee		Safeguarding Reports (Annual and quarterly)	Section 11 safeguarding assessment Annual CCG safeguarding assurance assessment Adults and Children's Quality Assurance Visit Internal Audit report	High	IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB 26.11.20 28.1.21 25.3.21 20.5.21 Audit Ctte 3.2.21	**Action** **Implement recommendations from internal audit report**	Director of Quality and Safety [IGC]
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	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	QRM 25/8/20 24/11/20 23/2/21 25/5/21		
			Health Safety and Security Committee Audit Committee		Health, Safety and Security Report (Annual / Quarterly Report) Health & Safety Annual Report	Internal Audit Report – H&S Service User Contact		TB 30.7.20 24.9.20 26.11.20 28.1.21 25.3.21 20.5.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 Audit		

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				
								15.9.20 3.12.20 9.2.21 27.4.21		
			Quality and Risk Management Committee		Quarterly Safety Reports Policy Compliance Report CQC Action Plan	CQC Insight Reports CQC TMA		QRMC 14.8.20 10.11.20 24.2.21 30.4.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB 28.1.21		
			IGC	Clinical and Professional Advisory Committee	Reporting Quarterly Integrated Safety Report	Internal Audit Reports - CQC Action Plan		IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 Audit Cttee 9.2.21 27.4.21 10.6.21		
		Quality Strategy	QRMC IGC Board	Service and SBU objectives related to the Quality Objectives as defined in the Strategy Covid19 Risk Register	HSCC QRMC IGC Quality Improvement reports Quality Strategy launched	CCG performance reports related to Quality Objectives	High	IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB: 30.7.20 24.9.20 22.10.20 26.11.20 28.1.21 25.3.21 20.5.21	**Action** **Quality strategy being roll out. Leads identified for four domains and reporting back to IGC.**	
		Quality Measures including Quality Strategy	IGC TB CCG QRM		Trust performance KPI report on Workforce Quality Strategy review & approval	POM UK Accreditation Quarterly CCG Quality Review Meeting/Reports	High	IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB: 30.7.20	**Action** **Roll out of Quality 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				
					Quarterly Claims Reports Briefing & Annual Claim Report			24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 QRM 25/8/20 24/11/20 23/2/21 25/5/21		
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 Quality Account 20/21 externally published Audited Annual Report 2020/21		FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 TB: 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 Assurance Cttee 9.7.20 Audit Cttee 9.2.21 27.4.21 10.6.21 AGM 21.7.21		Director of Service Delivery and Customer Experience / Director of Finance [IGC]
		Quality Impact Assessments	QRM – reports to Commissioners IGC	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	QRMC 14.8.20 10.11.20 24.2.21 30.4.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21		
	2.2 Failure to engage effectively with service users and carers will	Service User Feedback	QRMC Executive Committee	Complaints in real-time		Community Mental Health Annual Survey	High	TB 30.7.20 24.9.20	**Action** **Community Survey action plan and task and finish Group**	

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				
	impact on Trust's ability to transform services to best meet their needs		IGC Brd Ass Sub-Cttee Covid TB	Experience reports Friends and Family results Having Your Say	 Peer listening reports and feedback Friends and Family Test data Feeling Safe data	Commissioner reviews by carers in Herts and View Point		29.11.20 28.1.21 25.3.21 20.5.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21		
		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 TMA process	High	May 2019 December 2020		
	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 Qly reports on capital plan FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
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 Tool kit to support the physical health and wellbeing of people with severe mental illness	TMG TB Physical Health Committee IGC QRM QRMC	Audit of care plans and records Structured Judgement reviews Clinical and Professional Advisory Committee	CQUIN achieved and agreed with commissioners quarterly SBU Physical Health Leads Annual Physical Health Strategy Report Mortality Harm Panel FIC deep dive	CQC inspection CCG reports on CQUIN STP Ethics Committee	Medium	IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 TB: 30.7.20 24.9.20	**Action** **Implement new guidance to identify and manage physical health needs of services users.**	Director of Quality and Medical Leadership [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				
								29.11.20 28.1.21 25.3.21 20.5.21		
	3.2 Do not provide appropriate psychological intervention and treatment, leading to poorer outcomes.	Psychology Services Development Strategy Implementation Plan Clinical outcome measures Transformation Programme	TMG Transformation Board Exec	Implementation Plan Departmental review of clinical outcomes	Transformation Board TMG Performance monitoring and KPIs	Internal Audit programme	Medium	Monthly and quarterly perf reports Monthly transformation updates to Exec	**Action** **Roll out of additional psychology resource to target areas** **Development organisation wide performance metrics**	
	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	IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 Audit Cttee 9.2.21 27.4.21 10.6.21		
		Medicines Management	QRMC Executive Committee IGC TB	Service level feedback Datix reports	DTC Annual Report 6 monthly committee update Pharmacy & Medicines Optimisation Annual Report Medicines Management Strategy	CCG Quality report Internal Audit Report – Medicines Mgt.	High	IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
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 3.9.20 27.10.20 1.3.21 16.4.21 28.5.21 1.7.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21	**Action** **Implement actions to ensure improved employment experience** **Action** **Implement internal audit actions with regard to workforce planning**	Director of People and OD [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				
								IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21		
		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 External Well Led Review	High	TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21	**Action** **Well Led Review action plan**	
		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 3.9.20 27.10.20 1.3.21 16.4.21 28.5.21 1.7.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21		
	4.2 Failure to develop a sustainable, adaptive and resilient workforce model that will impact on Trust's ability to deliver safe and effective care.	Revalidation and appraisal of medical staff	IGC TB		Annual Report on Revalidation and Appraisal of Doctors	Internal Audit – Doctor Revalidation	High	TB 24.9.20		
	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	Internal Audits	Medium	TB 25.2.21 and 25.3.21 (National Staff Survey) TB	**Action** **Trust implementation plan for NHS People's Plan**	

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				
					Pulse Survey			30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
		External Systems for Staff Feedback	Executive Committee PODG IGC TB	FSUG report	PULSE quarterly report	National Staff Survey	High	TB 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
		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	PODG 3.9.20 27.10.20 1.3.21 16.4.21 28.5.21 1.7.21 Exec June 2021 TB 29.7.21	**Action** **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	PODG 3.9.20 27.10.20 1.3.21 16.4.21 28.5.21 1.7.21 IGC 19.8.20 11.11.20 20.1.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
		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	People and OD Report 24/7 staff helpline Interactive Q&A sessions for staff	CQC inspection Well Led Review	High	PODG 3.9.20 27.10.20 1.3.21 16.4.21 28.5.21 1.7.21 IGC	**Action** **Implement Well Led Review Action plan**	

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				
				Well being bulletins				19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
		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 25.2.21 and 25.3.21 Exec Feb and March 2021		
		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	TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21		
		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	Well Led Review Report	High	PODG 3.9.20 27.10.20 1.3.21 16.4.21 28.5.21 1.7.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 Monthly		
	4.5 Unable to provide appropriate learning, development and training	Discovery Learning Management System (easier access to e-learning and	PODG IGC FIC	Training Compliance to PODG		Internal Audits	High	IGC 19.8.20 11.11.20		

