Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC meeting

The Colonnades

30 September 2021 10:30 - 30 September 2021 13:00

INDEX

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 30 September 2021
Da Vinci A,B & C
Time: 10.30am – 13:20pm

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 29 July 2021**	Chair	**Approve**	Attached	11:00
5.	**Matters Arising Schedule**	Chair	**Review & Update**	Attached	
6.	**CEO Brief**	Tom Cahill	**Receive**	Attached	11:05
7.	**Chair's Report**	Chair	**Receive**	Verbal	
	QUALITY & PATIENT SAFETY				
8.	**Covid-19 Update**	Jacky Vincent	**Receive**	Attached	11.20
9.	**Report of the Integrated Governance Committee held: 16 September 21** **a) Q1 Integrated Safety report** **b) Q1 Safe staffing** **c) PSED and EDS2**	Diane Herbert Jacky Vincent Jacky Vincent Jacky Vincent	**Receive** **Receive** **Receive** **Receive**	Attached Attached Attached Attached	11.25
10.	**Emergency Prepardness, Resilience & Response – Core Standards**	Sandra Brookes	**Receive**	Attached	11.40
	OPERATIONAL AND PERFORMANCE				
11.	**Report of the Finance & Investment Committees held: 16 August 2021 and 22 September 2021**	David Atkinson	**Receive**	Attached	11.55
12.	**Performance Report**	Paul Ronald	**Receive**	Attached	12.05
13.	**Finance Report – Month 5**	Maria Wheeler	**Receive**	Attached	12.15
14.	**People Report**	Janet Lynch	**Receive**	Attached	12.20
15.	**East of England Collaborative**	Sandra Brookes	**Receive**	Attached	12.30
	STRATEGY				
16.	**Planning:** **a) Update on 2021/22**	Maria Wheeler	**Receive**	Attached	12.40

	b) H2 planning				
17.	**Mental Health and Learning Disabilities Collaborative Update**	Karen Taylor	**Receive**	Attached	12.50
	GOVERNANCE AND REGULATORY				
18.	**Report of the Audit Committee held: 9 September 2021**	Catherine Dugmore	**Receive**	Attached	13.05
19.	**Well Led Review Update**	Helen Edmondson	**Note**	Attached	13.15
	Any Other Business	Chair			
	QUESTIONS FROM THE PUBLIC	Chair			
Date and Time of Next Public Meeting: Thursday 25 November 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

September 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
Catherine Dugmore	Non-Executive Director	WWFUK Trustee RGB Kew Trustee Natural England Board Member

		Aldwickbury School Trust Limited Housing 21 Board Member
Helen Edmondson	Head of Corporate Affairs & Company Secretary	Nil Return
Diane Herbert	Non-Executive Director	Shareholder in own coaching/leadership business
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
Janet Lynch	Interim Director People & OD	Harpenden MacMillan Fundraising Committee Member
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
Jacky Vincent	Director Quality & Safety (Chief Nurse)	Member Director of Nursing Forum, National Mental Health & Learning Disability Honorary Fellow at University of Hertfordshire
Jon Walmsley	Non-Executive Director	Independent Board Member of Ravensbourne University, London | Would recuse from any relevant discussions. Trustee on Board of homelessness charity: 'Accumulate' (1170009) | Would recuse from any relevant discussions
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 29 July 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
Karen Taylor | KT	Deputy CEO & Director, Strategy and Integration
Paul Ronald | PR	Director of Performance Improvement
Dr Jane Padmore | JPad	Director, Quality and Safety
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Maria Wheeler | MW	Director Finance, Performance and Improvement
Janet Lynch JL	Interim Director of People and OD
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
Dr Rakesh Magon | RM	Deputy Medical Director
Jacky Vincent | JV	Deputy Director of Nursing, Quality & Safety & DIPC
Mark Graver | MG	Deputy Director Communications
Katie Dyton | KD	Interim Experience Lead (Agenda Item 3 only)
APOLOGIES	
Prof Asif Zia | AZ	Director, Quality & Medical Leadership

Item	Subject	Action
061/21	**Welcome and Apologies for Absence** SBe welcomed all to the meeting. Apologies for absence were received from Professor Asif Zia.	
062/21	**Declarations of Interest** The Declarations of Interest Register was noted. **NOTED**	
063/21	**Shared Experience** Michelle P shared a very emotive story of her daughter and their family's experience with the Crisis Team and Community Mental Health Team.	
064/21	**Minutes of the Meeting held: 20 May 2021** The minutes were reviewed and approved as an accurate account of the meeting.	

	Minutes of the Annual Accounts meeting held: 10 June 2021 The minutes were reviewed and approved as an accurate account of the meeting. **APPROVE** **The Board APPROVED the minutes**	
065/21	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
066/21 **Action**	**CEO Brief** TC presented the CEO Brief to the Board which was taken as read. Headline messages of note to the Board were: COVID figures nationally were declining however the rate of hospitalisations were still going up. TC noted the two groups with one welcoming the ease of lockdown restrictions and the other nervous about this happening. Major changes in terms of the NHS architecture with NHS England and Improvement (NHSE/I) publishing their final System Oversight Framework 2021/22 in late June also accompanied by the new oversight framework metrics. TC continued reporting that the work on ICS boundaries had now concluded with no changes for the East of England. In terms of national leadership Sajid Javid was appointed Secretary of State for Health and Social Care on 26 June 2021 and Amanda Pritchard had been appointed Chief Executive of NHS England, which was welcome news. The Mental Health Act had issued new guidance with a change to the sectioning of learning disability patients. On 22 July NHSEI had announced a consultation on proposed new MH access standards. An update would be brought back to a future board. TC reported on the appointment of Paul Burstow as Chair of the ICS although as yet there had been no formal announcement. Recruitment to the post of Chief Executive was now underway. Significant guidance had been released on Place Based Partnerships. The East of England (EOE) Provider Collaborative – New Care Models went live on the 1 July 2021. Following Nick Carver's announcement to retire as Chief Executive of East and North Herts Trust at the end of the year, Adam Sewell-Jones had been announced as the new Chief Executive. Jo Fisher had been appointed Director of Children's Services at Hertfordshire County Council following the retirement of Jenny Coles. Operationally we were extremely busy and under constant pressure. In terms of COVID, we had one inpatient and seventeen suspected in the community. There were eight members of staff who were positive with thirty four staff in	

	self-isolation however most of these were able to work. As a Trust we would be keeping a close eye on these figures. For our workforce we were seeing pressures from the impact of COVID with our vacancy rate increasing. We continued to implement our wellbeing programme with a range of virtual activities offered to staff with a summer Wellbeing festival being held throughout August. Finance wise were stable and meeting our targets however we did not know what the second half of the year would look like. The Election process for Governors completed with our new Governors starting on the 1 August 2021. The process to recruit a new Chief Executive Officer had started and was expected to complete by the end of August. TC concluded the update noting it was Jane Padmore's last day after 7 years of service with the Trust. Questions were invited. Board members discussed CAMHS's waiting list times pre and post Covid. Herts LD collaborative MH Strategy consultation and work with PCN's and primary care. It was noted that service visits had been implemented for NEDs. **RECEIVED** **The Board RECEIVED the CEO Update**	
067/21	**Chairs Brief** SBe provided the Board with a verbal update on her activity since the last Board meeting. SBe advised she had attended a number of meetings and sessions with high profile speakers, all giving similar messages of tremendous pressure, people recovery and an overarching note that the answer was not 'more of the same'. SBe continued reporting she had attended a number of Trust sites including Oxford House, Holly Lodge, Gainsford House, Hampden House and The Beacon with SBe commenting on the positive attitude of staff. SBe had also visited The Lister where she had met with Ellen Schroder. SBe concluded advising she and TC had meet with Richard Roberts, the new Council Leader on the 26 July. No questions were put forward. **RECEIVED** **The Board RECEIVED the Chairs verbal Briefing**	
	QUALITY & PATIENT SAFETY	
068/21	**Report of the Integrated Governance Committee held:** **15 July 2021** DH presented the report which was taken as read and provided a short	

	summary with the key highlights: The Group considered a paper on Respect Training. It was noted that this remained a high-risk area with some issues outstanding. The Committee had agreed to keep on the item on the IGC agenda to monitor and gain assurance. The Group had received the Gender Pay Gap (GPG) noting the reduction in the percentages from March 2019. It was agreed that a future Committee would consider a more detailed report on the Gender Pay Gap. The Committee received a Deep Dive on the MOSStogether Strategy. The Committee had noted the strategy included proactive approaches and methodologies with shared decision making at its heart. The Committee approved two new risks which were were added to the Trust Risk Register relating to CAMHS Eating Disorders Team demand exceeding capacity and national shortage of specialist CAMHS beds. The Committee received an update on the People Internal Audits noting a significant proportion had been closed and the majority of the remaining actions related to workforce planning and were on track for completion. DH made acknowledgment to JL and her team for the good work. The Committee was informed that nationally the CQC had begun a programme of announced well-led and unannounced core inspections and preparations at the Trust were underway. DH concluded the update reporting on the award won by the Pharmacy Team for a pharmacist-led medicines optimisation clinic at Colne House. This had been shortlisted at the Health Service Journal (HSJ) Patient Safety Awards, and its evaluation published in the Journal of Medicines Optimisation. DH paid tribute to the staff who, despite the challenges faced, had continued to innovate and share best practice. JL commented stating she would like to draw the board's attention to the review of the Disciplinary Policy which was being undertaken and providing assurance we were compliant. HE referenced the ICO Data Breach confirming this had formally closed with no further action required. No questions were put forward. **RECEIVED** **The Board RECEIVED the report**	
	Q1 Guardian of Safe Working RM presented the paper which provided the Board with the Quarterly Guardian Report, covering the period April to June 2021. In this quarter there had been one exception report. Overall, there had been a significant decrease in bank locum spend since the previous report. In addition, sickness overall had reduced. **RECEIVED**	

	The Board RECEIVED the report	
	Quality Accounts RM presented the Quality Accounts which gave an overview of our performance against the priority indicators for 2020/21. The paper also introduced the agreed priority indictors for 2021/22 following a period of consultation. Of note to the Board: Ten priority indicators were chosen of which six of these were a continuation from last year and four were new. Greater detail was contained within the paper which provided an overview of which indicators were chosen, the rational as to why they were chosen and demonstrated how the target had changed from the previous year if the goal remained the same. **RECEIVED** **The Board RECEIVED the report**	
069/21	**Medical Appraisal & Revalidation Annual Report** RM advised the report provided the Board with Quality Assurance with regard to the Responsible Officer and Revalidation. The report was taken as read with the below points noted to the Board. There were 184 doctors linked to HPFT and of these 123 had completed their appraisal. Reasons for those who had not undertaken were: 8 doctors were on long term sickness 3 on maternity leave 21 had left the Trust 29 had approved missed appraisals which were due to challenges of COVID 19 were in line with national deferral policy Overall, the Trust was compliant. No questions were put forward. **RECEIVED** **The Board RECEIVED the report**	
	OPERATIONAL & PERFORMANCE	
070/21	**Report of the Finance & Investment Committee held: 21 July 2021** DA presented the report which provided a summary of the items discussed at the Finance & Investment Committee meeting held on the 21 July 2021. The meeting had welcomed MW to her first meeting in the role of Director of Finance, Performance and Improvement. The Committee had received an excellent presentation as part of a Deep Dive into the Model for Improvement. An update on the Capital Investment Programme for Quarter One had been received with the Committee noting the allocation for 2021/22 was confirmed at	

	£16.1m. It was noted that the Trust had made a bid for further funding and was awaiting confirmation from NHSE/I.I The Committee considered a number of business cases which formed part of the Capital Investment Programme for 2021/22, in particular: Kingfisher Court – Replacement Windows CCTV Installation – Warren Court & Albany Lodge Safety Suites for Astley Court and Beech Ward It was noted that where required the Board would be asked to approve the relevant Business Cases. DA advised that the Committee had noted that the business case for the refurbishment within Lexden was currently not finalised with agreement an extraordinary Finance and Investment Committee to be held prior to the scheduled meeting in September to consider the Business Case. The Committee had received a report which had provided an update on the National Cost Collection (NCC) work. The Committee received an update on the business development work underway noting that discussions with commissioners continued to be positive with the Trust being near to finalising the contract for 2021/22. The Committee received a presentation on the quarter one Annual Plan performance and noted the significant progress across all seven Strategic Objectives. An update was provided for the Annual Accounts and Annual Report process for 2020/21 with the Committee noting this had been completed on time and laid before Parliament on the 28 June. The Trust was expected to continue to be on plan for Half 1 with relative high level of confidence to be on plan for Half 2. The Committee received a report which detailed performance of the Trust up to month two of 2021/22 against the 68 national, regional and local indicators. An update was provided on the Delivering Value Efficiency Programme with the Committee noting the target value was set at £7.0m for 2021/22. The Committee were advised that good progress had been made with the EoE Collaborative with all contracts signed, finance agreed and the establishment of the central commissioning team. DA concluded his update advising the Committee had received the first of what would be a regular report on the Digital strategy and noted the positive progress. No questions were put forward. **RECEIVED** **The Board RECEIVED the report**	
	Q1 Performance Report PR introduced the report which set out the Trust's performance against both	

	the NHS Oversight Framework (NHSOF) targets and the Trust Key Performance Indicators for Quarter 1 2021/22. The report was taken as read with the below points highlighted to the Board. PR reflected on the demands and pressures with annual leave, test and trace, reduction of beds etc commenting this was a difficult landscape to navigate. It was important for the Board to note that critical KPIs including access into all services (in both crisis and referrals), safety and safe staffing remained strong. To address the pressures the Trust were looking at sourcing extra beds, looking at recruitment to increase staffing, accelerating digital spend and rescheduling non priority work. PR reported on our forward forecast along with areas of strong performance and those areas of concern/focus. Further detail was laid out in the body of the report. PR concluded advising that at the end of Quarter 1 we were slightly behind some of our performance indicators. It was reported there had been the recent announcement of potentially five new access targets, the Trust was reviewing the impact of these and this would be reported to FIC at a future meeting. **RECEIVED** **The Board RECEIVED the report**	
071/21 **ACTION**	**Q1 Annual Plan update** KT presented the report which was taken as read. Points of note for the Board were: Quarter 1 had been a busy and challenging quarter commenting that our teams had worked extremely hard and continued to deliver great care despite the pressure from increasing demand and acuity. 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 were the increased number of suspected suicides during the quarter, increased out of area placements, IAPT referral rates, and progress with social care placements. For those areas currently not on target action would be taken during Quarter 2 to mitigate this and recover the position. **RECEIVED** **The Board RECEIVED the report**	
072/21	**Q1 Finance Report** MW advised that the report set out a summary of the year end for 2020/21, and the financial position to 30 June 2021 along with an early indication of the expected position for the remainder of Half 1 and for Half 2. The report was taken as read and the below points of note highlighted for the Boards attention.	

	The Annual Accounts and Annual Report process for 2020/21 were submitted on time with the Accounts receiving an unqualified audit opinion. In terms of income, it was made up of two halves with Half 1 on track and Half 2 having a lesser degree of certainty. Significant additional income was expected from SDF and SR monies and discussion continued with Hertfordshire commissioners which was expected to be completed imminently. Planning guidance was not expected until September however the Trust would act to mitigate as far as possible. In conclusion it was fully expected the Trust would report on Plan for Half 1 and also for Half 2 with a degree of less certainty given the lack of information. This would continue to be monitored and the Board kept briefed. **RECEIVED** **The Board RECEIVED the report**	
	PEOPLE	
073/21	**Q1 People & OD Report** JL introduced the paper which was taken as read. The paper provided the Board with an update on the People and OD activities during Quarter 1 along with the key metrics/outcomes achieved during the period. Key headlines for the Board's attention were: Vacancy rates and staff turnover had increased. Work was in place to address this with detail outlined in the body of the report. Reasons for staff turnover were linked to work/life balance and career development. There was good news for appraisal compliance which was now at just over 89%. Statutory and essential training was now very close to target. Respect training remained a risk. In terms of activity this quarter we had: Implemented our refreshed People Plan Priorities, which flowed from the Annual Plan and the NHS People Plan. A workforce plan for the Trust was developed during Q1 following a workforce planning audit. We have continued to make progress in supporting staff wellbeing including launching a number of new strategic projects and continuing to develop our 'on the ground' support for staff. Our focus for quarter 2 would be recruitment and retention. JL concluded stating during August we would be holding a Summer Wellbeing Festival and welcomed Board members to attend. JL invited questions.	