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				
	opportunities to enable staff to be skilled to the right levels, both clinically and managerially	training compliance)		Training Compliance to IGC				20.1.21 8.3.21 13.5.21 FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21		
		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	PODG 3.9.20 27.10.20 1.3.21 16.4.21 28.5.21 1.7.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21	**Action** **Continued roll out of Great Teams.**	
		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 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
		Mandatory Training Programme	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	Internal Audits	High	PODG 3.9.20 27.10.20 1.3.21 16.4.21 28.5.21 1.7.21		

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				
		Statutory & Essential Training Policy			training report Quarterly report to WODG & TB Statutory & Essential Training Policy Ratification			TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 Assurance Cttee 9.7.20 19.8.20 Monthly flash reports to Exec		
	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	TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 Assurance Cttee 9.7.20 19.8.20 Audit Cttee 9.2.21 27.4.21	**Action** **Implement action plan to support People and OD strategy**	
		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	Well Led Review	High	PODG 3.9.20 27.10.20 1.3.21 16.4.21 28.5.21 1.7.21 TB 30.7.20 24.9.20 29.11.20 28.1.21		

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				
								25.3.21 20.5.21 Exec Cttee Monthly reports Oct 2020		
		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 2021 Report on Key Findings and action plan in place	High	Staff Survey TB 25.2.21 25.3.21 Exec Feb and March 2021		
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 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 Exec Team Monthly reports TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		Director Finance and Performance [FIC and Audit]
			TB Audit Committee			Annual Governance Statement Annual Financial Statements & Audit Report Head of Internal Audit Opinion External Audit	High	Audit Cttee 9.2.21 27.4.21 10.6.21 TB 10.6.21 AGM 21.7.21		
		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 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 Exec team monthly flash reports	**Action** **Implement use of Model Hospital** **Delivering Value programme**	Director Finance and Performance [FIC and 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				
		Trust Contracts with Commissioners	TB FIC		Contract Update Reports	5 Year contract signed with commissioners	High	FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
		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 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
	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 Digital 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	Audit Cttee 9.2.21 27.4.21 10.6.21 TB 24.9.20 28.1.21 25.3.21 20.5.21	**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**	Director of Operational Finance [FIC & TB]
		Performance Monitoring Processes	Executive Committee 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 CQC TMA	High	Exec: Monthly and quarterly FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		

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				
	5.3 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	IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 Audit Cttee Deep dive 3.12.20 TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21		
	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	Weekly to Exec IGC 19.8.20 11.11.20 20.1.21 8.3.21 13.5.21 FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21		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 QRM 11/2/20 2/6/20 25/8/20 24/11/20 23/2/21 25/5/21		Deputy CEO and Director of Strategy and Integration [FIC or IGC]
		Stakeholder Map and plans	Exec Committee	Intelligence sharing via EC	Exec Buddies for Collaboratives	Feedback from Commissioners	Medium	Exec Team December 2020 Trust Board 24.6.21	**Action** **Stakeholder plans to be updated to reflect 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	High	At least monthly Weekly to Executive Committee SLT		

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				
						(Reviews)		QRM 11/2/20 2/6/20 25/8/20 24/11/20 23/2/21 25/5/21		
	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 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 24.6.21 FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21	**Action** **Ensure appropriate representation and engagement at system meetings**	
	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 Collaborative	TMG Exec TB	PRM SBU reporting	Executive reports Monthly TMG reports	EoE Collaborative ICS reporting OSM with NHSI/E Scrutiny	Medium	Weekly to Executive Committee FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 Qly PRMs	**Action** **Lead System actions in relation to pathways and capacity for Children and Young People services** **Delivery of relevant MH & LD Collaborative 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 Collaborative work stream Transformation programme	TMG Exec FIC TB	PRM Transformation programme	TB reports	Scrutiny	Medium	Weekly to Executive Committee FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21 Scrutiny 7.7.21 Qly PRMs	**Action** **Continued active involvement in system wide work for Crisis services, and external partners e.g. police** **Delivery of relevant MH & LD Collaborative work stream**	
7. We will shape and influence	7.1 Fail to develop the	MH & LD Collaborative Board	Exec		Exec monthly	ICS CEO Board	High	Weekly to		Deputy CEO

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				
the future development and delivery of health and social care to achieve better outcomes for our population(s)	Hertfordshire MH and LD Collaborative, which may mean voice of service users not represented and has adverse impact on resources available and care provided in the future	Collaborative Development Group Co Chair of MH & LD Collaborative	FIC TB		updates Board updates	ICS Partnership Board E&N and South West Partnership Boards		Executive Committee TB 30.7.20 24.9.20 29.11.20 28.1.21 25.3.21 20.5.21 24.6.21 FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21		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 Place Based Partnerships Leadership of MH and LD Collaborative streams Place Based Partnership Board East of England Provider Collaborative Locality Board membership across Herts	Executive Committee FIC TB	Clinical staff involved in system meetings Executive Committee Minutes	Updates to TB Board workshop to agree approach to emerging system architecture	Place Based Partnership delivery group East of England collaborative Board	High	Weekly to Executive Committee Trust Board: 27.2.20 28.5.20 25.6.20 30.7.20 24.9.20 22.10.20 26.11.20 28.1.21 FIC 18.8.20 17.11.20 19.1.21 16.3.21 10.5.21	**Action** **Update stakeholder map and plan.**	
	7.3 Fail to develop relationships with the Place Based Partnerships to ensure the needs of those with LD and/or SMI, services users and communities served by HPFT are appropriately addressed	Relationships with all Key Stakeholders to drive and deliver key priorities	Executive Committee	Update to Executive Team	Weekly reports Stakeholder map and plan Aligned NEDs and EDs to emerging system infrastructure		Medium	Weekly to Executive Committee Trust Board 24.6.21	**Action** **Stakeholder plans to be updated given changing external landscape** **Develop relationships with emerging PCNs**	
	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	Executive FIC TB		Annual plan Quarterly reports CCG Commissioning Intentions. Aligned NEDs and	ICS CEO Board	High	Exec Quarterly reports on Annual Plan FIC 18.8.20 17.11.20		

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				
		Emerging system strategy for MH and LD East of England Collaborative (leadership role for CAMHS)	Executive Committee FIC TB	Partnership Advisory Board for MH and LD Collaborative	EDs to emerging system infrastructure East of England Collaborative Directors Group	EoE Provider Collaborative CEO Group		19.1.21 16.3.21 10.5.21 Trust Board: 27.2.20 28.5.20 25.6.20 30.7.20 24.9.20 22.10.20 26.11.20 28.1.21 Board workshop 24.6.21		

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 20
Subject:	Annual Review of Fit and Proper Person Test Checks	**For Publication:** Yes
Author:	Louise Thomas, Deputy Director of People and OD	**Approved by:** Janet Lynch, Executive Director, People and OD
Presented by:	Janet Lynch, Executive Director, People and OD	

Purpose of the report:

The purpose of this paper is to provide annual assurance that all Board directors remain fit and proper for their roles.

Action required:

Members of the Board are asked to approve the recommendation.

Summary and recommendations to the Board:

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the introduction of regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations"), the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'. The Test is carried out by way of various checks, certain of which must be repeated annually. This paper sets out the checks that must be carried out as part of the Annual Review and the outcome of the Annual Review for 2020/2021.

The Board is asked to note and record that the Annual Review of the Fit and Proper Persons Test has been conducted for the period April 2020 – March 2021 and that all Directors satisfy the requirements.