	A discussion was held around turnover rates with JL reporting work was underway to look into more granular detail around this. SBr added that for CAMHS it was key to develop new and different roles and to promote the organisation and market ourselves as a 'stand out' Trust. We were also looking at the re-introduction to the rotation of nurses. **RECEIVED** **The Board RECEIVED the report**	
074/21	**Gender Pay Report** JL presented the report which was taken as read. Of note to the Board were the below points: The report 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. This had been delayed due to Covid. 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%. There was a limited amount of data compared to other Trusts however ours did seem to compare favourably with other organisations however it was too early to do a full comparison. Page 8 of the report outlined our actions to improve our current situation. It was noted that the IGC would be receiving a detailed report at a future meeting, including information on disability. **RECEIVED** **The Board RECEIVED the report**	
	STRATGEY	
075/21	**System Developments** **Future demand for Mental Health** KT presented highlights from the Niche report , taking the full report as read, she set out next steps. KT noted the overwhelming evidence from the impact of the COVID pandemic on mental health and learning disabilities both in the short and longer term. 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	

ACTION	take some time to fully implement. They are expected to contribute to a permanent change in the way services function. KT referred to the slide deck which set out four key areas of focus: • Promoting Wellbeing and earlier intervention in mental illness • Building resilience in disadvantaged communities • Developing specialist services • Enabling recovery / encouraging engagement with services The Niche report had been presented to the ICS Partnership Board and, in the main accepted. Next steps will be to: Develop a more detailed plan and response to be developed and reviewed by the ICS Partnership Board in the early Autumn. Ensure that we recognise the need for investment. Finalise our role as a specialist provider (HPFT) and invest into other services. Develop our role as leaders and how we coordinate this. **RECEIVE** **The Board RECEIVED the report**	
076/21	**East of England Collaborative** SBr presented the paper and drew out the below key points for the Board's attention. The Collaborative had formally 'gone live' on the 1 July 2021.We were now moving into the operational and transformation stage and were making good progress SBr was leading on developing a new team to oversee HPFT's role within the Collaborative. SBr asked the Board to note the below three key points which outlined HPFT's role and responsibilities, noting it was early days however we were making headway. 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. 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. Key risks remained the same, namely pressures with CAMHS with emerging risks in the delivery of the required transformational change given the national and regional demand and capacity issues. No questions were put forward. **RECEIVE**	

	The Board RECEIVED the Report	
	GOVERNANCE & REGULATORY	
077/21	**Report from the Audit Committee held: 19 July 2021** CD presented the paper which provided the Board with an update on the work of the Audit Committee at its last meeting held 19 July 2021. Points highlighted to the Board were: CD provided assurance that this had been an additional meeting held in the form of a workshop to provide an opportunity for a more in-depth discussion and consideration of issues which had been reported to the Committee in the previous year. CD thanked Committee members stating it had been positive and constructive. The workshop had focused on: An update on the work underway to embed the recommendations from the advisory internal audit report on pay costs and eroster. MW had given a presentation which had provided detail on the financial control systems in place for 2020/21 and the recommendations from recent internal and external audits of financial systems and the end of year accounts. The Committee had received an interesting update on three elements relating to digital. The Committee received a comprehensive presentation which updated them on the NHS People Plan and People Promise. The Committee received a comprehensive presentation that set out the work underway to improve the process for safeguarding service user's property. The Committee had considered and approved the proposal to undertake a procurement of Internal Audit and Counter Fraud Services to the Trust, as the current contract was due to end March 2022. CD concluded advising the Deep Dives presented to the Committee would continue. CD also provided assurance that the workshop meeting did not replace formal meetings which provided assurances to the Committee. **RECEIVE** **The Board RECEIVED the Report**	
078/21	**Trust Risk Register (TRR)** JPad presented the TRR advising the report had been discussed at the IGC meeting held in July. Points of note for the Board were: During this reporting period 3 risks had been added to the TRR: • Quality and safety: CAMHS Eating Disorders Team demand exceeds capacity. • Quality and safety: National Shortage of specialist CAMHS beds impacting on 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 were two risks which had reduced in score: • 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 were two risks being considered for inclusion in the next reporting period: • The preparation for winter. • The increased acuity in community services The EU exit risk had been closed and the constituent parts are being managed in the local risk registers. No questions were put forward. **RECEIVE** **The Board RECEIVD the report**	
079/21	**Board Assurance Framework** HE presented the Board Assurance Framework highlighting that this was the latest iteration and included updated controls and lines of assurance together with the most recent dates for the assurance evidence. The BAF had been reviewed and supported by members of the Integrated Governance Committee. Appendix 1 of the paper outlined the changes which had been made. Board members noted the recommendation from the Integrated Governance Committee and the assurance which was in place and provided approval. **APPROVE** **The Board APPROVED the Board Assurance Framework**	
080/21	**Fit and Proper Person Compliance** JL introduced the paper which was taken as read advising the purpose was to provide annual assurance that all Board Directors remained fit and proper for their roles. The Board was asked to note and record that the Annual Review of the Fit and Proper Persons Test had been conducted for the period April 2020 – March 2021 and that all Directors, including the Chair of the Trust satisfied the requirements. It was noted that the ARC meeting would receive details of Chair's FPP declaration. **RECEIVED** **The Board RECEIVED the report**	

081/21	**Trust Constitution** HE presented the paper which was taken as read. HE advised this was the annual review of the Trust's constitution highlighting that one amendment had been made to remove the amendment made in 2020 regarding election to the Council of Governors (CoG). Board members supported the proposed changes and provided approval. HE advised this was now be put before the Council of Governors at their meeting to be held 8 September 2021. **APPROVE** **The Board APPROVED the Trust Constitution**	**HE**
082/21	**Mental Heath Act Managers Annual Report** TB advised that as set out in the Mental Health Act Managers (MHAM) terms of reference, an annual report was to be provided to the Board to give an overview of the activity undertaken by the MHAM use of the Mental Health Act (MHA) in HPFT during 2020/21. Priorities going forward were: • 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. **RECEIVE** **The Board RECEIVED the MHA Annual Report**	
083/21	**Nominations & Remuneration Committee Terms of Reference** SBe presented the paper which was taken as read and highlighted the changes which had been made to the Terms of Reference as set out below: 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). All in attendance approved the changes. **APPROVE** **The Board APPROVED the Nominations & Remuneration Terms of Reference**	
084/21	**AOB** KK highlighted the government had launched their national strategy for autistic children, young people and adults with TC acknowledging. SBe paid tribute to JPad recording an enormous thank you for her time with the Trust over the past 7 years and acknowledging the huge impact she had made. Members of the Board all concurred. No further items of business were put forward.	
085/21	**Questions from the Public** No members of the Public were present.	
086/21	**Date of Next Meeting** The next Public meeting is scheduled for 30 September 2021	

Close of Meeting

Agenda Item 5

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 30 September 2021

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
29/7/21	**24**	AOB	Review national strategy for autism and impact for the Trust		TC	August 2021	G
29/7/21	**21**	Trust Constitution	To recommend the amended constitution to CoG	Considered and approved at CoG on 8 September 2021	HE	September 2021	G
29/7/21	**20**	Fit & Proper Person Compliance	SBe self-declaration to be considered by ARC		HE	October 2021	A
29/7/21	**14**	Gender Pay Report	IGC Deep Dive into pay gaps (gender, race and disability)		JL	November 2021	A
29/7/21	**10a**	Q1 Performance Update	Consultation on MH Access Targets – future performance report to set out how this stands against proposed standards		PR	November 2021	A
29/7/21	**3**	Shared Experience	Reach out and feedback to Crisis team		SBr	August 2021	G
20/5/21	**13**	Essex LD Partnership	FIC to consider risk associated with delayed bed consolidation in LD services in Essex		SBr	November 2021	A
29/4/21	**16**	Well Led Review	Confirm NED buddying	Final review to be completed in September	SBe/TC	June 2021	G
29/4/21	**16**	Well Led Review	Board to receive updates on WLR Action Plan	On the agenda	HE	September 2021	G

Board of Directors PUBLIC

Meeting Date:	30 September	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:

Funding Announcements

During August the government announced that the NHS in England will be given an extra £5.4bn over the next six months to respond to the impact of COVID-19 and tackle the care backlog, saying that £1bn of the funding will be used to help clear the backlog. £2.8bn will be allocated towards improving infection control in hospitals, while a further £478m will be spent discharging patients in order to free up more beds. However, although due imminently, the detailed planning guidance for the second half of the year (H2) has not yet been released.

The planning guidance for the second half of the year (H2) is due imminently the Trust continues to work to the agreed financial plan, which will be refreshed, if required following the publication of the guidance. The financial environment for 2022/23 is still not finalised and guidance is expected later in the year.

On 6 September the prime minister announced that the government would increase national insurance contributions to raise £36bn for the NHS and social care. He outlined that over the next three years, £5.4bn will go towards reforming the social care system, with additional funding in the longer term. The NHS welcomed the funding but there remain concerns that this will still leave a shortfall for the next financial year. More detail is awaited following the announcement in particular greater clarity is needed with regard to the help for mental health, community, ambulance and primary care services capital spending which is not included in this settlement.

Demand

The NHS continues to experience significant demand for services across all sectors, in particular demand for urgent and emergency care. In addition, there is the pressure to recover the backlog of care across waiting lists against the backdrop of a steady increase in hospitalisation due to COVID. Nationally, mental health services are seeing significant increases in demand across adults, children and young people, crisis services and older people. Recent analysis by the Royal College of Psychiatrists of the first quarter 2021-22, also identified this significant increase, compared to the same quarter for 2020/21 in children and young people with eating disorders users waiting for urgent and routine treatment.

The NHS Confederation's Mental Health Network has published a new report *Reaching the tipping point: children and young people's mental health*, which identifies as many as 1.5 million children and young people may need new or additional mental health support as a result of the pandemic. Addressing the increased demand has been hampered by continuing infection control measures, which restricts capacity and as well as staff self-isolating and signs that staff are taking time off due to stress and mental health issues. Over the summer there have also been high levels of leave recognising the need for staff to recover and as a result of leave being postponed from earlier in the pandemic.

There is a sense that the pressure may well intensify in the coming months as the NHS contends with continuing COVID-19 infections; the challenges of extending the vaccination programme for COVID and flu.

COVID-19

Across the country the recent surge in COVID transmission appears to have plateaued and the R rate is back under 1. The situation is being closely monitored as children and young people return to education as well as the continued relaxation of 'lockdown' measures. The Government has also launched a consultation on mandatory COVID-19 and flu jabs for all health and care staff.

Health and Care Bill

The past couple of months has seen an increase in the publication of guidance to support implementation of the new health and care bill.

Integrated Care Board (ICB) Guidance

In mid-August the Government published interim guidance that sets out the proposed core components of integrated care board governance arrangements as outlined in the Health and Care Bill and the Integrated Care System (ICS) Design Framework. It confirms the expected mandatory requirements (subject to legislation), as well as key considerations for system leaders as they design arrangements for April 2022. The guidance should be read alongside the draft ICB Model Constitution and accompany guidance that will be provided to integrated care system (ICS) leaders on the statutory Clinical Commissioning Group functions to be conferred on ICBs.
https://www.england.nhs.uk/wp-content/uploads/2021/06/B0886_Interim-guidance-on-the-functions-and-governance-of-the-integrated-care-board-August-2021.pdf

Key points from the guidance are:

- Integrated care boards will be statutory organisations that bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnerships across the ICS.
- Each ICB must be set out its governance and leadership arrangements in a constitution formally approved by NHS England and NHS Improvement.
- While preparations for these new arrangements are being made, all NHS organisations must continue to operate within the current legislative framework retaining any governance mechanisms necessary to maintain operational delivery (including patient safety, quality and financial performance).

Further in this report is a section of local arrangements in place to help implement the actions identified.

Provider Collaborative guidance

On 3 September 2021 NHSE published guidance on the development of 'Collaboratives' Working together at scale https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf
Provider Collaboratives are seen, along with place-based partnerships, as a "key component of system working". By working at scale, they provide the opportunity to tackle unwarranted variation. The Guidance states that all Trusts providing acute and mental health services are expected to be part of one or more collaboratives by April 2022. Community and ambulance trusts should be part of collaboratives where it would make sense.

The expectation is that by April 2022, ICS leaders, trusts and their system partners, with support from NHS England and NHS Improvement regions, as appropriate, will:

- identify the shared purpose of each collaborative and the specific opportunities to deliver benefits of scale and mutual aid
- develop and implement appropriate membership, governance arrangements and programmes (or reflect on this where collaboratives are already in place)

- ensure purpose, benefits and activities are well aligned with ICS priorities

There are a number of considerations for the Trust and the MH and LD Collaborative a paper later on the agenda will provide an opportunity to discuss this further.

Digital

As a signal of the importance of digital and it role in transforming services on 31 August NHS X published three papers:

- What Good Looks Like framework which outlines seven national digital success measures of transformation at ICS and organisational level.
- Who Pays for What proposal the future of digital investment which proposes that that ICSs are tasked to manage investment for digital from their own budgets (ICS and organisational) from 22-23 onwards.
- Unified Tech Fund prospectus which consolidates national funding for technology for 21-22 with a total of around £680m funding available across 8 components

The new guidance provides clarity and set out the implications for the Digital Aspirants programme. The Framework enables trusts to measure their level of digital maturity, helping them to identify gaps and priority areas for local improvement.

The Who pays for what guidance sets out the barriers to investment in digital technology and how NHSX proposes to fix them in 2021/22 and beyond. In particular the guidance provides more information on what initiatives should be funded by integrated care systems going forward and what trusts can expect to be funded nationally.

The final report sets out the consolidation of funds for 2021/22 set out in the Unified Tech Fund. The FIC at its meeting discussed this and the report later on the agenda will provide further details, including the implications for the Trust.

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.

Integrated Care System

Locally the ICS and its members are working together on the transition work taking place across the three CCGs, with all local partners. The established "task & finish" groups are helping develop coherent proposals / options that will support the launch and initial functioning of our ICS. Their inputs are overseen by the Partnership Board and managed day-to-day through System Leaders meetings and shared with the Chairs meetings at the new Transition Oversight Committee.

NHSEI recently published the much anticipated first tranche of ICS guidance included a HR Framework document to guide the HR transition process and technical guidance relating to CCG closedown and ICS set up, including: due diligence requirements; ICS readiness to operate and ICS model Constitution. In particular the Task and Finish Groups are using it to guide their work, it is worth noting that further tranches of guidance are expected over the coming weeks.

The ICS has established an ICS Transition Board accountable to the Partnership Board and will oversee the following work streams during the transition process:

- o Leadership & People.
- o Governance & Accountability.
- o Finance & Use of Resources.
- o Quality and Safety.
- o Communications & Engagement.
- o Digital & data.
- o Strategic Alignment (with existing and future ICS programmes).

The Transition Oversight Board is intended as an assurance group for Chairs and Lay Members to review progress and take assurance that all the necessary actions to properly close the three former CCGs and formally establish the new ICS are in hand.

The ICS has also established five Task and Finish (TAF) groups in order to progress key workstreams in anticipation of expected shadow ICS operation in quarter 3 of 22/23.
These are:

1. **Priorities and outcomes:** identify objectives and describe framework for priorities. Define range of desire principles and outcomes. Led by Christine Allen.
2. **Operating model:** outlined the System Operating Model, including broad functions. Led by Elliot Howard-Jones.
3. **Governance:** consider membership of ICS Statutory Board and Integrated Partnership Body. Led by Jane Halpin.
4. **System Organisational Development:** consider ICS Organisational Development Needs. Led by Tom Cahill.
5. **Provider Collaboratives:** Make recommendations for wider and deeper provider collaboration. Led by Lance McCarthy.

Each Task and Finish Group is attended by a member of the HPFT Executive Team and updates are regularly considered by the Executive Team.

Hertfordshire MHLD Collaborative
The MHLD Collaborative has continued to work towards formalising and strengthening the Partnership, with significant work taken forward in the following areas:

- Collaborative interim governance arrangements,
- Transformation and delivery governance and oversight
- Memorandum of Understanding

In addition to this the Collaborative also held its inaugural Clinical and Practice Advisory Committee, Chaired by Dr Asif Zia, in August and the draft terms of reference were presented to the Collaborative Partnership Board in September and approved.

Throughout this period, there has been a continued focus on responding to immediate mental health and learning disability system pressures, maintained focus on delivering our longer-term transformation priorities whilst finalising our strategic response to COVID-19.

The Collaborative has developed the next phase of its governance structure, which includes the development of the Collaborative Transformation and Delivery Board and alignment of the Hertfordshire Commissioning Group. Further detail is provided in a later paper on the agenda.

East and North Health and Care Partnership (ENHCP)
Work is progressing on the development of the EN HCP Strategy and we have ensured an interface with the evolving Adult Mental Health Strategy that is currently in development by the MHLD Collaborative. Options for the ENHCP Operating Model are being developed in alignment with the recently established ICS T&F groups.

The ENHCP MOU has now been signed off by all Partners. Recruitment is in progress for three key roles with the EN HCP programme team, to expand the resource to support the development of the partnership.

A review of transformation programmes is now being undertaken with input from the relevant sub-group Chairs and SRO's with a number of programmes moved into business as usual further streamlining is being considered. An ENHCP Community Assembly will be held on 27 September, facilitated by Healthwatch and will include representatives from HPFT.

South West Herts Health and Care Partnership (SWHHCP)
SWHHCP Strategy is due to be finalised by the end of September 2021. The first draft Shadow Partnership Agreement has been developed and shared with Partners. Engagement and further development of the agreement will take place over September, with the aim of final approval at October. HPFT continue to participate in workshops for both Strategy and Shadow Partnership Agreement.

The Virtual Hospital (HF & COPD) business cases have been supported by Partners and approved by HV CCG; with implementation is planned for November 2021. Design work has commenced on phase 4, which will ensure that all patients in all settings to access and benefit from Virtual Hospital. HPFT are actively involved in this work to ensure that it is fully inclusive of the MH and LD population.

The next phase of work is to focus on exploring their future operating model, in line with the wider ICS development work.

East of England (EOE) Provider Collaborative – New Care Models
Following going live on 1 July 2021 the Collaborative continue to develop and establish itself. Since the last board report non-recurrent funding has been secured via the accelerated transformation fund to support the role out of LD community forensic services in Norfolk.

There continues to be pressure on CAMHS services throughout the region. There are a number of initiatives underway to help relieve these pressures e.g. reducing 100+ day length of stays for young people. The finance controls and reporting within the Provider Collaborative are established. There remain some challenges around the data quality to enable accurate reporting on the financial position to take place. Working in partnership with the TACT team, the Trust is now in a position to agree sub-contracts in its role as Lead Provider for CAMHS. Additionally, it is also in a position to agree its sub-contract for the delivery of adult secure services. A review of these contracts notes no significant changes from the previous contracts with NHSE.

The FIC Committee at its meeting in September considered a detailed report on the Collaborative and a report later on the agenda from FIC and the Collaborative provides further detail.

Hertfordshire Health and Wellbeing Board (HWB)
The Hertfordshire Health and Wellbeing Board met on 22 September 2021. It provided an opportunity to receive an update on the response and impact of COVID-19. The Mental Health and Learning Disability Collaborative provided an update following its report in February 2021. The meeting welcomed the development of the Collaborative noting the planning underway on the future needs of the future Mental Health and Learning Disability population. The meeting discussed the Collaborative's response to current system pressures, highlighting its concerns for the health and wellbeing of children and young people.

The HWB considered the proposal to undertake a refresh of the Health and Wellbeing Strategy for Hertfordshire. This was supported and a commitment made to consider the development of a single strategy for the whole of Hertfordshire that would be for the HWB and the ICS.

Local Leadership Changes
The Princess Alexandra Hospital NHS Trust (PAHT) has appointed a new chair of their board following the retirement of their former chair. Hattie Llewelyn-Davies OBE joins PAHT in September and will continue in her current role as chair of Buckinghamshire Healthcare NHS Trust until March 2022 when she is due to step down as her term of office completes.

Tom Abell has been appointed as the new permanent Chief Executive of the East of England Ambulance Service. Tom is currently Deputy Chief Executive at Mid and South Essex NHS Foundation Trust, will formally take up his role in the autumn.

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 remain under pressure in terms of demand, acuity, complexity and workforce challenges, in line with the national picture. Due to the pressures being seen across all service lines the incident management framework has been used to focus on management of demand and capacity. This has led to improved use and access to data, triangulation of operational and workforce issues and a wider understanding across operational and corporate services of the issues and potential solutions. Evaluation of this approach and implementation of a recovery plan to move out of incident, is now underway with a view to stepping this approach at the end of the month.

Children and Adolescent services continue to be 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 across the local system and the Region. Business cases that have been developed jointly with Acute, Community Trust and Primary Care colleagues for a paediatric liaison service and a Matron and support worker team based in the Acute trusts have been approved and are now in the mobilisation phase. We are continuing to explore the development of an integrated, evidence-based Eating Disorder pathway including paediatric, mental health and dietetic input, with a view to reducing admissions into specialist beds.

Demand for acute mental health beds has remained consistently high. A contract with an Independent Sector provider to provide an additional 10 acute beds is now in place but the use of other out of area beds (OOAPs) has continued to remain high. We are currently reviewing our trajectory originally put in place to meet the target for zero by the end of Quarter 2, as this will not be achieved, in negotiation with NHSI/E. The Chief Information Officer is leading a piece of work to develop a digital approach to patient flow to improve efficiency. Commissioners have been working with acute staff and the voluntary sector to consider what further alternatives to admission could be commissioned.

S136 numbers remain high and we are working with police colleagues to continue to review practice and processes to reduce the number. This includes training, review of cases and improved use of crisis options.

Caseloads remain high in community services. Work is underway to better understand the waiting times for the different services, from referral treatment to in order to; agree appropriate actions; identify how to use resources to reduce waits; put risk mitigation into place and improve communication to referrers and service users with regards to waiting.

Learning Disability in- patient services have continued to have high bed occupancy and continue to experience delayed transfers of care. Two service users were admitted into our secure services following the closure of an independent sector hospital in Norfolk.

The transformation programme continues to focus on programmes to manage demand and capacity in particular, including the development of psychological services in acute in-patients and community transformation.

A number of services are finalists in the Positive Practice in Mental Health Awards to be held in October; SPA, CAMHS DBT and Essex LD.

The Trust is also supporting the local work to provide support to the Afghan refugees which have been placed in Hertfordshire.

Quality

The Trust recently had a CQC unannounced visit to Warren Court in response to concerns raised. The visit included meeting with a number of staff individually, to talk through staff support, the acuity

levels and the care and treatment we provide. They will come back to meet with more staff over the next week and to also meet with service users.

We have already taken a number of actions prior and in response to the CQC visit, including increasing the staffing levels, increasing the Team Leaders' presence in the unit and providing additional support to the staff.

Our People

Due to high vacancy and turnover rates the focus in the past two months has been on recruiting to our vacancies, supporting our people's health, wellbeing and morale. We have also seen sickness absence reduce from 5.23 % in July, to 4.91% in August.

We launched our first Summer Health and Wellbeing festival in August, across all our sites, including food vans, massages, wellbeing and union stalls, our wellbeing wagon and goody bags for staff. Feedback has been overwhelmingly positive and take up was high, with over 250 people accessing our food offer per day at the Kingsley Green festival site. We are finalising preparations for the launch of our fully trained health and wellbeing champions, our World Mental Health Day event, Freedom to Speak up in October and Black History month events in October. Our Here for You Service continues to support our people and NHS staff across the ICS and has been providing focussed support for staff affected by the recent events in Afghanistan and to help prevent staff burnout.

Our quarter two pulse survey results continue to show high engagement levels, with 86% of our people agreeing that care of service users is our top priority, 82% saying they would be happy with our standards of care if their own friends and family needed it and 75% recommending us as a place to work to their friends and family.

Our appraisal compliance has reduced slightly from 89% in July to 88% in August. Our mandatory training compliance has remained similar to July (90.59%) at 90.4% in July, against a target of 92%. We continue to implement our comprehensive recovery plan to ensure training and appraisal rates reach compliance, following the negative impact on both as a result of the pandemic. Cohort 11 of the HPFT Leadership Academy programme commenced in September and our local Mary Seacole Programme is now taking place, with Cohort 10 and 11 having started in July and September and Cohort 12 starting in October 2021.

The national staff survey was launched on 22 September with communications to encourage staff to complete, supported by incentives. The survey closes on 26 November 2021 with results due in new year.

COVID-19 Update

Within the Trust the number of service user inpatient and community cases this week has broadly static. Staff reporting positive LFTs has increased in the past few weeks and the number of confirmed positive staff has stayed consistent with numbers over the past 2 months.

Critical actions for the past month have included preparing for the new guidance for the public, which went live in mid-August, meaning anyone who is double vaccinated and in close contact with a positive case can potentially return to work. However, for NHS staff, there is the continued need for vigilance regarding risk to others and the NHS has instigated a process that is different to the public. This means that the Trust has adopted a risk-based approach and will continue with the risk assessment 'exemption' approach making decisions on the potential risk to vulnerable service users, with clear communications for staff.

The Trust reviewed the potential impact of legislation regarding only double vaccinated being able to legally enter Care Homes and all service lines have given assurance that they can mitigate care delivery by swapping staff duties should this issue arise.

The Trust has been notified about and is actively engaged in support to five separate COVID outbreaks within Independent Hospitals. The Trust is actively supporting and providing IPC

expertise, providing mutual aid, and actively participating in outbreak meetings. Furthermore, the Trust has been seeking daily assurance about the welfare of service users placed within these hospital settings.

Finance 2021/22

The Trust is reporting a position on Plan for the month and year to date. As detailed in the report later on the agenda both income and expenditure are behind Plan for the month and for the year to date. This is due to some delays on new or expanded services meaning that income has not been released for them but has been held to match expenditure. Pay costs are behind Plan for the year for the same reason, although high levels of bank and agency usage have been the gap against plan reduced with substantive pay remaining below Plan. It is noted that revised guidance on H2 is expected imminently and that for Hertfordshire contract discussions have continued and are almost complete.

Senior Team

It was been confirmed that Tom Cahill will stand down from CEO on 30 November 2021 and Karen Taylor will start as the new CEO on 1 December 2021. It also been agreed to start the recruitment process to fill the Director of Strategy and Partnerships substantially, with the process due to conclude by the end of the year. In the meantime, the Trust will recruit, on an interim basis to the Director of Strategy and Partnerships role, until the substantive post holder starts. During this period of transition and to support the senior team it was been agreed that Paul Ronald will retire and return, taking the lead on performance until the successor is appointed.

Tom Cahill

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 8
Subject:	COVID-19 and Incident Command	**For Publication:** Yes
Author:	Fiona McMillan Shields, Managing Director, East & North SBU	**Approved by:** Jacky Vincent, Executive Director of Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director of Quality and Safety (Chief Nurse)	

Purpose of the report:

To update the Board on the work overseen through Incident Command regarding the COVID-19 pandemic and describe the actions being taken to address surge in community transmission of covid and trust wide activity and acuity.

Action required:

The Board is asked to receive the report and agree the recommendations made.

Summary and recommendations:

This report gives an overview of the current status, in terms of the incident management and reporting. It describes the actions in place to ensure that Covid infections and suspected or confirmed cases are managed effectively 7 days a week. It also provides an update to the approach the Trust has been taking to manage the Trust-wide surge in activity and demand.

Across the country, the recent surge in Covid transmission plateaued with the R rate under 1. Within the Trust, the number of service user inpatient cases is currently 0; the number of cases for community service users is 14.

Staff reporting positive LFTs had increased in the past few weeks; the number of confirmed positive staff this week is currently 5.

Critical actions included preparing for the new guidance for the public, which went live from Monday 16th August, meaning anyone who is double vaccinated and in close contact with a positive case can potentially return to work. However, for NHS staff, there is the continued need for vigilance regarding risk to others and the NHS has instigated a process that is different to the public. This means that the Trust will adopt a risk-based approach and will continue with the risk assessment 'exemption' approach making decisions on the potential risk to vulnerable service users, with clear communications for staff.

The Trust reviewed the potential impact of legislation regarding only double vaccinated being able to legally enter Care Homes and all service lines have given assurance that they can mitigate care delivery by swapping staff duties, should this issue arise.

The Trust was notified and actively engaged in support to 5 separate Covid outbreaks within the following Independent Hospitals:

1. Baldock Manor, Nouvita, Baldock
2. Potters Bar Clinic, Elysium Potters Bar
3. Cornerstone, Vison Mental Healthcare, Borehamwood
4. Rhodes Wood, Elysium, Hatfield
5. Eltisley Manor, Nouvita, St Neots.

The Trust actively supported and provided IPC expertise, mutual aid, and actively participated in outbreak meetings. Furthermore, the Trust has been seeking daily assurance about the welfare of service users placed within these hospital settings.

The Trust incident response was stood up with Tactical Command meeting daily throughout August to address Trust service wide pressures. Covid related oversight was incorporated into this approach.

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

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

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

The staffing, financial, IT and legal risks are identified within the risk register part of this paper; Actions taken to medicate risks may have budgetary or financial implications.

Equality & Diversity and Public & Patient Involvement Implications:

Individual risk assessments of BAME staff.

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

None

1. Introduction

1.1 This report provides an overview of the status for the Covid and builds on previous reports. It initially sets out the national and local position, before using the framework to give an overview of issues that are currently being managed through incident command.

2. Current Status of Incident

2.1 The NHS response to Covid continues to be managed as a Level 3 incident, with coordination of the incident now overseen at regional level.

2.2 Within the Hertfordshire system, Gold Command (for surges in activity and acuity) stepped up to daily calls most days, with HETCG reinstated weekly and under daily review whether more frequent oversight is needed. Most providers across the region continue to report OPEL 3 or above, and conveyance to and activity within the two local Acute Trusts remains high, ambulance services have brought in support from the army although the trend for hospital Covid-related admission is flattening.

3. Trust Incident Response Structures

3.1 The Trust is continuing to respond flexibly and pitch the level of response according to activity and need, including standing up Tactical and Operational Command meetings more frequently to respond to current conditions. To this effect, Tactical Command meetings were reinstated to 5 x week for the immediate future from 9th August. This is to oversee and manage the volume of Trust-wide activity, rising staff absence (including annual leave and sickness and self-isolation) and to oversee business continuity during this period.

3.2 The Trust has been reporting **OPEL 3 (Red**) bed state for several weeks; for Covid, the OPEL status for the Trust remains at **OPEL 1 (Green),** as detailed in **table 1.**

Table 1 Opel

	OPEL 1	OPEL 2	OPEL 3	OPEL 4
Bed occupancy (all beds)	<92%	92-95%	96-99%	100%
Staffing (RAG rating from SafeCare)	Expected thresholds	Concerns mitigated	Services at risk	Risk to core service
DToCs	<8	8 - 12	13 - 19	20+
Number waiting in acute trust for MHAA	0 - 1	2 - 4	5 - 8	9+
Decision to admit made and waiting in acute	0 - 1	2 - 4	5 - 8	9+
Management of COVID + VE patients	*0-4*	*5-10*	*11-14*	*15+*
Maximum No. Beds Closed in any given service (COVID and Non-COVID Related) Excluding Essex and Norfolk	*0-3*	*4-6*	*7-10*	*11+*
Swabbing Access (Patient Level)	*On the day*	*Within 24 hrs*	*Within 48 hrs*	*Over 48 hrs*

4. Infection Prevention and Control (IPC)

4.1 At the time of this report, there has been one positive service user in the Trust's inpatient services, and no confirmed outbreaks in the inpatient services.

4.2 Also, at the time of this report, there are 14 reported positive service users in the Trust's community services.

4.3 There have been further Covid-related service user deaths reported in the past weeks and the total is now 203.

4.4 The number of Trust staff with confirmed Covid illness is 5 at the time of this report, which is similar to the preceding two months.

4.5 The Trust was made aware of 5 current Independent Provider Outbreaks. These are:

1. Baldock Manor, Nouvita, Baldock
2. Potters Bar Clinic, Elysium Potters Bar
3. Cornerstone, Vison Mental Healthcare, Borehamwood
4. Rhodes Wood, Elysium, Hatfield
5. Eltisley Manor, Nouvita, St Neots.

4.6 Trust staff actively supported and provided IPC expertise, mutual aid and actively participated in outbreak meetings, seeking daily assurance about the welfare of service users placed within these hospital settings.

4.7 There is, however, remaining ambiguity about the system leadership for these outbreaks in independent providers which the Trust is seeking to address with system partners - whilst focussing on the care and support of any Trust placed service users affected.

4.8 Sadly, one person, a 73-year-old male in adult services, was Covid positive and has died in Eltisley Manor.

5. Service Users Support and Care Delivery

5.1 All services are operating with increased demand and acuity, with some services facing particularly persistent staff challenges; Incident Command was, therefore, reinstated daily in the week to maintain clear and timely oversight of the issues.

5.2 A new command framework was developed to provide clear and comprehensive daily oversight of issues affecting service delivery, with the following established work streams:

1. Data
2. Workforce
3. Bed flow
4. Mental Health Act Assessments
5. Mental Health Services for Older People (MHSOP)
6. Set up of Incident Command
7. Expert Advice / Clinical Oversight
8. Communications.

5.3 To date, new daily Sitreps have been developed (bed flow, staff recruitment) and actions have been taken to support bed management decisions, strengthen the Approved Mental Health Practitioner (AMHP) rota and to reinstate the Trust wide safer-staffing daily reporting to support us in looking forward with the proactive planning of staffing rotas.

6. Business Continuity

6.1 There are several services taking daily decisions regarding the impact of staffing levels, including the acute wards, Lexden and Warren Court. In a small number of instances, community staff have been redeployed to support inpatient services; however, all community service are operational.

6.2 Staff absence through annual leave, sickness and Covid-related absence is being tracked daily as an early warning marker. Proactive decisions regarding staffing, the use of overbooking Bank and using Agency has, for the most part, contained the current surge in demand. However, when Trust absence reaches 20%, this has been a tipping point for enacting business continuity decisions over winter. Absence reached 20% on Friday 13th August and was back to 18% by 16th August. Annual leave is the biggest variant and the most influenceable driver.

6.3 The biggest issue for staffing is when booked agency staff do not turn up for shifts, causing last minute reactive changes to rotas - often out of hours. There is intelligence suggesting agency bookings are being dropped owing to more preferential rates being offered elsewhere.

6.4 The Trust is working effectively with system partners regarding winter planning, which included planning for August Bank Holiday. All the actions being taken to strengthen support and oversight of operational pressures will be reflected in updated Trust and system plans (which are being rapidly developed in the next few weeks). Trust bank holiday planning is in place and reviewed to strengthen the upcoming weekend plans daily.

7. People

7.1 The number of staff self-isolating at home, owing to exposure, is detailed in **table 3**.

Table 2 self-isolating staff

	1st July	8th July	14th July	18th July	23rd July	29th July	4th August	9th August	16th August	1st Sept
Self isolating working	19	23	23	21	26	22	17	15	17	12
Self isolating not working	9	10	10	8	8	10	9	3	9	5
Total	28	33	33	29	34	32	26	18	26	17

7.2 Daily e-roster scrutiny and safer staffing meetings continue to support Business Continuity Planning and decision making.