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:

The recruitment and selection process complies with the Equality Act, NHS and Trust requirements in relation to equal opportunities in recruitment and selection.

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

N/A

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

N/A

Annual Review of Fit and Proper Person Test Checks

1. Introduction

1.1 The purpose of this paper is to provide annual assurance that all Board directors remain fit and proper for their roles.

1.2 As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the introduction of regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations"), the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'.

1.3 The Fit and Proper Person Test is undertaken upon appointment to a Board role and certain checks are repeated annually. This paper presents the outcome of the checks carried out for the period April 2020 – March 2021.

2. Annual Review

2.1 As part of the Fit and Proper Person Test, the Trust is required to undertake regular reviews by way of annual checks against certain of the Fit and Proper Person Test criteria for people holding Director posts.

2.2 The Trust's agreed process (dated November 2017) sets out that the Annual Review includes the following items:

a. Confirmation of renewed insolvency and disqualified directors checks
b. Confirmation of renewed self-declaration form
c. Confirmation of up to date photograph
d. Confirmation of DBS check having been carried out within the last three years.

3. Outcome of the 2020/2021 Annual Review

3.1 In Q1 of 2021/22, all Executive and Non-Executive Directors' (including the Chair and Chief Executive) insolvency and disqualified directors checks were completed. All checks were clear.

3.2 In Q1 of 2021/22, all Executive and Non-Executive Directors (including the Chair and Chief Executive) were asked to reconfirm their self declaration. All self-declaration forms have been completed and returned and were clear, i.e. none contained any self-declared reason that would mean the individual was not a fit and proper person under the Regulations.

3.3 In Q1 of 2021/22, it was reconfirmed that the Trust holds up to date photographs of all Executive and Non-Executive Directors (including the Chair and Chief Executive).

3.4 In Q1 of 2021/22, it was confirmed that all Executive and Non-Executive Directors (including the Chair and Chief Executive) have a DBS check carried out within the last three years and that these were all clear.

3.5 All self-declaration forms and annual review documentation have been sent to the Trust Chair and signed off in accordance with the Trust's agreed process. The self-declaration form for the Chair has been signed off by the Chair of the Finance and Investment Committee in the absence of the Senior Independent Director.

3.6 In line with the Trust's agreed process the Chair's self declaration form will be presented to the ARC and then the Trust Board.

4. Conclusion

4.1. All current and newly appointed Directors of the Trust Board satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

4.2 The Trust's agreed process is dated November 2017 and will therefore be reviewed during 2021/22.

4.3 The next annual review will take place in March 2022 and will be reported to the Board in April 2022.

5. Recommendations

5.1. The Board is asked to note the content of this paper and record that the Annual Review of the Fit and Proper Persons Test has been conducted for the period April 2020 – March 2021 and that all Directors satisfy the requirements.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 21
Subject:	Review of Trust Constitution	**For Publication:** Yes
Author:	Helen Edmondson. Head of Corporate Affairs and Company Secretary	**Approved by:** Sarah Betteley, Chair
Presented by:	Sarah Betteley, Chair	

Purpose of the report

1) To update the Board on the annual review of the Trust's constitution.
2) To make a recommendation that the Trust Constitution is amended to remove the amendment made in 2020 that allowed for the routine election to the Council of Governors (CoG) to not be held in 2020 and that those Governors whose term of office was due to end in July 2020 are offered an extension of up to a year to July 2021.
3) To make a recommendation to amend any formatting or typographic errors in the constitution.
4) To gain support for a recommendation to be made to the Council of Governors to support the proposed amendments.

Action required:

To review the proposed amendments and make a recommendation to the Council of Governors for the amendments to be approved.

Summary and recommendations:

Summary

It is good practice to undertake an annual review of the Constitution.

The Head of Corporate Affairs and Company Secretary has undertaken a review of the Trust's constitution in consultation with the Trust Chair and is recommending the following amendments:

1. To remove the amendment made in September 2020 that allowed for the routine election to the Council of Governors (CoG) to not be held in 2020 and that those Governors whose term of office was due to end in July 2020 are offered an extension of up to a year to July 2021 – Section 13.1.5
2. To amend any formatting or typographic errors in the constitution.

The Board is asked to note that a further review of the constitution will be undertaken following the adoption of the NHS Bill by parliament, due later in 2021.

If supported by the Board the proposed changes will be considered at the Council of Governor meeting being held on 8 September 2021.

Recommendations

The Board are asked to consider and approve proposed amendments to the Constitution:

1. To remove the amendment made in 2020 that allowed for the routine election to the Council of Governors (CoG) to not be held in 2020 and that those Governors whose term of office was due to end in July 2020 are offered an extension of up to a year to July 2021 – Section 13.1.5.
2. To amend any formatting or typographic errors in the constitution.
3. Make a recommendation to the Council of Governor to amend the Constitution as outlined.

Board Approval.
Section 48 of the constitution sets out the basis on which the Board can agree changes to the constitution. Namely:

48.1.2 more than half of the members of the Board of Directors present and voting at a meeting of the Board of Directors approve the amendments.

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

N/A

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

N/A

Equality & Diversity /Service User & Carer Involvement implications:

N/A

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

Evidence to support the NHSI/CQC Well Led Standard.

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

Considered and approved by Council of Governors on 11 June 2020

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 22
Subject:	MHAM Committee Report to the Board	**For Publication:** Yes
Author:	Hattie Llewelyn-Davies/Tina Kavanagh	**Approved by:** Tim Bryson, Non-Executive Director
Presented by:	Tim Bryson, Non Executive Director	

Purpose of the report:

To report on the activity of Mental Health Act Managers (MHAM) and the use of the Mental Health Act (MHA) in HPFT during 2020/21

Action required:

As required by the Terms of Reference of the MHAM Committee meeting a report is to be presented to the Board for information about MHAM activity.

Summary and recommendations:

For information only and to provide assurance that the statutory functions of the Trust Board is carried out within HPFT in relation to the MHA.

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

All MHA legislation is integrated into the Business Plan. Board to agree that the report provides assurance that all statutory responsibilities under the MHA are undertaken.

Summary of Financial, IT, Staffing & Legal Implications:

MHAM are not employees of the Trust. There is a legal requirement for the Board to authorise individuals to exercise the power of discharge (S26(3) MHA) and to ensure that there is a scheme of delegation in place to ensure all other responsibilities of the Trust are met in respect of the MHA.

Executive Summary

This report covers activity in respect of the Mental Health Act Manager (MHAM) Service from April 2020 to March 2021. The MHA Code of Practice requires an annual report to the Board of MHAM activity as well as information in relation to the on-going development of processes, guidance and training requirements for the MHAM.

This report includes information in relation to the White Paper, Reforming the Mental Health Act, and the consultation.

Following a court case, Devon Partnership NHS Trust v SSHSC [2021] EWHC 101 (Admin), it was ruled that, despite previous guidance from NHSE/I that remote examinations for the purpose of detention under the Mental Health Act was acceptable during the COVID-19 pandemic, this was now deemed to be unlawful. All necessary actions were taken and completed by the Trust i.e. all unlawful detentions discharged and patients advised accordingly.

The use of the Mental Health Act continues to rise nationally. COVID-19 guidance within HPFT has been updated as soon as national guidance is issued and lockdown measures eased.