7.3 The exemption process to return staff to work (if 'pinged' by the NHS App) has been effective and to date, the Trust returned about 12 staff members back to work, using this approach. A further change to national government policy came into place on 16th August; the Trust needs to be clear that NHS staff have a different 'bar' to pass and will be working to ensure that the communications to staff are fully understood (meaning that if staff are not double vaccinated and if they have a positive contact case at home they still would not be allowed to work and must remain self-isolating despite the new national changes).

7.4 The Trust will also take a case-by-case view on whether a staff member can return to front line, dependant on how much risk they pose to vulnerable service users. Communications are being updated and Matrons, Team Leaders, Service Line Leads and Heads of Nursing targeted to ensure consistent messaging.

7.5 5 members of staff have been identified as having long Covid and remain on sick leave.

7.6 Staff testing continues to remain a priority. Current testing rates for front line staff, as detailed in **table 4**, show a slight decline since last week. LFT management information continues to be shared daily with operational teams to support improved insight and compliance.

Table 3 LFT 1 Sept frontline staff

SBU	% Compliance
367 Corporate Services	32%
367 SBU Essex and IAPTS	41%
367 SBU Learning Disability and Forensic	38%
367 SBU MH East and North Herts	47%
367 SBU MH West Herts	22%
TOTAL	**37%**

7.3 The Trust has now distributed all remaining LFT stock and, going forward, staff will have to access replacement kits via the government portal. Communications to this effect is being planned for this week.

7.4 There is continued focus on staff support and wellbeing, with food runs at the weekend being received favourably. Operational leaders in the Trust believe staff morale and burn out is the most pressing concern facing staff currently.

8. Infrastructure

8.1 There are currently no ongoing concerns reported.

9. Leadership

9.1 The Senior Nurse on call rota was reinstated and needed to support system outbreak meetings out of hours and at weekends.

9.2 Much of the operational leadership teams has been focussed on the bed management and flow and proactive planning around how services are staffed, to support effective operational delivery.

10. System

10.1 System pressures are escalating, and Gold Calls are scheduled daily through which Directors on call escalate and manage provider level issues, such as bed availability or emergency department pressures.

10.2 As indicated, there has been ambiguity regarding responsibility and oversight of independent provider outbreak management, and further work with the East of England Provider Collaborative and Public Health teams is needed regarding responsibilities for oversight of independent sector hospital outbreaks.

11. Governance

11.1 The frequency of the formal review of the Covid risk register has been increased, in response to the increase in risks relating the pandemic and its management and owing to operational pressures.

11.2 The risk register for Covid Incident Management covers the risks being reviewed for the broader service pressures incident approach and the Trust is confident that they are overlapping risks. The key areas to note are the work to ensure there is adequate safe staffing and to ensure services are operational and running safely.

12. Communication

12.1 Communication with staff continues to be a high priority and the Trust's Covid communication plan is frequently updated. In addition, the Trust has been strengthening the information available to service users as alternatives to Trust services, such as crisis support.

13. Conclusion

13.1 The current phase of Covid means that services and staffing are being impacted by the levels of circulating Covid-related cases and that mitigation is in place, to ensure services are maintained.

13.2 The new self-isolation exemption process has been implemented so that, on a case-by-case basis, frontline staff may be able to return to work from self-isolation, provided they test daily and have a negative PCR. Further communications are being prepared to support staff to manage when they can return to work in instances of contact with Covid positive cases and when returning from amber risk countries.

13.3 The priority for the Trust continues to be to strengthen infection prevention and control (IPC) practice and encouraging staff to test twice a week, in order to maintain high quality effective and safe services.

13.4 The Trust's Incident Command structure will increase in frequency during August and September, owing to cross-Trust service pressures.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 9
Subject:	Integrated Governance Committee Report: 16 September 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 16 September 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 16 September 2021 is outlined in the body of the report. The Committee did not escalate any items for the Board to consider.

No matters for escalation to the Board.

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 16 September 2021 in accordance with its terms of reference and was quorate.

2. Reports were received from the IGC Sub Committees

2.1 People and OD Group

The Group received reports from the People and OD Group meeting held on 6 August 2021 and 2 September 2021. The Committee considered the reports noting the meetings received updates on the key People metrics and the extensive recruitment activities. Progress was noted concerning SBU workforce plans and Respect training. The September meeting focused on a range of OD activities, with initial feedback from the recent Pulse Survey, plans for the national staff survey and black history month, a health and wellbeing update and a staff engagement plan.

In response to Tim Bryson's question, it was agreed that the next Committee meeting would receive the Annual Report on Wellbeing.

There were no 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 3 September 2021. The meeting received a report from the E&N SBU that set out the SBU's work during the pandemic to ensure that service users continued to receive high-quality care. In particular, the work to improve patient flow in MHSOP inpatients services that had utilised CQI methodology was noted. The SBU reported on the high acuity of service users in Forest House, noting that the risk had been added to the Trust Risk Register.

The Committee received an update on the clinical audit programme and the progress with the audits and identified actions. It was noted that the Quality Impact Assessments would be discussed later on the agenda.

There were no 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, which held its last meeting on 1 September 2021. It was noted that the subcommittee would receive the Q1 Information Governance Incidents/SARS/FOIs later on the agenda. IMGS reviewed the IM&T and IG risk registers. All risks had been updated in line with their current and agreed review dates.

IMGS received the July 2021 service report from HBL ICT and noted that there had been a slight reduction in the number of contacts. It was noted that during the period that there had been no significant cyber events. It was noted that following a query from the Audit Committee, IMGS received an update from the Trust CIO on the management of cybersecurity risks posed by Trust suppliers providing information systems either via a shared service agreement or software as a service contract.

IMGS agreed that the Trust's 2021-22 cybersecurity programme would be extended to cover supplier cybersecurity management

There were no matters for escalation to the IGC.

In response to Anne Barnard's question, it was reported that details of the Unified Technology Fund would be considered by Finance and Investment Committee at its meeting in September.

3. Deep Dive – Quarter One: Suspected Suicide Deep Dive

The Committee received a detailed report into deaths in quarter one, 2021/22 believed to be suspected suicide. The deep dive had been undertaken owing to a concern about an apparent rise in numbers compared to the previous quarter. The Committee considered the detailed information regarding the age ranges and gender of those who died and the main method of death, noting that the split was in keeping with the national picture.

The Committee noted that the World Health Organisation estimated that, globally, there are over 800,000 deaths by suicide each year - approximately 1 every 40 seconds. Suicide is a highly complex issue, with various causes at both the individual and contextual levels. The impact of suicide cannot be underestimated.

The deep dive reported that the main clinical setting of patient (service user) suicides in England during the pandemic was in community mental health teams; the majority of those who died had COVID-related stresses, and third had experienced disruption to care related to COVID-19 and loss of regular support. The pandemic has had a significant impact on mental health. Whilst this has not translated into a national rise in suicide/self-harm, serious risks remain in 2021.

The Committee noted that identified actions to help ensure the number of deaths in future quarters is kept as low as possible. It was agreed that a future Committee meeting would receive an update on the actions.

In response to Jon Walmsley's question, Jo Farrow reported that the current national data was only available for 2020 due to confirmation from Coroner offices being awaited. Jo Farrow also confirmed that the split between genders was similar to the figures seen nationally.

4. Governance and Regulation

4.1 Annual EPRR Report

The Committee received a report that set out the Trust's response to the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework. It set out that providers and commissioners of NHS funded services must show they can effectively respond to major, critical, and business continuity incidents whilst maintaining services to patients.

The framework assessment process is in four stages, and the report set out the outcomes of the first stage of a 'self-assessment' against the NHS Core Standards for EPRR. As a mental health provider, the Trust is compliant with all 58 mental health provider core standards. This year the deep dive did not apply to the Trust. It was reported that following the self-assessment, the Trust was reporting as compliant against all of the standards, an improvement

on last year. The report also set out the learning identified from the self-assessment.

The Committee noted that following the submission of the self-assessment, the Accountable Emergency Officer would be invited to a review meeting with CCG colleagues before final submission at the end of Quarter three.

It was agreed that the Trust would consider the identification of a Non-Executive Director linked to EPRR.

In response to Anne Barnard's question, Sandra Brookes identified that the main risk associated with the Trust's plans linked with facilities for evacuation and decamping of service users.

4.2 Q1 Information Governance Incidents/SARs/FOI

The Committee received a report that summarised the work of the Trust's Information Rights and Compliance function in the first quarter of 2021-22. It was noted that data incidents and breaches SAR and FOI demand has been high, with an increase against the same quarter last year. It was reported that a backlog has accumulated due to the team being redeployed to other functions to support the pandemic response. As a result, the compliance figure for the quarter is low. It was noted that the Trust's Executive Team has agreed additional resources to address this.

The report set out the number of data incidents reported by staff and those assessed as breaches. The main theme in data incidents remains disclosure of data in error due to misdirected paper or electronic correspondence. This is being addressed through a secure email system and training. During the quarter, the Trust has not had to escalate any incidents to the Information Commissioner's Office

In response to Anne Barnard suggestion, future quarterly reports will include additional information on overdue requests. Hakan Akozek confirmed in response to Diane Herbert's question it is planned for the backlog to be cleared by end of 2021.

5. People

5.1 People and OD Report

The Committee received the report that set out the Trust's performance against the key people and organisational development metrics and activity detailed in the Annual Plan for July and August. It was noted that whilst several people and OD activities are on plan, of particular concern is recruitment, retention and wellbeing, with increases in the vacancy and turnover rates. There was also an increase in sickness absence, with the top two known reasons for absence being mental ill-health and musculoskeletal issues.

The Committee received a detailed update on the actions being taken to recruit vacancies at pace and the headline activities regarding retention, including significant work on health and wellbeing, increasing morale and engaging with our people. It was noted that recruitment and retention and health and wellbeing support to our people would remain focus areas for the remainder of the year.

5.2 Quarter One Safer Staffing Report

The report provided an update on the first quarter. It outlined the staffing levels achieved against the safe staffing levels set for each patient unit for nursing staff, and it was noted that the emergency alternative staffing levels were not used. Business as usual staffing levels were maintained throughout.

The Committee was updated that there had been a significant increase in staffing levels across services. This was due to the acuity and complexity of service users and linked increase in the number of service users on safe and supportive observations. During this quarter, there was clear evidence of scrutiny and escalation process of staffing across the Strategic Business Units. To support quality, some wards have over established by recruiting newly Registered Nurses and Healthcare Support Workers. It was noted that a new escalation process would be discussed at the next Safer Staffing Committee.

In response to a question, it was agreed that the Committee would receive a presentation on safe care, e-roster and Allocate at a future meeting.

5.3 Public Sector Equality Duty (PSED) compliance and Equality Delivery System 2 (EDS2) Grading update report 2020/21

The Committee received a report setting out that the Trust must comply with both the general duties and the specific duties of the PSED and is mandated to publish the results of exercises concerning the EDS2. It was noted that Trust compliance with the general duties is given in the form of some narrative regarding key pieces of project work, as detailed in this report. Following this, data is published on workforce and service users/carers as part of the Trust's compliance with the specific duties

The Committee noted that EDS2 reporting is given in the form of grades from our previous grading. All EDS2 grading must be completed by Trust stakeholders (rather than self–assessed) based on evidence supplied. The Trust is awaiting National guidance from the Equality and Diversity Council (EDC) on EDS3. Hence, a partial re-grading took place as EDS3 has not been implemented due to the need for all NHS trusts to operate their Business Continuity Plan.

The report set out the activities that had taken place in the last year concerning equality, diversity and inclusion and the future actions planned.

When approved, it was noted that the report would be recommended to the Board for approval before being published on the Trust website.

5.4 Carer Plan Performance update Dec2020/June 2021

The Committee received a report that provided an update on activities undertaken by the Trust to develop its response to the needs of carers. It also covered the contractual responsibilities to deliver high-quality social care for carers of people with a functional mental health need (excluding carers under 18). All of which are supported by the co-produced Carer Plan.

The Committee considered the results in the report and the expected improvement in community-based carer services over the next period. It noted the proposed reporting from SBUs to be reporting progress against local Carer actions.

The Committee welcomed the proposed refresh of the strategy and the inclusion of young people.

6. Quality and Safety

6.1 COVID -19 Update

The Committee considered a report that provided an overview of the current status of the pandemic in terms of incident management and reporting. It set out the actions to ensure that COVID-19 infections and suspected or confirmed cases are managed effectively 7 days a week. The report provided an update to the approach being taken by the Trust to manage the surge in activity and demand.

The critical actions over the past month were reported and included preparing for the public's new guidance, which went live from Monday 16 August, which had seen the Trust adopt a risk-based approach. And that the Trust had reviewed the potential impact of legislation regarding only double vaccinated being able to legally enter Care Homes.

In response to Anne Barnard's question, the ongoing challenge of improving reporting compliance rates for LFTs was noted.

6.2 Flu Campaign 2021/22

The Committee considered a report that set out the 2021-22 flu vaccination campaign plans. It was noted that the Trust had reviewed last year's campaign and taken on board the learning. It was noted that the Trust would continue to use an evidenced model for encouraging behavioural change in the 2021-22 campaign.

The Committee welcomed the increased use of digital technology to support maximum coverage and national reporting.

6.3 Quarter One Integrated Safety Report

The Committee received the quarter one Integrated Safety report that provided assurance and detail on the actions taken in response to safety-related incidents, particularly when reported higher acuity on inpatient wards and complexity in community services.

Key areas to note were: reduction in the number of incidents in quarter one, with no Never Events and one Prevention of Future Death report issued by HM Coroners to the Trust. The slight increase in the number of Serious Incidents was noted, alongside an increase in unexpected deaths and self-harm incidents; continued downward trend in absence without authorised leave (AWOL) and Missing Person incidents; decrease in incidents resulting in moderate or severe harm; increase in service user to service user assaults; increase in the use of physical; increase in the use of seclusion which was attributed to increased acuity.

The Committee noted the work undertaken in response to the learning from previous quarters, focusing on racial abuse, violence and aggression, sexual safety, and restrictive practice.

Jacky Vincent provided a specific update on recent incidents and detailed the pressure on services, noting the mitigating actions in place.

In response to a question from Tim Bryson, it was agreed that the data on safeguarding incidents would be clarified. Jacky Vincent explained that a small number of service users drive the numbers of seclusions and segregation but confirmed that all cases of restrictive practice are actively reviewed.

6.4 Quarter One Freedom to Speak Up Report

The Committee received the quarter one report from Freedom to Speak up Guardian. It noted the number of concerns that had been received, including those made anonymously. The report provided detail on the breakdown of the concerns by service, noting that they all had an element of service user safety/quality. It was noted that a number of the cases are still being followed up to ensure they are being managed appropriately.

The Committee discussed the level of detail on these concerns that it would be appropriate to receive, and it was agreed that the Committee would have a deep dive at a future meeting to consider themes. The Committee also noted that Diane Herbert, nominated Freedom to Speak Up NED, had regular meetings with the Guardian.

6.5 GMC Training Survey 2021

The Committee received the report on the 2021 National Training Survey of junior doctors and consultants. It set out that during a time of extraordinary challenge, high-quality training had continued within the Trust.

The report provided detailed feedback, and it was noted that the Trust had received positive responses to questions on teaching, supervision, and overall training experience. However, it was noted that the pandemic and ongoing recovery impacted the wellbeing of the healthcare workforce, including trainees and trainers.

In response to Anne Barnard's question, Rakesh Magon reported that comparator data from other mental health Trusts were not available via the GMC but that the Trust would review the data from neighbouring mental health trusts.

7. Quality – Effectiveness

7.1 KL Inquest Conclusion from Coroner

The Committee received a report that set out the Coroner's final comments and the Trust's response to the letter from Ms Alison McCormick, Assistant Coroner's with recommendations for preventing future death, which has been circulated to the Hertfordshire Police Probation and HPFT.

The report set out the actions already taken or planned by HPFT concerning organisation Section 28: Potentially Dangerous person and family's wishes. It was noted that the response had been sent within the required timescale.

7.2 CPAC Update

The Committee received a report that provided an overview of the work undertaken by the Clinical Professional Advisory Committee (CPAC). It outlined all the guidance reviewed in July and August to ascertain if it applied to HPFT and advised appropriately. It was noted that over the past 17 months, 252 different guidance documents have been discussed at CPAC.

It was reported that due to regular changes in Government guidance and additional national guidance being issued, a large part of the work of the CPAC committee is updating existing Trust guidance to ensure Trust guidance is in line with government guidance. The PACE team holds a full log of all guidance.

7.3 Quality Impact Assessments (QIA)
The Committee considered a report that provided an update on progress on the schemes that were identified as requiring a Quality Impact Assessment to support Delivering Value Programme for 2021-2022. It was noted that year on year schemes with a QIA have been reviewed to ensure that they continue to remain current and up to date. The Committee was informed that the QIA policy has been reviewed and updated and is currently out for consultation.

In response to Anne Barnard's question, Sandra Brookes set out that the QIA process allowed the original assessment to be reviewed and updated when further information regarding the scheme becomes available.

8. Quality and Experience

8.1 Experience and Involvement, Inclusion Update.
The Committee received an update on the activities of the Experience, Involvement and Inclusion teams. It was noted that Experience Champions were being recruited to help increase the amount of service user and carer feedback received by the Trust. It was reported that the team was looking at how to increase the use of digital technology to encourage feedback and build up peer observation and peer experience projects.

The Committee received an update on the volunteering programme and the range of involvement activities undertaken in quarter one. The report highlighted the successful recruitment of young people to the involvement team and increased membership of the staff networks.

8.2 Annual Nutrition report
The Committee considered a report that provided a summary of the work completed in the last year concerning meeting service users' nutrition and hydration needs. The Committee noted that the Trust was compliant with 23 out of 24 KLOEs set out by the CQC concerning nutrition and will be compliant with all KLOEs when the strategy is approved. The Committee noted the positive scores on PLACE for food.

It was agreed that the Trust would consider the identification of a Non-Executive Director linked to Nutrition.

8.3 Mental Health Legislation Ethnicity Update from MH Legislation Quality and Policy Group
The Committee agreed to consider a report on ethnicity data relating to the Mental Health Legislation at its meeting in November.

9. Recommendations

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

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 9a
Subject:	Quarter 1 2021/22 Integrated Safety Report	**For Publication:** Yes
Authors:	Nikki Wilmott, head of Safer Care and Standards Simon White, Practice Development and Patient Safety Team Karen Hastings, interim Head of Social Work and Safeguarding	**Approved by:** Jacky Vincent, Executive Director Quality & Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality & Safety (Chief Nurse)	

Purpose of the report:

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

Action required:

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

Summary and recommendations:

The number of incidents reported in quarter 1 reduced by 4%, with an overall 1.5% decrease in the number of incidents resulting in moderate or severe harm. There have been no Never Events and 1 Prevention of Future Death report issued by HM Coroners to the Trust.

The number of Serious Incidents increased from 29 to 32 in this quarter, with an increase in unexpected deaths (10 in quarter 4 and 16 in this quarter) and also in self-harm incidents (9 in quarter 4 to 10 in this quarter) reported.

There has been a decrease in ligature incidents from the last quarter from 62 to 60 incidents within inpatient services. However, there has been an increase from 4 to 8 incidents in ligature events in service user homes.

There continues to be an overall downward trend in absence without authorised leave and Missing Person incidents from 64 to 30, however there has been an increase this quarter from 10 to 30 incidents on the previous quarter.

The number of reported incidents of service user to staff assaults has increased and the number resulting in moderate or severe harm has decreased. Service user to service user assaults have increased and the number where moderate harm has resulted remains within the 0-4 range seen previously.

The Trust saw an increase in the use of physical interventions from 436 in the last quarter to 506. Trust wide, there was an increase in the use of seclusion which was attributed to increased acuity reported. Increased scrutiny and the review of Long-Term Segregation continued to be a focus during the quarter and 8 individuals were in LTS during the quarter.

Work has been undertaken in response to the learning from previous quarters with particular focus on racial abuse, violence and aggression, sexual safety and restrictive practice.

The Board is asked to receive and note the content of the report.

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

Relation to the Trust Risk Register:

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

- COVID-19: The Trust may not be able to sustain core operational services and maintain service user and staff safety during the COVID19 outbreak (Risk 1253)
- COVID-19: Increased harm or death of service users due to mental health related illness (Risk 1273)
- Workforce: The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff (Risk 215)
- Workforce: The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services (Risk 657)
- Changing External Landscape: The changing external landscape and wider system pressures/agenda leads to a shift of influence and resources away from mental health & Learning Disability services and from the Trust (Risk 749)
- Section 136: Unlawful detention of service users under S136 breaches beyond 24hrs (Risk 882)
- Adult Community: Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites (Risk 773)

Relation to the BAF:

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

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

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

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

There are no implications arising from this report.

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

This report sets out actions taken in quarter 1 2021/22 as part of the Care Quality Commission Key Lines of Enquiry.

Seen by the following committee(s) on date:

Quality and Risk Management Committee 3rd September 2021
Integrated Governance Committee 16th September 2021

Quarterly Integrated Safety Report Quarter 1 2021/22

Executive Summary

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

The Trust's annual plan objective for safety is:

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

Key priorities were:

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

This report is divided into the following sections:

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

The number of incidents reported in quarter 1 reduced by 4% when compared to the previous quarter, with an overall 1.5% decrease in the number of incidents resulting in moderate or severe harm. There have been no Never Events and 1 Prevention of Future Death report issued by HM Coroners to the Trust.

The number of Serious Incidents increased from 29 in quarter 4 to 32 in this quarter, with an increase in unexpected deaths (10 in quarter 4 and 16 in this quarter) and also in self-harm incidents (9 in quarter 4 to 10 in this quarter) reported. The Trust ended the quarter with no cases outside of timeframe submitted to the Clinical Commissioning Groups (CCG) and no new cases going over the deadline for submission. The Trust also had no outstanding actions plans for completion at the end of the quarter.

The Mortality Governance Team continues to screen all deaths in the Trust and disseminate this learning, as well as any learning from the learning Disability Mortality Review Programme (LeDeR). The team has been in contact with the regional Medical Examiner to establish a close working relationship with the roll out of the national Medical Examiner process

There has been a decrease in ligature incidents from the last quarter of 2 from 62 to 60 incidents within inpatient services. However, there has been an increase from 4 to 8 incidents in ligature events in service user homes.

There continues to be an overall downward trend in absence without authorised leave (AWOL) and Missing Person incidents from 64 to 30, however there has been an increase this quarter from 10 to 30 incidents on the previous quarter.

The number of reported incidents of service user to staff assaults has increased and the number resulting in moderate or severe harm has decreased. Service user to service user assaults have increased and the number where moderate harm has resulted remains within the 0-4 range seen previously.

The Trust saw an increase in the use of physical interventions from 436 in the last quarter to 506. Trust wide, there was an increase in the use of seclusion which was attributed to increased acuity reported. Increased scrutiny and the review of Long-Term Segregation (LTS) continued to be a focus during the quarter and 8 individuals were in LTS during the quarter.

Work has been undertaken in response to the learning from previous quarters with particular focus on racial abuse, violence and aggression, sexual safety and restrictive practice.

Priorities remain in line with the annual plan and the quality strategy. The ‘soft’ launch of the MOSStogether strategy has supported actions taken forward in the quarter and continued to be implemented.

Part A- Governance and Assurance

1. Introduction

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

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

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

2. Priorities

2.1. A number of priorities were set in relation to safety in the Trust's 2020/21 Annual Plan:

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

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

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

3. Trust Risk Register

3.1. The Trust's Risk Register (TRR) is reviewed regularly and has a number of risks that relate specifically to safety, with the following having an impact on safety and service user harm:

- Quality and Safety: 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 (Risk 1370)
- Quality and Safety: CAMHS Eating Disorders Team demand exceeds capacity (Risk 1300)
- Quality and Safety: Reduced provision of face to face mandatory training and the impact on staff compliance and consequently staff and service user (Risk 1284)
- Quality and Safety: S136: Unlawful detention of service users under Section 136 (S136) breaching beyond 24 hours which has legal implications and an impact on service user care, treatment and experience (Risk 882)
- Workforce: Insufficient workforce to meet predicted increased demand and deliver commitments in Long Term Plan (Risk 1320)

- 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 (Risk 1253).

3.2. A report was last presented to the IGC on 15th July 2021 providing additional information about the work being undertaken to address and to mitigate against these risks. Safety specific updates related to:

- 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 to the TRR 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
- CAMHS Eating Disorders. This has been escalated to the TRR 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
- Reduced provision of face to face mandatory training. This risk has been escalated to the TRR 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 and Handling (basic and advanced patient (service user) 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.
- Unlawful detention in the Places of Safety. Daily demand and capacity meetings discuss all service users detailed under 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 S136 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.

- COVID19 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 COVID19 wave and continues to have sufficient controls and mitigation in place, such as good infection prevention and control (IPC) compliance, a robust vaccination programme and the use of lateral Flow Tests (LFT)
- Insufficient Workforce to deliver long term plan. The Recruitment and Retention Strategy is being refreshed. A Trust-wide workforce plan and Strategic Business Unit (SBU) level workforce plans are being implemented during quarter 2. Healthcare Support Worker (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**.**

4. Health and Safety Executive

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

- Risk Assessment for violence and aggression to employees and those not in our employment from or by service users. Carry out a suitable and sufficient assessment of the risks to Health and Safety for staff whilst working with service user (a service user at Lexden was highlighted as an example but the recommendations were to be expected be rolled out to all other service users)
- Put arrangements in place to ensure that all the reusable slings used for moving and handling service users are thoroughly examined at least every six months.
- Put arrangements in place to review and update moving and handling risk assessments, making these less generic and including situations where the risk of violence and aggression are increased.
- Violence and aggression against staff and need to improve processes, plans, learning and risk assessment. Produce a policy detailing how and when incidents of violence & aggression will be investigated.

5. Safety Alerts

5.1. There were a total of 21 Central Alerting System (CAS) Alerts received during the quarter, which have been reviewed and the learning and actions taken forward, disseminating to the relevant services and accompanied by changes to policy and practice, where required.

5.2. Those that were applicable are detailed as follows:

- NatPSA/2021/002/NHSPS: Urgent Assessment/Treatment following ingestion of ‘super strong’ magnets. An internal safety alert was developed following this NPSA
- SDA/2021/007: Dexamethasone 0.1% (Maxidex) 5ml eye drops. Although pharmacy have not issued in the past year there are alternatives that can be used in the meantime should pharmacy need more (currently 1 in stock)
- COVID-19 Vaccine AstraZeneca: COVID-19 Vaccine AstraZeneca and thromboembolic events with concurrent low platelets – revisions to product information. This was shared with Tactical Command and the Chief Pharmacist. Information was provided via comms and to our Trust vaccinators

- Personal protective equipment and heat: risk of heat stress. Comms information was provided to staff on the 15th June 2021 following escalation to Tactical Command
- CAPA-2021-07: Clinell Universal Wipes – Urgent recall. Only Victoria Court had affected batches. UBV2033020A, 3 packs already used (6 packs in a unit of issue), 3 packs disposed of (1 in the team leaders office, opened, one at reception, opened, 1 in cleaners cupboard, unopened). The affected batches were disposed of
- FSN: BD Venflon Pro Safety (VPS) Needle Protected IV Cannula. This product was listed in the catalogue (now removed) last orders were 2018 for Owl Ward. Owl ward confirmed not used.

5.3. Overdue alerts closed:

- NatPSA/2020/005/NHSPS – Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults. Final version of the Standard Operating Procedure will be taken to the Drugs and Therapeutics Committee on 21/06/2021 and then on for final sign off at Safety Committee on 30/06/2021. Following this, training will be planned with the Pharmacy team and into ward areas. SOP signed off and available, training will be picked up as part of a work plan. This was closed on 8th July 2021.

5.4. There were 5 Internal Safety Alerts issued by the Trust. These were following learning from incidents either within the Trust or externally and are detailed as follows:

- HPFT/2021/006: Clinell Universal Wipes and Spray, Allergy Risk
- HPFT/2021/008: Non-Fixed Ligature Incident – Stitched on Paper Bags
- HPFT/2021/009: HMRC Scam
- HPFT/2021/010: Seclusion Observations & Monitoring
- HPFT/2021/012: Safer Needle Device.

6. Care Quality Commission

6.1 The Care Quality Commission (CQC) Insight is a monitoring tool which tracks trends in quality (declining or improving) at provider, location and/or core service level to support decision making). CQC Insight aims to make it easier for inspectors to monitor their portfolio and identify potential changes in quality by having routine access to key information. It will also contribute to a shared view of quality across services.

6.2 The following was identified in the CQC Insight report dated 27th April 2021:

- The following was identified as 'worse' compared nationally:
  - CAS alerts being dealt with in a timely way:
    - The Trust has a policy for the cascading of all safety alerts (including NPSAs). The Trust's Safer Care and Standards Facilitator is responsible, on behalf of the Trust, to confirm that they have received the alert on the CAS system and that it is being cascaded to all relevant areas within the Trust, as appropriate. There are deadline dates on all alerts by which the Trust has to confirm all necessary action has been completed, actions will be followed up and escalated by the Safer Care and Standards Facilitator
    - All alerts are stored and updated on Datix, noting whether the alert is applicable or non-applicable to the Trust and any actions that need to be taken. Evidence of actions taken, and compliance is saved on Datix as a contemporary record of the alert
    - Compliance with the implementation of alerts is provided with a quarterly report which is presented at the Trust's Safety Committee,

Health and Safety Committee and Medical Devices Committee as appropriate to the type of alerts received. This will detail any alerts which are applicable to the Trust, actions being taken and any alert which are overdue for completion
        - The Trust has implemented an outlook reminder/flagging process for all alert completion deadline dates
    - Risk of under-reporting patient safety incidents to the National Reporting and Learning System (NRLS):
        - The Safer Care Team confirmed that all NRLS applicable incidents have been reported in the most recent time period.
- The following was identified as 'declined' compared nationally.
    - Proportion of patient safety alerts resulting in harm.
        - The level of harm and trends with regards to the level of harm is reported in the quarter 4 and Annual Integrated Safety Report. The number of incidents resulting in moderate or severe harm and death combined increased from 811 to 1,114 from 2019/20 to 2020/21
        - There was an increase in the total number of incidents reported overall and the proportion of incidents resulting in moderate or severe harm has therefore increased by 5.3%.

6.3 Changes from the April insight report reported in the June report are:

- Risk of under-reporting patient safety incidents to the National Reporting and Learning System (NRLS) – this is no longer listed as 'worse' compared nationally (Trust has improved)
- Proportion of patient safety incidents reported as resulting in harm (%) – this is no longer listed as 'declined' (Trust has improved).

7. Conclusion

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

Part B- Incidents, including Serious Incidents

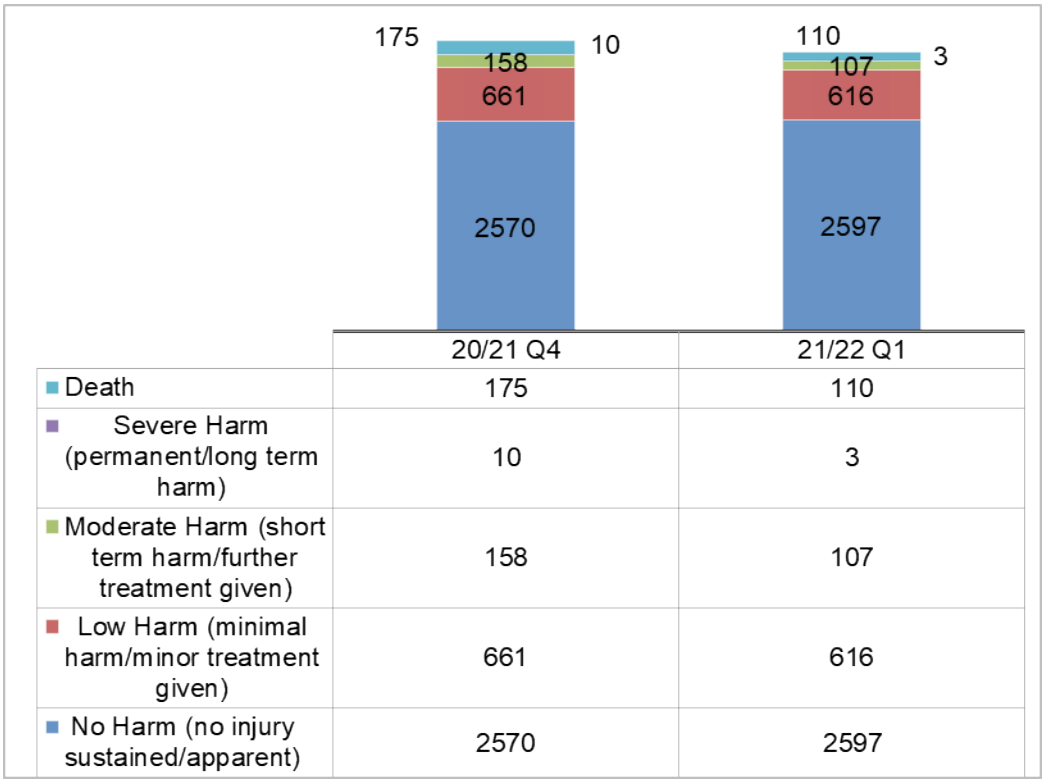
1. Introduction

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

2. Incidents

2.1. The total number of incidents reported on Datix in this quarter was 3,433 which is a decrease of 4% from 3,574 reported in quarter 4; however, when compared to the same quarter in 2020/21, this is an increase of 9%. Fluctuations overtime can be expected, for example if wards have high acuity. The number of incidents graded as *moderate* or *severe harm* was 3.2% compared to 4.7% in quarter 4 of (figure 1).

2.2. Reporting of incidents continues to be encouraged and high numbers of report that are of a lower level of harm can indicate a strong culture of safety.