There are currently 36 active MHAM covering our sites in Hertfordshire, Norfolk, N. Essex and Buckinghamshire. All patients who have had their MHA compulsory order renewed or extended must have the renewal/extension reviewed by the MHAM, they also have the right to appeal to the MHAM. All hearings have been held remotely since March 2020.

The MHAM area of the HPFT website is updated to include relevant information and useful links for the MHAM; this has been welcomed by the MHAM.

Governance arrangements continue regarding recruitment and DBS checks for MHAM.

The robust reporting system for the MHAM to raise operational/clinical concerns to ensure that issues highlighted during a review hearing by the MHAM has been working well and means that issues are dealt with in a transparent manner and there are clear governance arrangements around this.

The focus for the following year is to ensure that any disruption caused by the COVID-19 pandemic is minimised and that any lessons learned about different ways of working will be taken forward.

The MHAM aim to encourage service user feedback about their experiences of MHAM hearings. The Non-Executive Lead and the Manager of the MHAM service will continue to support all MHAM and ensure a consistent and integrated service across all sites.

1) Introduction

This report covers activity in respect of the Mental Health Act Manager (MHAM) Service as required by the MHA Code of Practice (2015) and also by the Terms of Reference for the MHAM Committee, which is reviewed and reapproved by the Board for Hertfordshire Partnership University NHS Foundation Trust.

The report focuses on the period April 2020 – March 2021 and the on-going development of processes, guidance, training requirements in respect of the Mental Health Act and the evolving implications of the Mental Capacity Act 2005 (and Deprivation of Liberty Safeguards).

Loyola Weeks, the lead Non-Executive Director for the MHA Managers, has left the board however has remained as a valued MHA Manager. Tim Bryson has replaced her role as the lead NED for the MHAM.

2) Responsibilities of the Trust Board

NHS Trusts are defined as Hospital Managers for the purposes of the Mental Health Act 1983, (as amended by the MHA 2007), in effect this is the Board of Directors made up of executive and non-executive members. It is the Hospital Managers (known as MHAM) who have the authority to detain patients under the Act and they have the primary responsibility for ensuring that the requirements of the Act are followed, in particular:

- They must ensure that patients are detained only as the Act allows;
- That treatment and care comply fully with the provisions of the Act;
- That patients are fully informed of, and are supported in exercising their statutory rights.

MHAM have various powers and duties which include:

- The power of discharge from compulsory powers (detention and Community Treatment Orders).
- Receipt and Scrutiny of Mental Health Act Documents.
- Provision for access to the First Tier Tribunal Service (Mental Health)
- Provision of information to patients and their nearest relatives.

In practice, the decisions and actions of the MHAM are actually taken by individuals (or groups of individuals) authorised by the Board to act on their behalf, in particular, decisions about discharge. Section 26(3) of the Act states that any three or more persons authorised by the Board, that are not Executive Directors of the Board or an employee of the Trust can exercise the power of discharge from compulsory powers:

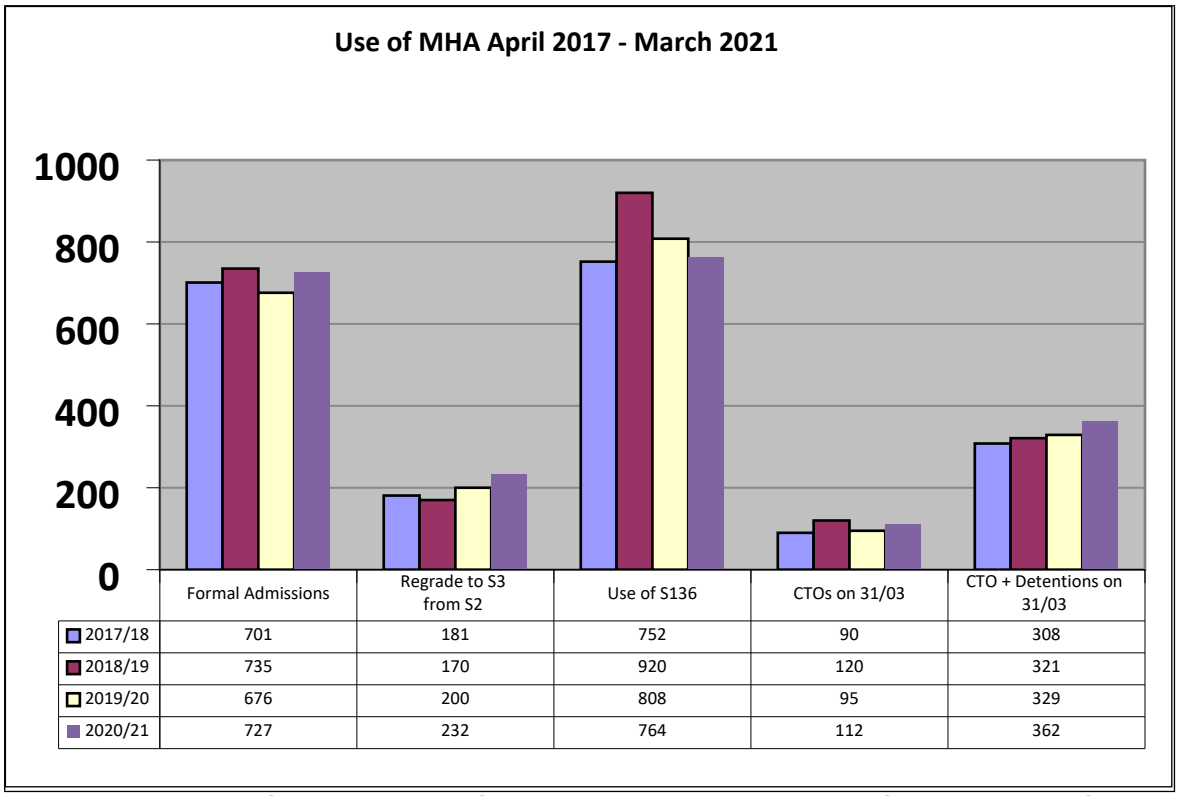
- Only non-executive directors or other non-employees appointed for the purpose can exercise this power.
- These other non-employees are referred to in HPFT as Mental Health Act Managers (MHAM).
- MHAM may be paid a fee for their role, but their role and activity within the organisation must not be such that it would amount to the MHAM being classed as an employee.

The Mental Health Act Managers Committee is a Committee of the Trust Board for these purposes.

3) Information in relation to the use of the Mental Health Act within HPFT:

The use of the MHA nationally has increased year on year which has led to a review of the MHA legislation and its use, however due to COVID-19 progress was limited. The MHA white paper consultation has now been concluded.

The following graph shows a snapshot of the use of the MHA in HPFT during 2020/21 compared to previous years reporting periods.



	Formal Admissions	Regrade to S3 from S2	Use of S136	CTOs on 31/03	CTO + Detentions on 31/03
2017/18	701	181	752	90	308
2018/19	735	170	920	120	321
2019/20	676	200	808	95	329
2020/21	727	232	764	112	362

* 7% ↑ 17% ↑ 5% ↓ 17% ↑ 10% ↑

**Changes from 2019/20 to 2021/20 reporting period.*

Although there has been a decrease of 5% in the number of patients detained under S136 to an HPFT PoS from 2019/20 to 2020/21 there has been an increase in the number of patients who were detained and assessed at other places of safety e.g. General Hospitals, in this reporting year

The Trust is actively involved in the S136 Interagency meeting, which reports into the Crisis Care Concordat, working to address increases and ensure best practice is applied.