	20/21 Q4	21/22 Q1
Death	175	110
Severe Harm (permanent/long term harm)	10	3
Moderate Harm (short term harm/further treatment given)	158	107
Low Harm (minimal harm/minor treatment given)	661	616
No Harm (no injury sustained/apparent)	2570	2597

Figure 1

Never Events

2.3. The Trust had no reported incidents that would meet Never Events criteria.

Eliminating Mixed Sex Accommodation

2.4. NHS England and Improvement (NHSE/I) suspended the collection and publication of official statistics including Eliminating Mixed Sex Accommodation (EMSA) owing to COVID-19 and the need to release capacity across the NHS to support the response. Suspension is continuing until further notice from NHS England.

2.5. Despite this the Trust decided to continue to monitor this internally, including near misses. There have been no breaches of the regulations in the quarter.

Medicines Safety

2.6. In quarter 1 the reporting rate for medication incidents (both internal and external to the Trust) showed a 4% increase to 166, when compared to the previous quarter of 159. Of the reported 153 medication incidents internal to the Trust, 147 (96%) resulted in *no harm,* 5 (3.3 %) resulted in *low harm*. One incident (0.7%) was classified as moderate harm.

2.7. Administration incidents remained the top sub-category of medication incidents reported in the quarter (figure 2).

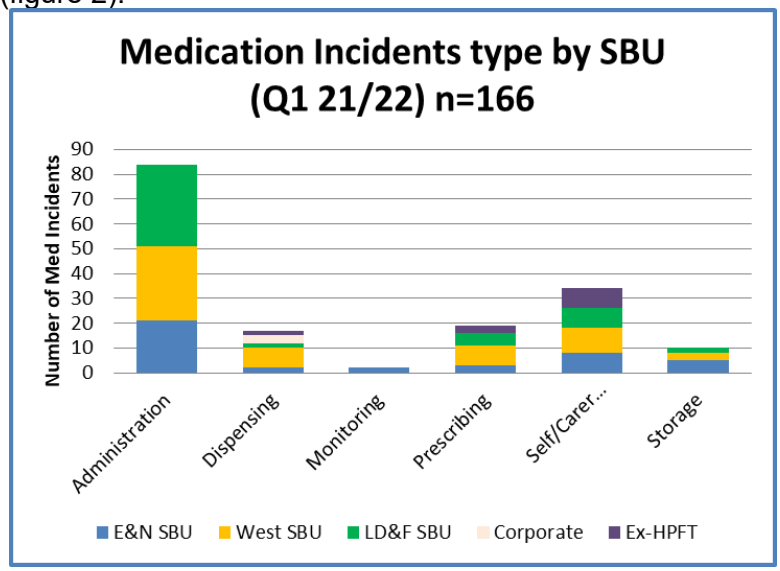


Figure 2

Serious Incidents

2.8. The Trust reported 32 SIs externally during the quarter; an increase compared to 29 in the previous quarter (figures 3 and 4). There was also an increase by 1 in self harm SIs and an increase by 2 for unexpected deaths reported. Furthermore, there was a decrease in the number of reported incidents relating to violence and aggression.

Category	Q1 2020	Q1 2021
Unexpected or avoidable deaths	7	12
Disruptive, aggressive or violent behaviour	4	2
Apparent, actual or suspected self-inflicted harm	8	10
Slip, trip or fall	2	2
Abuse or alleged abuse of adult patient by staff	0	2
Unauthorised absence	1	0
Abuse or alleged abuse of adult patient by third party	1	2
Commissioning incident meeting SI criteria	0	1
TOTAL	23	32

Figure 3

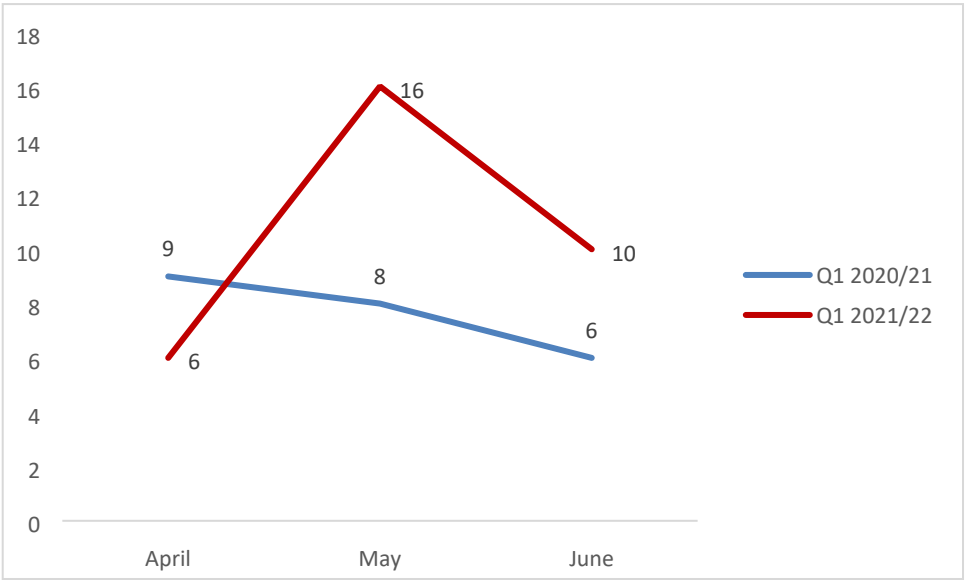


Figure 4

2.9. A total of 33 SI Root Couse Analysis (RCA) reports were completed and submitted to the CCG in the quarter all were within the 60-day timeframe or within an extension period agreed with the CCG.

2.10. At the end of the quarter, there were no SI RCA action plans, that were outside of the timeframe.

Duty of Candour

2.11. The Trust's Duty of Candour policy sets out the requirement to meet the Statutory Duty and this is assessed through the Quality Schedule, with records on Datix. A copy of the SI reports continues to be shared in full with the service user or the family and also with HM Coroner.

2.12. The Trust continues to embrace the principles of open and transparent communication in keeping with a just and learning culture. Discussions around whether compliance has been met for individual incidents takes place at the weekly Moderate Harm Review Panel, where decisions are made on whether an SI will be called and if further actions are required.

2.13. This work will inform a library of recommendations that are built on to ensure systematic learning that builds on previous experience of what worked and what has not worked previously.

3. Mortality

3.1. All deaths that are reported continue to be screened each week. Those that meet red flag criteria undergo a Structured Judgement Review (SJR). Some deaths in the quarter had not been screened at the time of this report, primarily due to delays in reporting.

3.2. SPIKE2 includes deaths reported on the national spine. It is anticipated this will improve the timeliness of screening of deaths and updating of Trust systems, to show a person as deceased and not open to services.

3.3. 110 deaths were reported during the quarter (figure 5), a decrease of 65 when compared to the previous quarter (175), which is in line with the national picture around COVID19 deaths. Although fluctuations in numbers can be expected between quarters, quarter 1

2020 was an exceptional period as this was during the first wave of COVID19 and when deaths due to suspected or confirmed COVID19 occurred and were recorded. Conversely, this quarter reflects the national picture of deaths reported returning to pre pandemic numbers.

	East and North Hertfordshire Strategic Business Unit	Essex & IAPT SBU	Learning Disabilities & Forensic Strategic Business Unit	Non HPFT	West Hertfordshire Strategic Business Unit	Total
20/21 Q1	158	15	22	0	16	211
20/21 Q2	78	15	12	0	19	124
20/21 Q3	81	12	14	0	24	131
20/21 Q4	111	23	18	1	22	175
21/22 Q1	72	12	8	0	18	110
Total	500	77	74	1	99	751

Figure 5

3.4. The higher numbers of deaths were in the East and North SBU, as would be expected, as it includes the older aged adult services.

Structured Judgement Reviews

3.5. There were 15 SJRs completed in the quarter, which included deaths that occurred outside of the period.

3.6. The most frequently occurring learning themes from the 15 SJRs included:

- Insufficient Risk assessments
- Lack of medication review and listing on electronic patient records (EPR)
- Physical heath monitoring
- Inclusion of alerts
- Involving GP and including GP summary
- Safeguarding referral for risk of self-neglect.

3.7. Details of learning themes are disseminated in governance structures within the SBUs, with relevant learning notes disseminated. Moving forwards, audit will be used as a method of ensuring improvements in practice.

3.8. Details of learning themes are disseminated in governance structures within the SBUs, with relevant learning notes disseminated. Moving forwards, audit will be used as a method of ensuring improvements in practice.

Learning Disability Mortality Review

3.9 There were 9 deaths of service users known to the Trust's learning disability services reported to the national Learning Disability Mortality Review (LeDeR) programme in this quarter, which is a decrease of 72% when compared to the cases reported in the previous quarter of 32.

3.10 Details of each completed LeDeR review is disseminated via the Learning Disability and Forensic SBU governance process. The Trust's Mortality Governance Lead also liaises with other LeDeR groups in the region to improve the feedback from reviews and disseminate learning.

COVID19 deaths

3.11 In March 2020, NHSE/I developed the COVID19 Patient Notification System (CPNS) to enable all confirmed COVID19 deaths to be reported on one central system. There were 0 deaths reportable to the national system in the quarter therefore the Trust has reported a total of 15 deaths via this system.

Suicide

3.12 In the quarter, the number of deaths that were thought to be as a result of suicide was 16. For the same reporting period last year, there were 9. These figures are before the coroner has determined whether or not they were suicides.

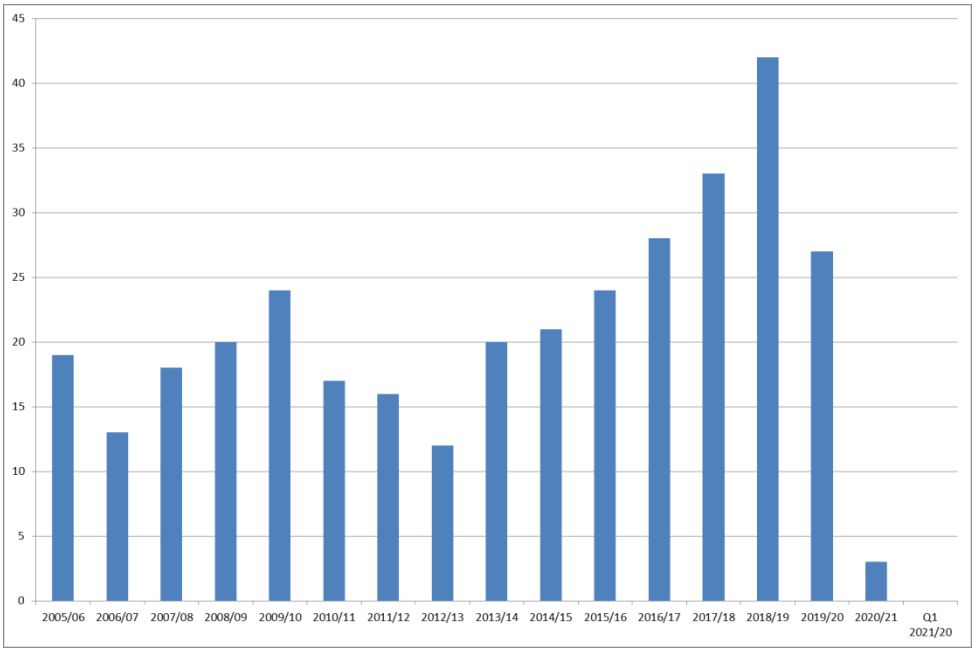


Figure 6

3.13 Deaths which are reported and believed to be suicide are included in the Trust's data set, all of which are investigated and followed through inquest to the outcome (figure 8)**.** The Trust will classify as suspected suicide until the outcome of the inquest is known. Every quarter, since quarter 3 2015/16, has shown that at least 1, and at most 8, per quarter have been returned as not being a suicide.

3.14 The Court of Appeal in 2019 ruled that the standard of proof for requiring a suicide conclusion should be the civil standard (on the balance of probability) rather than the criminal standard (beyond reasonable doubt). The lowering of the threshold is expected to lead to an increase in deaths recorded as suicide and therefore data will not be comparable with previous years. As a result from this quarter, only data from 2019/20 and 2020/21 will be reported.

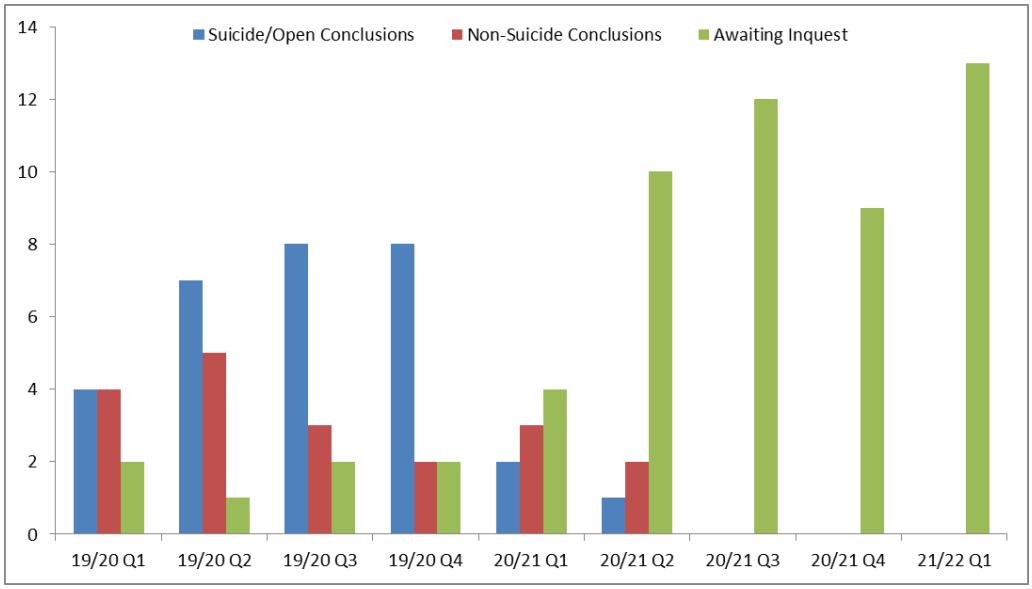


Figure 7

Prevention of Future Deaths

3.15 In the quarter, the Trust reviewed 52 national publications of Regulation 28 Prevention of Future Death (PFD) reports published from HM Coroners. Whilst it is acknowledged that PFD reports only provide a 'snapshot' of evidence heard at an inquest and therefore have some limitations, the reports provide the Trust with an opportunity to review processes and systems and reflect on whether any actions are required.

3.16 From the national publications of PFD reports, 13 were relevant for the purposes of learning; key areas included:

- Lack of family involvement
- Risk management and planning for discharge
- Internal Investigations: delay and involvement of key individuals
- Incomprehensive falls risk assessments
- Autism awareness and training around eating disorders.

3.17 Learning from PFD reports continue to be discussed at the Safety Committee and SBU Quality Risk Meetings for onward dissemination and have informed suicide prevention work streams as well as used in safeguarding training.

3.18 The Trust received 1 PFD in June 2021 from HM Assistant Coroner for Hertfordshire, following the conclusion of the inquest into the homicide of a member of the public by a Trust service user. The Coroner returned a Narrative Conclusion, concluding that the deceased 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 the death.

3.19 HM Assistant Coroner for Hertfordshire concluded that the evidence regarding knowledge of the Potentially Dangerous Persons process within Hertfordshire Constabulary, the Trust, and the National Probation Service was sporadic, and issued a Prevention of Future Deaths (PFD. The report requested that the three Organisations disseminate information to raise awareness and deliver training regarding the Potentially Dangerous Persons process throughout the organisations.

3.20 The Trust responded to the PFD within the statutory timescales, confirming the actions being taken across the Trust to strengthen awareness of the Potentially Dangerous Persons process.

4 Harm free Mental Health Care

Self Harm

Ligature Incidents

4.1 Within the quarter, there were 59 reported ligature incidents within inpatient services which is a 5% decrease on the previous quarter of 62 (figure 8). There was an increase of 4 in the community on the previous quarter from 4 to 8 in quarter 1 2021/22. The breakdown across the SBUs is 40/59 (68%) SBU West, 9/59 (15%) SBU Learning Disability and Forensic, and 10/59 (17%) SBU East.

4.2 40/59 incidents involved items of clothing which is consistent with national guidance.

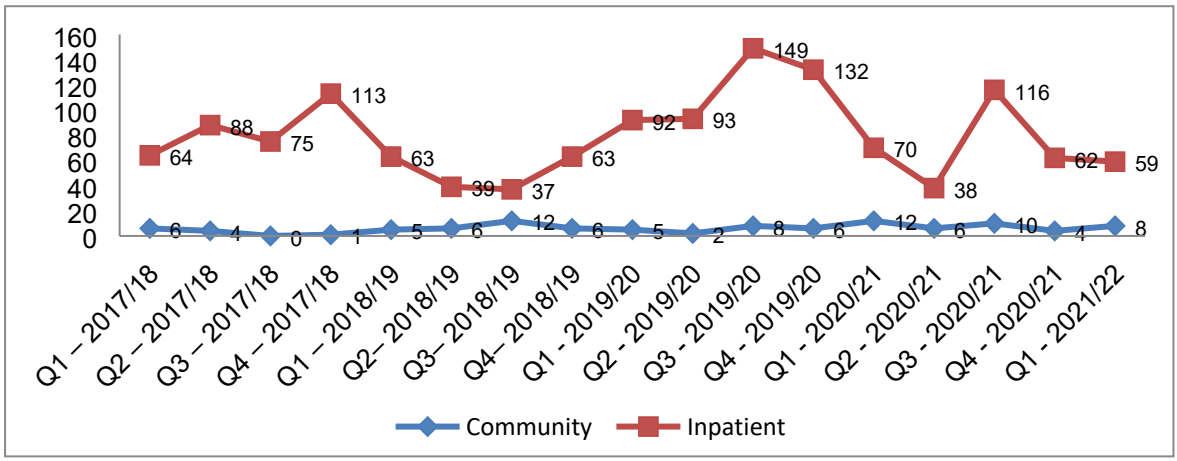


Figure 8

4.3 There were 3 reported ligature incidents involving anchor points over the quarter, with no change reported in the previous quarter. All 3 of these incidents involved different service users using doors as an anchor point within Aston and Hathor wards, with 2 incidents in the latter.