4) Legislation Update

4.1 MHA Legislation Review

The government published its White Paper on 13th January 2021. This was followed by a 12-week public consultation and the government plans to draft a revised Mental Health Bill, which will be introduced when Parliamentary time allows.

The Trust responded to the White Paper on 21st April 2021. The consultation within the trust was led by the Directorate Manager for Mental Health Legislation.

The Government response to the White Paper consultation was issued 15th July 2021, more information here.

In order to be prepared for the potential requirement for restructuring the teams to support these changes and any additional resources that may be required, a scoping and proposal will be drawn up by the Directorate Manager for the Mental Health Legislation, with support from the Finance Department. The Mental Health Legislation Quality and Policy Group, operational leads and multi professional representatives will be consulted to inform this early work.

4.2 Liberty Protection Safeguards

The Liberty Protection Safeguards are due to replace the Deprivation of Liberty Safeguards and it was envisaged that these would be implemented in October 2020 however, due to COVID-19 this was delayed until April 2022 and it is not now expected to come into effect until October 2022. The MH Legislation department (MHLD) will continue to monitor any progress through Parliament to ensure that any changes to MH Legislation are implemented and communicated in a timely manner.

5) COVID-19 and the Mental Health Act

5.1 Coronavirus Act

The Coronavirus Act was passed on 26th March 2020, within the Act there were a number of amendments to the MHA which could be enacted if they were needed in specific circumstances, however these amendments were withdrawn September 2020 as they were deemed to be unnecessary.

5.2 Visitor Guidance

The majority of hospitals in England stopped all visitors regardless of COVID status, however NHSE national guidance issued incorporated the requirement for visits to be facilitated wherever possible and alternatives sought to facilitate visits although not solely face to face. Visitor guidance has been revised and issued in line with national guidance by the MH Legislation department as lockdown is gradually lifted.

5.3 Section 17 Leave

Section 17 leave guidance continues to be updated in line with national guidance as the lockdown has lifted. The guidance also ensured that there were no blanket restrictions on patients s17 leave.

5.4 Guidance when patients refuse to self-isolate

Guidelines were issued to staff so that they were able to distinguish when or if MH legislation was appropriate to isolate a patient showing COVID-19 symptoms. As the MHA does not authorise treatment for a physical health need unless it is a manifestation of a mental disorder, the MHA cannot be relied upon to isolate a patient purely because they are detained under the MHA. The Mental Capacity Act would only apply if a patient did not have the capacity to understand why they needed to isolate and it was in their best interests to do so. Each case must be considered on its merits and decisions must not include blanket restrictions.

5.5 Virtual Assessments & Unlawful Detentions

Due to the risks associated with COVID-19 NHSE and the Department of Health issued guidance for the use of technology i.e. video links could be used for MHA assessments.

However in February 2021 there was a court ruling, Devon Partnership NHS Trust v SSHSC [2021] EWHC 101 (Admin), that deemed that remote examination for the purpose of detention under the Mental Health Act was unlawful. All HPFT detentions from March 2020 to March 2021 were reviewed to ensure that there had been none completed virtually, we were satisfied that there were no unlawful detentions in HPFT. There were, however, a number of Community Treatment Order (CTO) patients, 17, who had been examined remotely for the purposes of extending the CTO, it was agreed by the Medical Director that they should be discharged from their section; all patients discharged were written to with an explanation of why their CTO was discharged, all letters were sent via their community team.

5.6 Electronic Forms

There have been amended MHA regulations and new statutory forms. The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 came into force on 1st December 2020. The Regulations allow for MHA statutory forms to be served by electronic means if the body or authority in receipt of the forms agrees to receive them electronically. There are two exceptions to this general rule:

- documents cannot be served on service users by electronic means, e.g. CTO recall notices, and
- hospitals cannot refuse to accept electronic service of applications for detention solely because they are being served electronically (NB. hospitals retain the power not to accept applications that do not appear to be duly made, irrespective of how they were served).

All statutory forms on the intranet have been updated and work continues with Hertfordshire County Council Approved Mental Health Professional (AMHP) service to support the safe and effective implementation of the new Regulations.
Systems are now in place for a fully electronic system but in practice most staff are still using paper and it may take some time to change this. Completion and transmission of forms in paper will remain a lawful option for the foreseeable future.

Hertfordshire County Council have commissioned an electronic document system through S12 Solutions, this is due to go live in September 2021 which should reduce the number of forms being completed incorrectly.

5.7 Video links for MHAM hearings and Tribunals

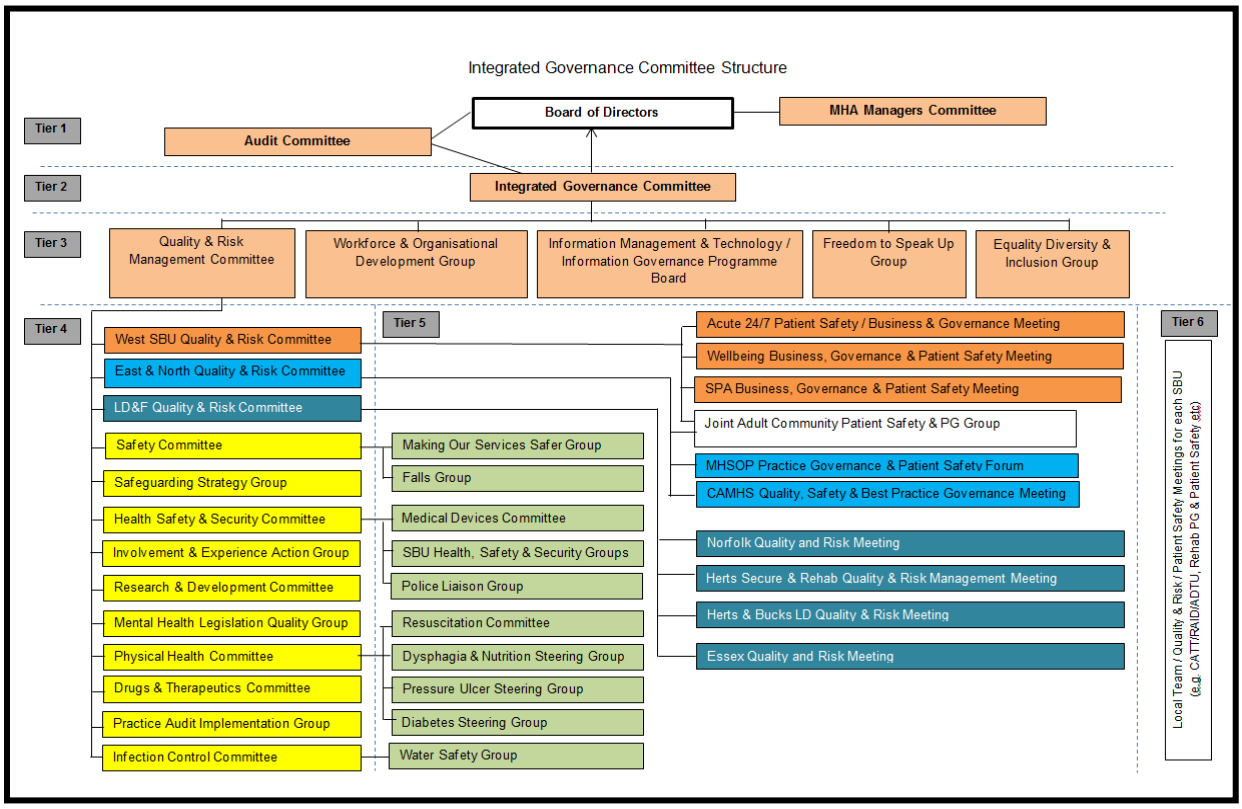
Since the lockdown MHAM and First Tier tribunals (FTT) have continued in HPFT, initially hearings were held as paper reviews and discussion took place via the phone, however these have been replaced by video hearings which enable the patient to attend should they wish. All MHAM hearings are now held as a MS Teams meeting which ensures that the patient and their legal representative can be seen and heard. Community patients are able to attend the hearing at their local CMHT or arrangements can be made for them to attend one of the inpatient units.

MHAM were given NHS.net accounts so that reports could be emailed securely to them with the strict instruction that they were not to be printed off.

IM&T department have been involved with ensuring that all units have satisfactory equipment to enable them to participate fully by video for both MHAM hearings and Tribunal Hearings.

6) MHAM Committee Meeting Structure

There is an annual Trustwide Committee meeting for all HPFT MHAM which is a Committee of the Board and membership of all NEDs is included in Terms of Reference; this meeting combines training, development and discussion events.



Until February 2021 there were 3 sub committees of the board, Hertfordshire, Essex and Norfolk, however as all hearings are now being done remotely, and this is envisaged to continue for some time, the committees have amalgamated so there is now just one pool of MHAMs.

7) The Team of MHA Managers

There is a NED lead for MHAM and a Manager of the Mental Health Act Manager (non-employee). These appointments continue to ensure a clear line of responsibility and accountability to the Board.

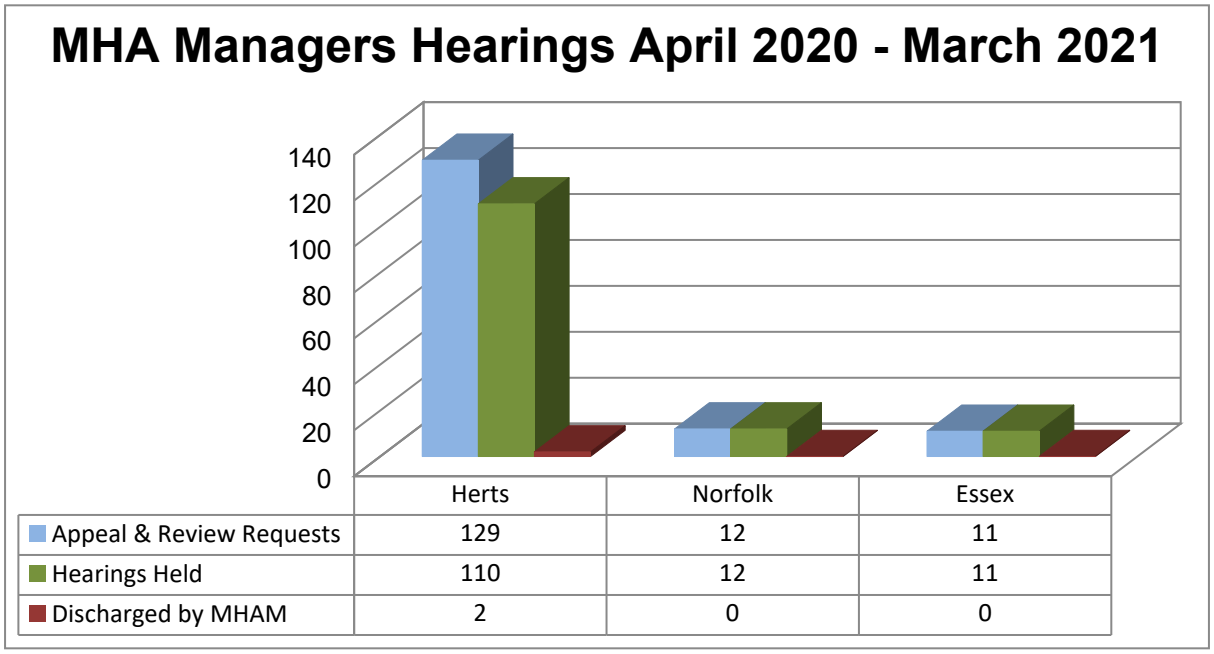
MHAM have an annual review/appraisal to reflect on their previous year's activity. In 2020/21 these were undertaken with the Manager of the MHA Manager Service and the NED lead. The Code of Practice states that appointments to MHAM Panels should be made for a fixed period and that any reappointment should not be automatic and should be preceded by a review of the person's continued suitability. The Trust complies with this by appointing MHAM for a further year subject to the successful outcome of the appraisal meeting. These review meetings are also used as an opportunity to identify potential new

Panel Chairs and to inform the training/discussion group programme and development of the Service.

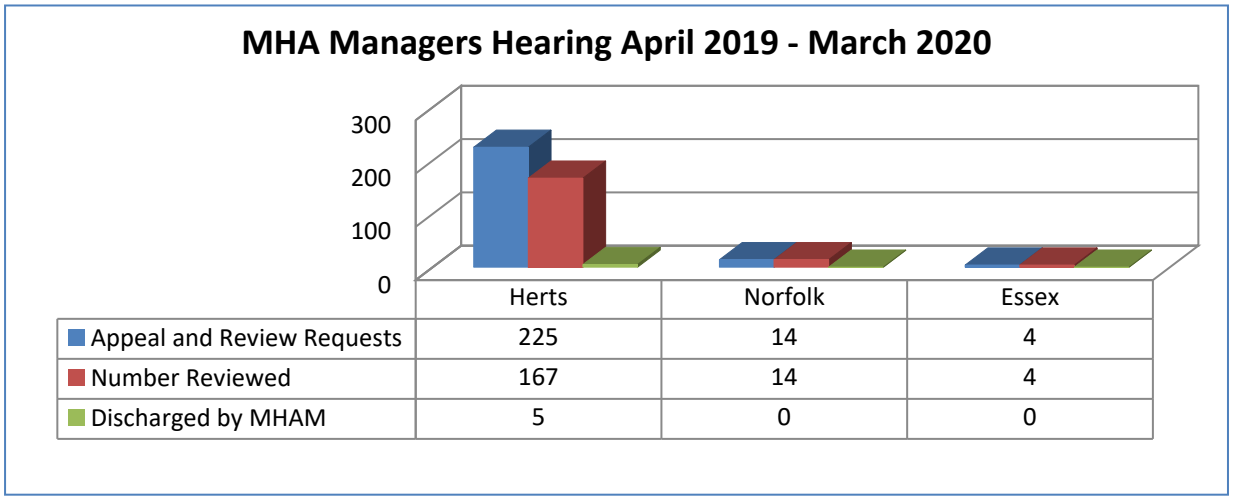
Hertfordshire Partnership University NHS Foundation Trust has 36 active MHAM, 15 of whom are Chairs. There has been a decrease in the number of active MHAM as hearings are taking place remotely due to connectivity issues.