4.4 Ligature incidents using clothing remains the category with the highest number of incidents of this type on the inpatient units. ANT, the review of environmental risk, has developed further over the year to improve assurance and evidence of reviews.

Absence Without Leave and Missing Persons

4.5 There continues to be an overall downward trend in AWOL and Missing Person incidents from 64 in quarter 1 2019/20 to 30 in quarter 1 2021/22 (figure 9) however there has been an increase from 10 to 30 incidents (200% increase).

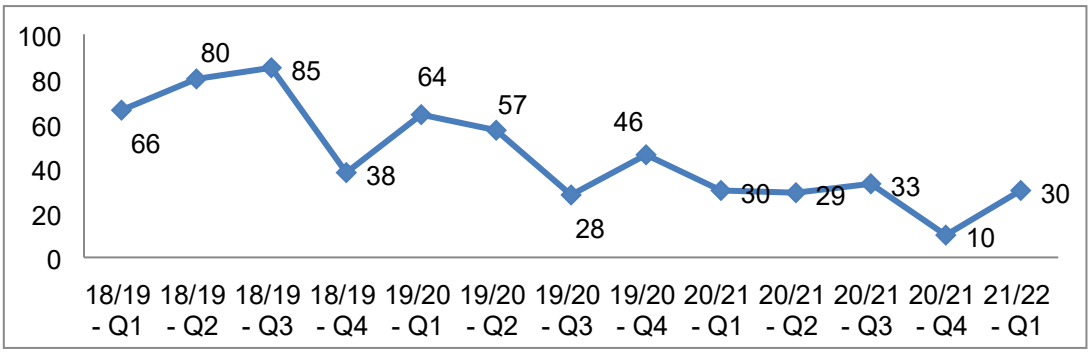


Figure 9

Violence and Aggression

4.6 As part of the assurance process for violence and aggression incidents, each SBU has developed local approaches (in line with the Making Our Service Safer Together Strategy - MOSStogether) to reduce Conflict (violence) and Containment (restrictive practices). These, alongside monthly targets for harm reduction, support the Trust targets as part of the Annual Plan.

4.7 Discussions held at the SBU's Quality Review Meetings are summarised in a monthly Flash Report focusing on areas of concern, innovation and best practice and presented to the Restrictive Practice Committee.

4.8 The Trust has implemented a Respect Training Recovery plan, this has been further strengthened through the recruitment of two of the three funded trainers through NMET funding. Expressions of interest for the third post are still ongoing.

Service User to Staff Assaults

4.9 386 service user to staff assault incidents have been reported within the quarter, which is an increase from the previous quarter (figure 10). Overall, 380 (98%) service user to staff assault incidents resulted in no harm and 6 (2%) in moderate harm (Figure 12).

4.10 The increase in assaults can be linked to a limited number of individuals involved in multiple incidents within inpatient services; this has further been exacerbated by the admission to the Trust from another Hospital following their closure by the CQC of three complex service users to the Assessment and Treatment services in Norfolk and Essex.

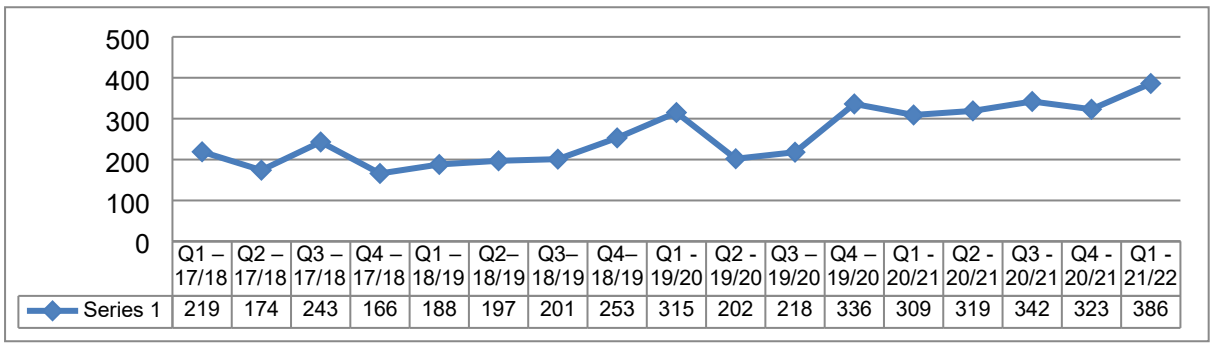


Figure 10

4.11 Lexden accounted for 126 (33%) of the total assaults on staff, although had no moderate or severe harm incidents. Of the incidents recorded within Lexden, 2 service users accounted for 86% (108/126); Trust wide this figure was 28% (108/386) of the total incidents. Both service users require specialised community single person

accommodation and are delayed transfers of care (DToC). There is a potential discharge date for one service user for mid-August.

4.12 There were 2 moderate harm incidents within the Learning Disability and Forensic SBU, the East and North SBU and the West SBU. As part of the reviewing process, all moderate harm incidents are reviewed and reported through the moderate harm panel.

Quarter1 2021/22 Service User to Staff Assaults by Harm					
SBU	**No Harm**	**Low Harm**	**Mod Harm**	**Sev Harm**	**Totals**
West	37	20	**2**	**0**	59
LD&F	72	58	**2**	**0**	132
East	31	36	**2**	**0**	69
Essex	72	54	**0**	**0**	126
Totals	212	168	**6**	**0**	386

Figure 11

4.13 The Annual Plan set a target for reducing service user on staff assaults that resulted in moderate or severe harm, rather than reducing overall, to prevent the risk of staff not reporting within inpatient services. There were a total of 29 moderate harm incidents reported in 2020/21; currently moderate harm incidents are below the mean average compared to the previous year.

4.14 The Police Liaison Group continues to meet and has focused on reviewing the police/Trust memorandum of understanding and ensuring staff are supported to report assaults.

4.15 There were 13 Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) reported within inpatient services in the quarter which is an increase from 8 in quarter 1. The break down is 4 each from the East and North SBU and the Essex and IAPT SBU.

4.16 As part of the reviewing process the Health and Safety Lead and the Practice Development and Patient Safety Team meet monthly to explore further all RIDDOR incidents.

Service User to Service User Assaults

4.17 The overall number of service user to service user assaults has increased by 62 (119%) from 52 in quarter 4 to 114 (figure 12).

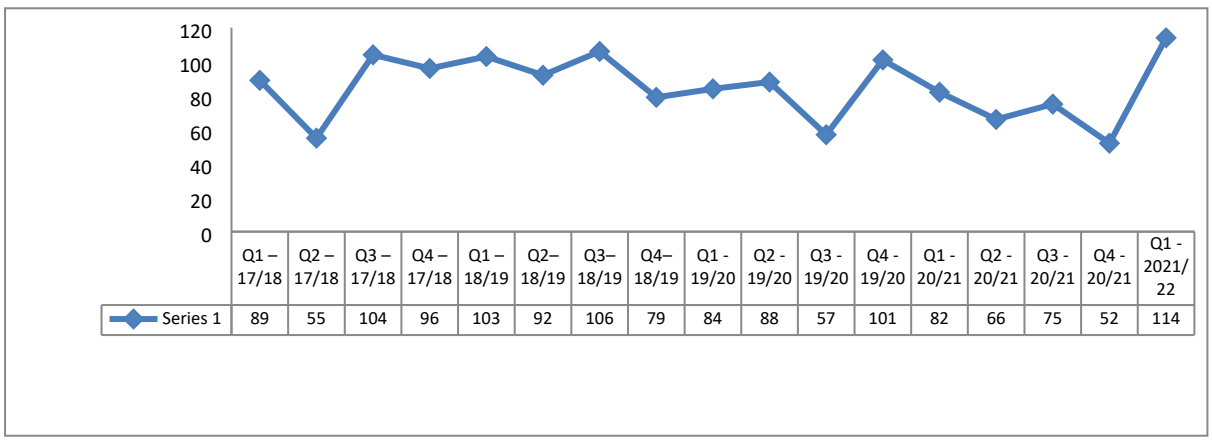


Figure 12

4.18 There has been increases incidents across all SBUs, except Essex and IAPT, however these incidents are specifically attributed to small increases across multiple sites. There are particular challenges regarding individual service users within Astley Court and Lambourne Grove.

4.19 The East and North SBU accounted for 48% (55/114) of the total incidents of service user to service assaults reported in quarter 1 (figure 13). Owing to the level of risk a single service user posed they have been placed in LTS.

SBU	No Harm	Low Harm	Mod Harm	Sev Harm	Totals
West	17	6	**0**	**0**	23
LD&F	27	7	**1**	**0**	35
East	41	14	**0**	**0**	55
Essex	0	1	**0**	**0**	1
Totals	85	28	**1**	**0**	114

Figure 13

4.20 There have been no incidents of severe harm to service users from other service users over the quarter. There was 1 incident of moderate harm involving service user on service user assaults with no severe harm incidents. All incidents of moderate harm are reviewed and reported through the moderate harm panel to the Safety Committee.

4.21 All incidents of service user to service assaults are reported to the local safeguarding team for review and any learning is implemented to minimise future risk.

5 Least Restrictive Care

5.1 The Trust continues to aim to provide care using the least restrictive approach. Restrictive practice includes restraint, seclusion, long term segregation and rapid tranquillisation. It also includes blanket restrictions.

5.2 The Dynamic Appraisal of Situational Aggression (DASA) is a structured violence risk assessment used in a clinical ward setting to identify acute risk of patient aggression within 24 hours of the assessment. This assessment process has been introduced to Oak Ward and the Broadland Clinic for evaluation.

Restraint

5.3 There has been a 16% increase in the use of physical interventions from the last quarter. 278 of the 505 (55%) of the incidents were attributed to the Learning Disability Assessment andTreatment Units. 3 service users admitted from the private hospital to Astley Court (2) and Lexden (1) accounted for 183 of the incidents.

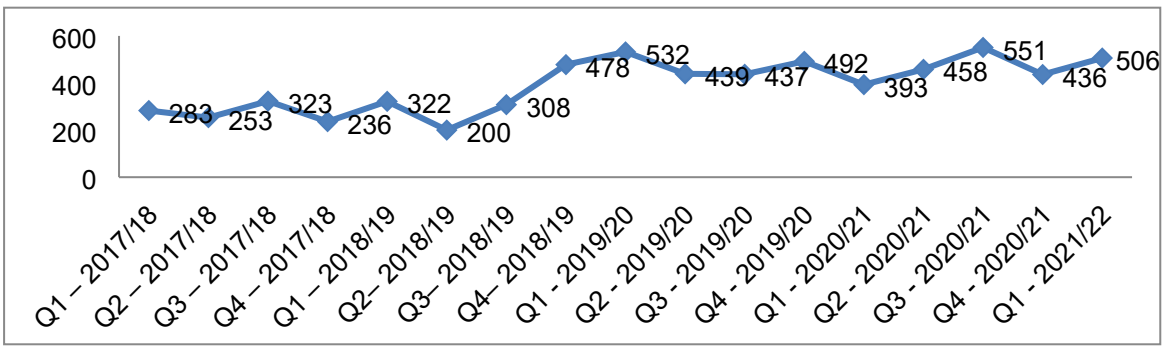


Figure 14

5.4 The Practice Development and Patient Safety Team met with senior clinicians from Lexden 3 times a week to offer ongoing support regarding one admission who was placed in LTS. Ad-hoc support has been provided to Astley Court when required and specialised advice given regarding the service user spitting at staff as part of their behaviour – goggles have been issued instead of visors due to the visors been deliberately targeted in order to knock them off.

5.5 Nationally it is recognised that Personal Protective Equipment (PPE) reduces the ability to read nonverbal signals impacting on the therapeutic interactions during de-escalation. There have been several incidents across the SBUs whereby during some incidents service users have attempted/removed staff PPE.

5.6 The Trust has developed a recovery RESPECT training plan which included the training/development of a further ten in-house trainers across the Trust and recruitment of a further two full time trainers. The recovery plan is in the early stages and it is anticipated that there will be a delay to the anticipated trajectory due to not all the training vacancies being filled.

5.7 This was supported through the launch of the Trust's MOSSTogether strategy and the continued monitoring and review of practices through the Restrictive Practice Committee. The impact of these actions will be monitored in 2021/22 and further work developed to reduce the use of restraint.

5.8 Prone restraint (when a person is held chest down, whether the service user placed themselves in this position or not) is not taught as part of the restraint teaching methodology. As part of ongoing assurance, each reported incident of prone is subject to a comprehensive review, by a subject matter expert in consideration of the potential risk of harm to the service user.

5.9 There has been a downward trend of prone restraint to quarter 4 2020/21, however within this quarter there were 5 incidents (figure 15). Each of the incidents has been reviewed in line with the violence and aggression policy; 2 incidents involved the administration of medication, 2 incidents were due to the service user placing themselves in a prone position and 1 incident was a consequence to challenges in stabilising the situation.

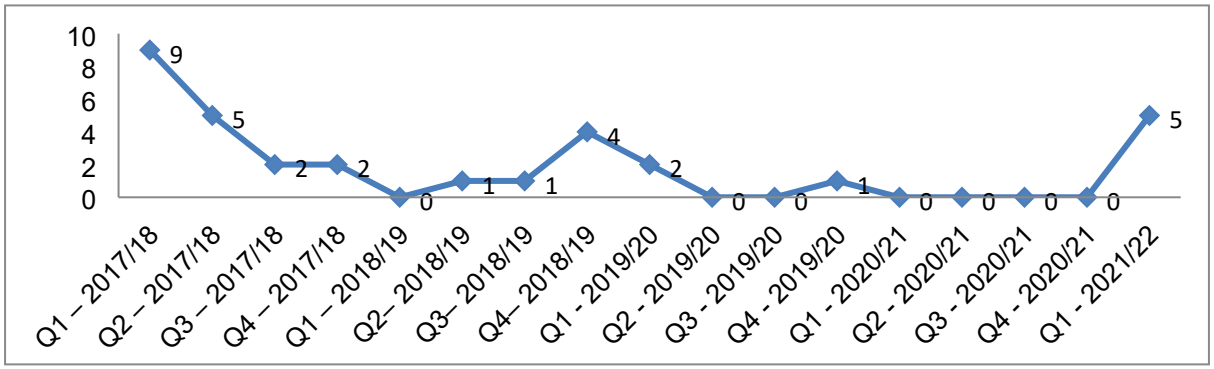


Figure 15

Seclusion

5.10 Seclusion is a restrictive practice where someone is confined, alone, in a room and is prevented from leaving. The use of seclusion is reviewed daily by the MDT team and reported on a monthly basis, both internally and externally through the NHS Digital and the Restrictive Practice Committee. Data is included in the SBU Flash Reports for the Restrictive Practice Committee and further reviewed and audited on an annual basis in line with the Mental Health Act (MHA) Code of Practice 2015 by the Practice Development and Patient Safety Team, with findings disseminated in the Trust.

5.11 An increase in seclusion has been reported from the previous quarter, from 71 to 80, 17 of the incidents (21%) were attributed to 3 service users from the closure of a private hospital by the CQC and the emergency admission into the 2 Learning Disability Assessment and Treatment Units in Norfolk (11 incidents involving 2 service users) and Essex (4 involving one service user) and the challenges involving meeting the individual service users' complex behaviours.

5.12 The number of seclusions has increased within the quarter to levels consistent with previous quarters (figure 16). This data mirrors the finding of the use of restraint data whereby it is a small number of individual service users who impact on the figures due to their high-risk presentation towards others.

5.13 There were 40 service users subject to seclusion in the quarter 1, however 8 service users accounted for 39 incidents (6 service users accounted for 30 incidents within the 3 Learning Disability Assessment and Treatment units and 2 service users accounted for 9 incidents within 2 Acute mental health units. The 3 Learning Disability Assessment and Treatment units accounted for 39/80 (49%) of all seclusion incidents.