8) MHA Managers Hearings

Patients subject to compulsion orders under the MHA that can be renewed or extended must have the renewal/extension reviewed by the MHAM, (patients subject to compulsion can also appeal against their section to the MHAM). The figures for 2019/20 are higher than those of 2020/21, this is possibly due to the reduction of MHAM appeals due to Covid.



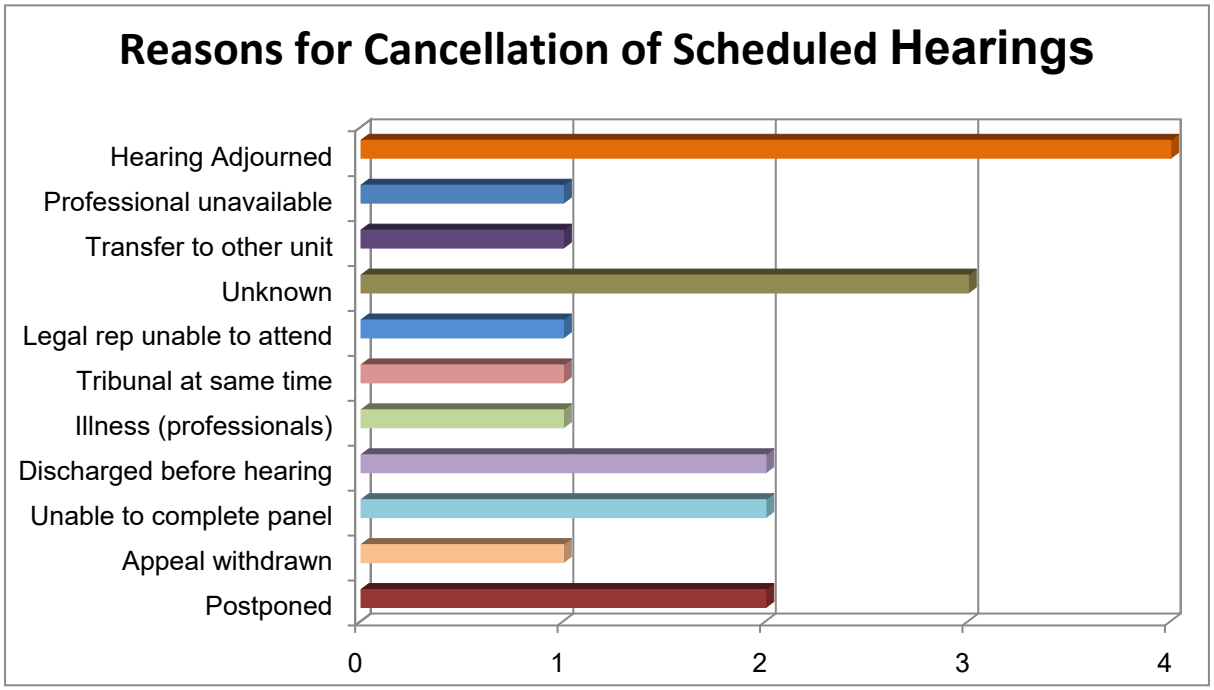
	Herts	Norfolk	Essex
Appeal & Review Requests	129	12	11
Hearings Held	110	12	11
Discharged by MHAM	2	0	0



	Herts	Norfolk	Essex
Appeal and Review Requests	225	14	4
Number Reviewed	167	14	4
Discharged by MHAM	5	0	0

*Excludes CTO Paper Reviews

The following chart shows reasons why hearings were not held across the Trust.



If a patient subject to a CTO has the capacity to decide that they do not wish to contest the extension of their CTO and do not want to attend a review hearing the MHAM can review the decision to extend based only on reports by the responsible clinician (RC) and care coordinator (CC), a paper review. Should further information be required in order to make a decision and the RC or CC is not available on the 'phone to provide the information the MHAM will adjourn the review and request that a hearing with the RC and CC is held.

There are no more than two consecutive paper reviews before a hearing with the RC and CC is held.

61 patients had their CTOs reviewed based on the reports during 2020/21, there were no adjournments for a full hearing.

9) First Tier Tribunals (FTT)

All patients subject to the MHA have the right to appeal to the FTT for a review of their section and the MHAM have a duty to refer a patient at specific intervals during their compulsion.

Appeals/Referrals Requested	Number Reviewed 2020/21	Discharged by FTT
317	**196**	**15**

10) Committee Meetings, Discussion Groups and Training 2020

The HPFT MHAM Annual Committee Meeting 11th December 2020 was held via MS Teams. This included:

- An HPFT update from Tom Cahill and Christopher Lawrence,
- Discussion around the outcomes of the annual appraisals
- Discussion of merging the sub-committees into one
- MH Legislation update by Tina Kavanagh

11) Achievements and Acknowledgements

The year has continued to provide challenges for all involved in the provision of this service as the demand continues to rise.

The on-going efforts and improvement in the structure and contents of Responsible Clinician, Nursing and Social Care Reports is acknowledged and particularly appreciated by the MHAMs.

The work of Hattie Llewelyn-Davies in her role as Manager of the MHAM is much appreciated and has provided cohesion in the service.

On behalf of the Board, I wish to thank Tina Kavanagh and the MH Legislation team, for the commitment, knowledge and professionalism that they have shown to our service users and carers.

Finally, I would like to thank the MHAM who carry out this delegated role on behalf of the HPFT Board for their contribution & dedication throughout the year.

The MHAM area of the HPFT website has been valued by the MHAM and our thanks to the Trust for providing this.

The process for MHAM to raise concerns directly with the Manager of the MHAM service appears to be working well. All issues highlighted as a concern when MHAM attend hearings have been dealt with in a transparent manner and there are clear governance arrangements around this.

Due to COVID-19 ways of working have had to be adapted in order for the MHAM to continue with the requirements of the Code of Practice to review all renewals and extensions. The use of MS teams has proven successful and is a similar way of working to how the First Tier Tribunal is currently operating. It may well be that when the pandemic subsides this could remain as an option for community patients to engage with the hearing process as they would not need to come to a hospital site for a hearing and could be at the CMHT or in their own home.

12) Priorities for 2020/21

There are a number of priorities for the forthcoming year for the MHA Manager Service

- On-going training and MH legal updates in respect of the MHA and its interface with MCA and DOLS in particular with regard to changes in the law.
- On-going work to try to gain feedback from Service Users about their experiences of MHAM Hearings and to actively take account of this feedback.
- On-going support to all MHAM to ensure a consistent and integrated service across all sites.
- To ensure that learning resources for guidance on the MHA and MCA is available electronically for the MHAM, including access to e-learning.
- To ensure vacancies are widely advertised in order to continue the progress being made towards achieving greater diversity in the pool of MHA Managers, particularly around age, ethnicity and disability.
- To encourage more MHAM to become chairs and develop a robust support plan for their training plan
- To ensure that MHAMs are aware of the MHA Code of Practice and that the training programme addresses the requirements of the Code of Practice overall and specifically in respect of understanding risk, in addition to all other relevant policies
- Ensuring that use of technology for hearings continues to be effective.
- Encouraging participation of community patients with hearings by the use of technology.

13) Future Annual Reports on the Service

A future report will be submitted to the Trust Board in one year.

Report produced by Hattie Llewelyn-Davies/Tina Kavanagh
on behalf of

July 2021

Board of Directors PUBLIC

Meeting Date:	29 July 2021	**Agenda Item:** 23
Subject:	Review of Committee Terms of Reference	**For Publication:** Yes
Author:	Janet Lynch, Interim Director of People and Organisational Development	**Approved by:** Janet Lynch, Interim Director of People and Organisational Development
Presented by:	Sarah Betteley, Chair	

Purpose of the report:

The purpose of this report is to update the Board on the recommendations for some minor changes to the Nomination & Remuneration Committee terms of reference. The recommendations follow the completion of a review in line with annual requirements.

The recommendations were approved at the Nominations & Remuneration Committee held 20 July 2021.

Action required:

Members of the Board are asked to consider and ratify the changes to the Nominations & Remuneration Committee Terms of Reference.

Summary and recommendations to the Board:

Summary

The Terms of Reference for the Nomination & Remuneration Committee were reviewed by the Committee at its meeting on 20 July 2021. The Committee considered and approved two amendments:

a) Inclusion of reference to national guidance/ advice in relation to all aspects of salary/ terms of service for those post within the Committee remit.
b) Delete reference to performance related pay (PRP).

Recommendation

The Board are asked to approve the amended Terms of Reference in line with the recommendation from the Nomination & Remuneration Committee.

The revised Terms of Reference are included as appendix 1.

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 and Public & Patient Involvement Implications:

There are no specific equality and diversity implications as a result of this paper.

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

Rem Com 20 July 2021

Appendix 1

NOMINATIONS AND REMUNERATION COMMITTEE TERMS OF REFERENCE (draft July 2021)

1. Establishment

1.1 The Nominations and Remuneration Committee is a Committee of the Trust Board of Directors.

2. Purpose

2.1 The Committee is responsible for:

2.1.1 Reviewing and making recommendations to the Board of Directors on the composition, balance, skill mix and succession planning of the Board. It recommends to the Board of Directors the appointment of Executive Directors.

2.1.2 Setting the remuneration policy for the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2.1.3 Approving contracts of employment for the Chief Executive, Executive Directors, and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2.1.4 Agreeing arrangements for termination of contracts, including severance payments paid to the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2.2 The Committee will also be mindful of the gender pay gap and take account of equal value and equal pay principles and legislation for the group of staff it has responsibility for.

2.3 The Committee will take into account relevant national guidance and advice where necessary.

3. Membership and Quoracy

3.1 The Committee shall consist of all Non-Executive Directors of the Board of Directors.

3.2 The quorum for any meeting of the Committee shall be attendance of a minimum of three members.

3.3. The chair of the Committee shall be the Chair of the Board of Directors.

4. Attendance at Meetings

4.1 The Chief Executive will attend all meetings, except when their own performance and remuneration are under consideration.

4.2 The Executive Director of People and Organisational Development shall be in attendance when invited by the Committee and shall provide the Committee with such information and advice as they require.

4.3 It is expected that all members will attend at least three quarters of all meetings per financial year. An attendance record will be held for each meeting and an annual register of attendance will be published.

4.4 Every effort shall be made to ensure that the decisions of the Committee are made within its properly constituted meetings. In exceptional circumstances, where very urgent and unanticipated decisions are required to be taken, these may be requested by email circulation to all Committee members. In order for a Committee decision made in this way to be effective, it shall require the prior approval of the Committee Chair that the urgent decision be made in this manner and a positive response from at least 70% of Committee members (which shall include the Committee Chair and Deputy Chair) signifying their assent to the decision.

4.5. The Chair may request attendance by relevant staff at any meeting.

5. Frequency of Meetings

5.1 Meetings of the Committee will be held at least quarterly.

5.2 Meetings will be convened by the Chair and can also be requested by the Chief Executive or their nominated deputy.

6. Authority

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference.

6.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent advice, and to secure the attendance of external individuals with relevant experience and expertise if it considers this necessary.

7. Duties

7.1 To regularly review the composition, skills and experience of the Board of Directors and to make recommendations to the Board.

7.2 To ensure appraisals are undertaken for all Executive members of the Board of Directors.

7.3 To ensure a succession plan is in place and appropriate actions are taken to ensure the continued leadership of the Trust.

7.4 To ensure an appropriate process is in place for the appointment of the Chief Executive and Executive Directors and to recommend the appointment of Executive Directors to the Board of Directors and the Chief Executive to the Board of Governors.

7.5 In conjunction with the Council of Governors Appointments and Remuneration Committee and the Council of Governors, ensure that the process for appointing the Trust Chair and Non-Executive Directors, and the process for appointing the Chief Executive and Executive Directors are aligned.

7.6 To maintain an overview of the relationship between total remuneration and that of the market equivalents for the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive. The Committee will, where appropriate, commission others to collect market information on salaries and other forms of reward to ensure it is sufficient to attract, retain and motivate the relevant individuals, whilst ensuring it is not more than is necessary for this purpose.

7.7 To advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Executive, Executive and non-voting Directors, and other senior managers reporting directly to the Chief Executive, taking account of such national guidelines as is appropriate. This will include:

- All aspects of salary (including any performance related element / bonuses).
- Provisions for other benefits, including pensions and allowances.
- Agreement of contracts of employment and if applicable terms of office.
- Arrangements for termination of employment and other contractual terms, including the proper calculation and scrutiny of termination payments taking account of such national guidelines as is appropriate.

7.8 To consider a report annually from the Chair on the performance of the Chief Executive and from the Chief Executive on the performance of Executive Directors and determine any adjustment to salary.

7.9 Ensure that the right performance and talent management arrangements are in place for the individuals and groups in 2.1.2.

7.10 To agree the annual inflationary uplift on pay and reward for the Chief Executive, Executive and non-voting Directors, and other senior managers reporting directly to the Chief Executive.

7.11 Scrutinise and agree severance terms for the termination of a contract of employment for an individual covered by this Committee giving due regard to HM Treasury requirements and ensuring compliance with the NHS Improvement guidance for NHS Trusts and Foundation Trusts on processes for making severance payments.

7.12 Undertake any other duties as directed by the Board.

8. Administrative Support

8.1 The Committee will be supported by the Company Secretary, in attendance for all meetings except when issues regarding their own salary are discussed.

8.2 The administrative support in this respect will include:

8.2.1 Agreement of the agenda with the Committee Chair.

8.2.2 Collation and distribution of papers at least five working days before each meeting.

8.2.3 Taking the minutes and keeping a record of matters arising and issues to be carried forward.

8.2.4 Providing support to the Chair and members as required.

9. Accountability and Reporting arrangements

9.1 The Committee shall be directly accountable to the Board of Directors.

9.2 The minutes of all meetings shall be formally recorded and a six monthly report provided to the Board of Directors on its work in discharging its responsibilities, delivering its objectives and complying with its Terms of Reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.

10. Monitoring Effectiveness and Compliance with Terms of Reference

10.1. The Committee will carry out an annual review of its effectiveness and compliance with its Terms of Reference.

11. Review of Terms of Reference

11.1. The Terms of Reference of the Committee shall be reviewed at least annually by the Committee and approved by the Trust Board.

Date approved: **Nominations and Remuneration Committee 20 July 2021**
Approved by: **Board of Directors xxx**
Next review date: **July 2022**