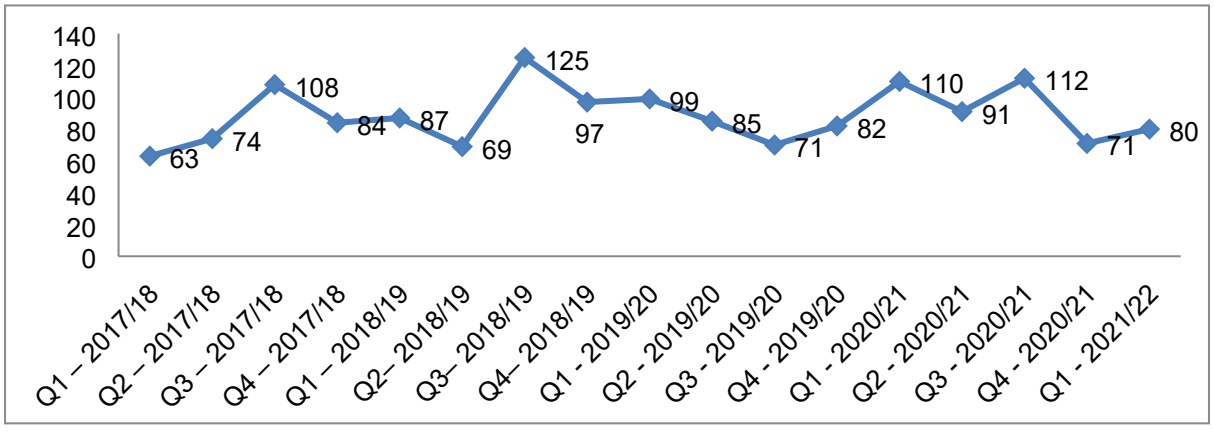


Figure 16

5.14 The annual plan set the objective of reducing the length of time in section. Quarter 1 set the base line. Where a seclusion takes place in a none identified seclusion room a safeguarding referral is raised.

Long Term Segregation

5.15 LTS refers to a situation where, in order to reduce a sustained risk of harm posed by service user to others, that is a constant feature of their presentation, a service user is cared for separately from others. All LTS reviews take place in line with the MHA Code of Practice (2015), including daily medical reviews MDT reviews, independent clinician reviews and external hospital reviews as part of agreed procedural safeguards, that

uphold Human Rights. As part of the national approach to monitoring the use of LTS within Trusts, each of the service users has a regular external Independent Care and Treatment Review.

5.16 There are 5 service users subject to LTS in the quarter and have been 4 new applications approved and 3 rescinded (figure 17). Additional use of the 'Barriers for Change Checklist' have been used as part of the HOPE model, with a focus on positive and proactive approaches.

Unit	Section	Start Date	End Date
Dove Ward	3	18 08 2020	06/06/2021
2 Forest Lane	3	18 02 2010	
Dove Ward	3	09 02 2021	14/05/2021
Oak Ward	3	12 02 2021	
Forest House	3	01 04 2021	03/06/2021
Hathor Ward	3	21 05 2021	
Lambourne Grove	3	15 06 2021	
A&T Lexden	3	18 06 2021	

Figure 17

5.17 The rights of service user in LTS has been placed on the safety risk register. This risk is specifically about the risk of not attending to the Human Rights of individuals whilst they are in LTS.

5.18 Updates from the clinical teams and policy adherence are received and reported to the Executive Team weekly by the Practice Development and Patient Safety Team, The Deputy Director of Nursing then liaises with the CQC regarding ongoing updates.

5.19 All new LTS applications are referred to Safeguarding and an Independent Mental Health Advocate is appointed to support the individual.

Rapid Tranquilisation

5.20 Rapid tranquilisation is the use of medication to manage acute, behavioural disturbance by calming or slightly sedating an individual to reduce the risk of harm to self or others. 24/53 (45%) RT incidents (figure 18) were within the acute mental health services and needs to be seen within the context of the work that has been done in relation to Stopping Over Medication of People with a Learning Disability, autism or both (STOMP).

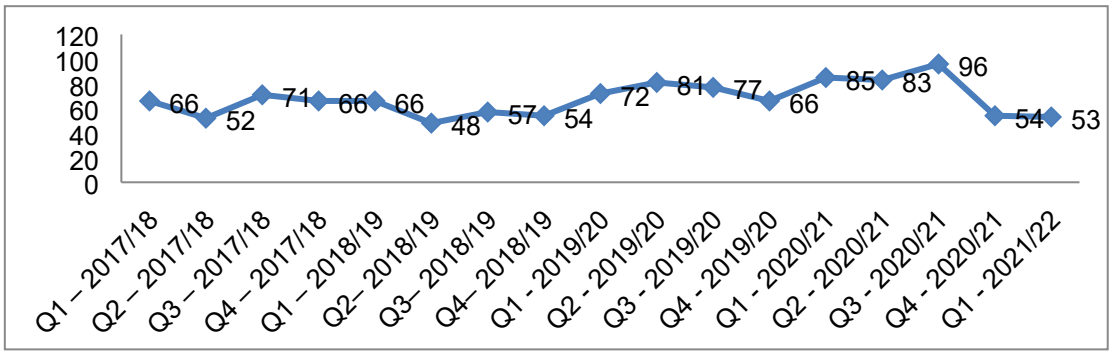


Figure 18

5.21 45% of incidents reported within the West SBU are associated with acute behavioural disturbance within the acute care pathway often attributed to higher levels requiring psychiatric intensive care and ongoing assessment to support behavioural challenge. All efforts are taken to proactively manage, so they are proportional least restrictive and in the best interests of the individual.

5.22 There is a difference in the use of Rapid Tranquilisation across the SBUs, owing to different approaches used in terms of Positive Behavioural Support and pre-planned interventions undertaken in learning disability services and through initiative such as 'STOMP' to reduce unnecessary levels of enforced medication. Conversely acute adult care reflects unassessed presentations as part of the acute care pathway, leading to assessment and treatment, requiring safety interventions which result in different levels of restraint and use of Rapid Tranquilisation.

5.23 As part of the ongoing governance procedures, all clinical areas receive a clinical visit from a pharmacist who monitor Rapid Tranquilisation prescriptions as part of their routine work. Rapid Tranquilisation is included in the POMH-UK audit cycle and was also the subject of a PAIG audit following CQC visit. This process is further monitored through the SBU's Monthly Quality Risk Meetings.

6. Harm free physical health care

6.1 National data collection for the 'classic' Safety Thermometer and the 'next generation' Safety Thermometers ceased after March 2020 with the introduction of nationally produced replacement data planned and temporarily paused due to COVID-19. There is currently no further update on nationally produced replacement data. The Trust decided to continue to monitor the areas covered by the safety thermometer.

Pressure Ulcers

6.2 There were 9 reported pressure ulcers incidents in the quarter acquired whilst receiving Trust care. There were 4 moisture associated skin damage incidents; 3 unclassified; 1 category 1 and 1 category 2.

Service user slips, trips and falls

6.3 The Trust is part of the regional Frailty Pathway work to inform best practice and innovation around frailty and falls prevention, overseen internally by the Falls Group. The number of falls being reported is 130 compared to 98 in the last quarter.

7. Safeguarding

7.1 Safeguarding covers both adult and children. This report will initially consider child safeguarding and then move onto adult safeguarding. Specific areas of work are then addressed including radicalisation and knife crime. This section will conclude with an overview of audits that have taken place.

7.2 The declaration of a global pandemic on March 11th 2020 and subsequent measures taken by the Government continue to pose changes and challenges in service delivery, both within the Trust and the wider system. Following the challenges raised regarding COVID-19 and continuing to ensure service users and families safety, the Corporate Safeguarding Team instigated a business continuity plan for a 'business as usual' approach to ensure consistent oversight of all concerns and processes.

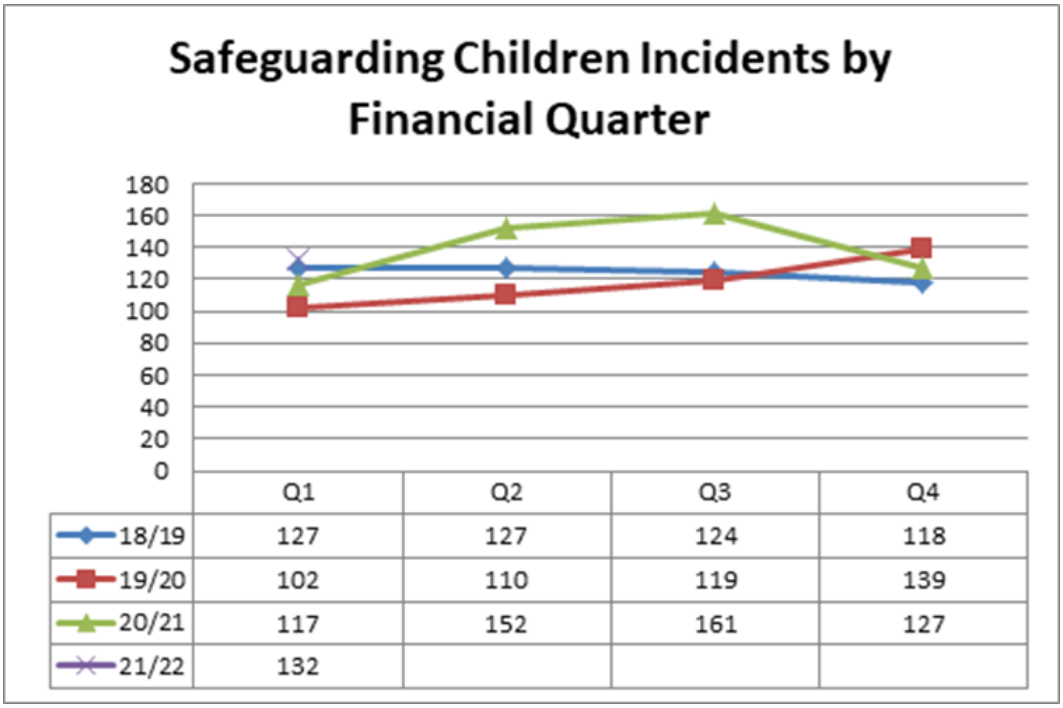
7.3 Adoption of technology has created opportunity in terms of staff development and the Corporate Safeguarding Team delivered online seminars on topics including Domestic Abuse, Self-Neglect and Gangs with more sessions planned for quarter 3. This is a model which can be adopted to allow a more varied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

Children

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

Referrals

7.5 There were 132 safeguarding children referrals made in the quarter. Figure 20 shows the highest number of safeguarding incidents reported in the quarter for the past 4 years, with an increase of 5 incidents on quarter 4 2020/21. This would reflect the high number of referrals for mental health support coming into the Trust, as a result of the COVID19 pandemic.



	Q1	Q2	Q3	Q4
18/19	127	127	124	118
19/20	102	110	119	139
20/21	117	152	161	127
21/22	132			

Figure 20

7.6 Figure 21 illustrates the incidents by categories of abuse. Emotional abuse remains the most reported type of child safeguarding incident, with incidents for physical, sexual abuse and neglect roughly the same. Quarter 4 2020/21 saw a notable reduction in incidents of neglect, which could be attributable to the national lockdown and children having less contact with professionals. The reporting of incidents of neglect in this quarter has increased and is almost on par with reporting in quarters1-3 in 2020/21.

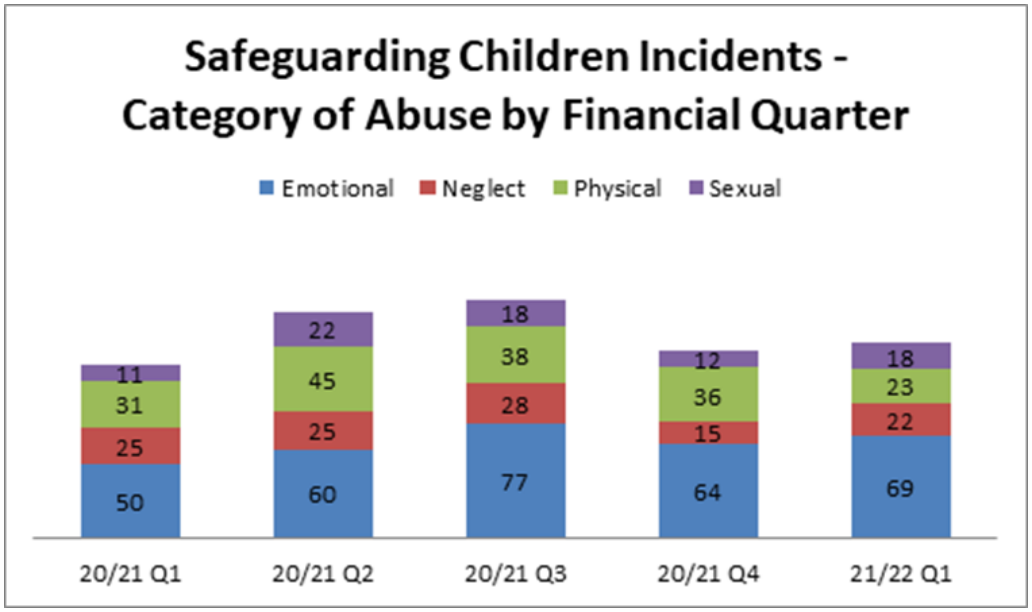


Figure 21

7.7 Figure 22 illustrates the teams reporting the safeguarding children incidents in the quarter. Owing to the nature of the CAMHS crisis assessment and treatment team (C-CATT), they consistently report the highest number of incidents, followed by other CAMHS services in north, east, west and the Eating Disorders Team. The Wellbeing services in east and north-west reported the highest number of referrals from adult services.

7.8 The Community Peri-Natal Team and Thumbswood Mother and Baby unit both reported 3 incidents in the quarter.

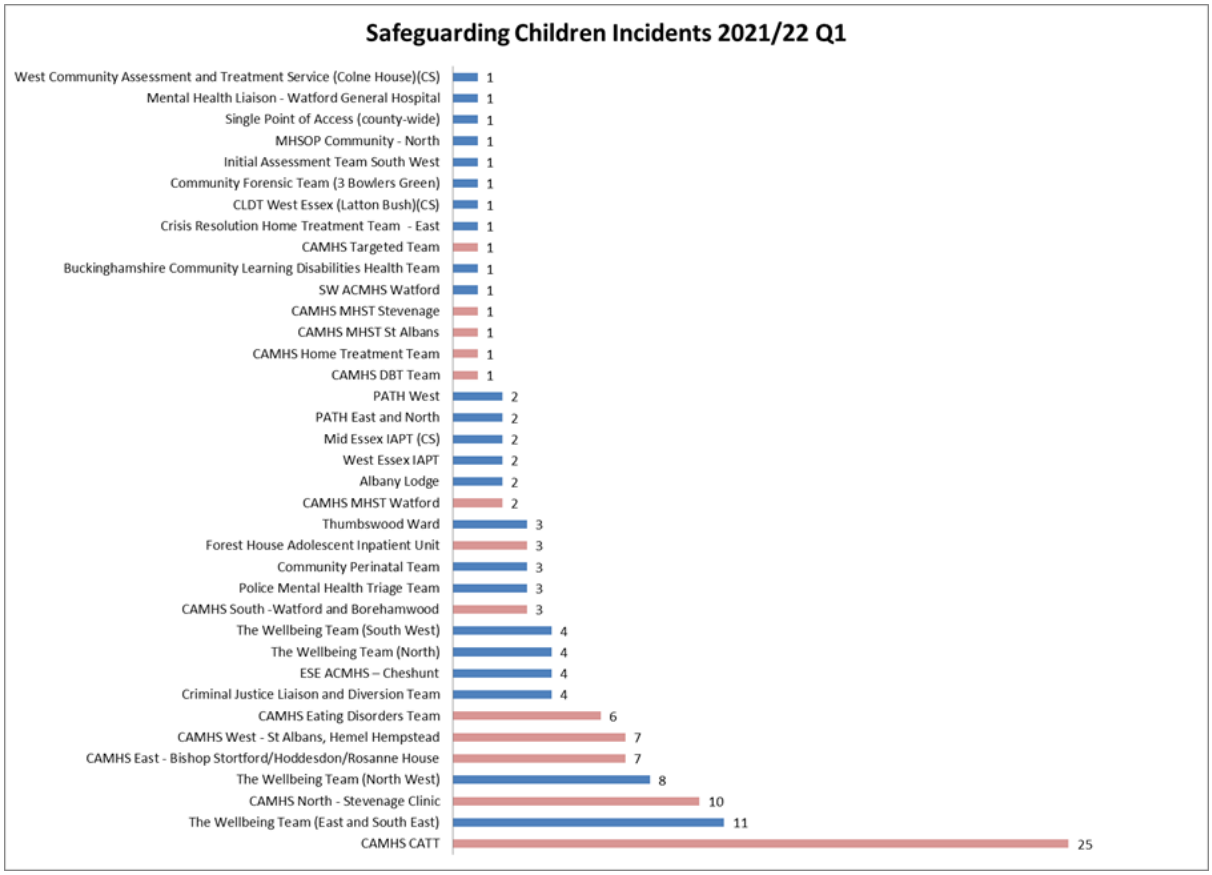


Figure 22

7.9 The Trust is involved in multiagency reviews and policies. High profile multi-agency cases for children include:

- Child L and Child N- serious case reviews completed and awaiting publication (delayed due to ongoing criminal and family court proceedings)
- Family B/SJ MAPPA Serious Case Review in Kent
- Child sustained serious injury in November 2020. The Trust has completed an SI Multi-agency learning event pending
- The death of 7-month-old. Multi-agency learning event pending.

Adult Safeguarding

Referrals and investigations

7.10 Safeguarding adult concerns have remained high during the quarter, although have not reached the levels seen in the last quarter (figure 2). The conversion rate remains within the expected range.

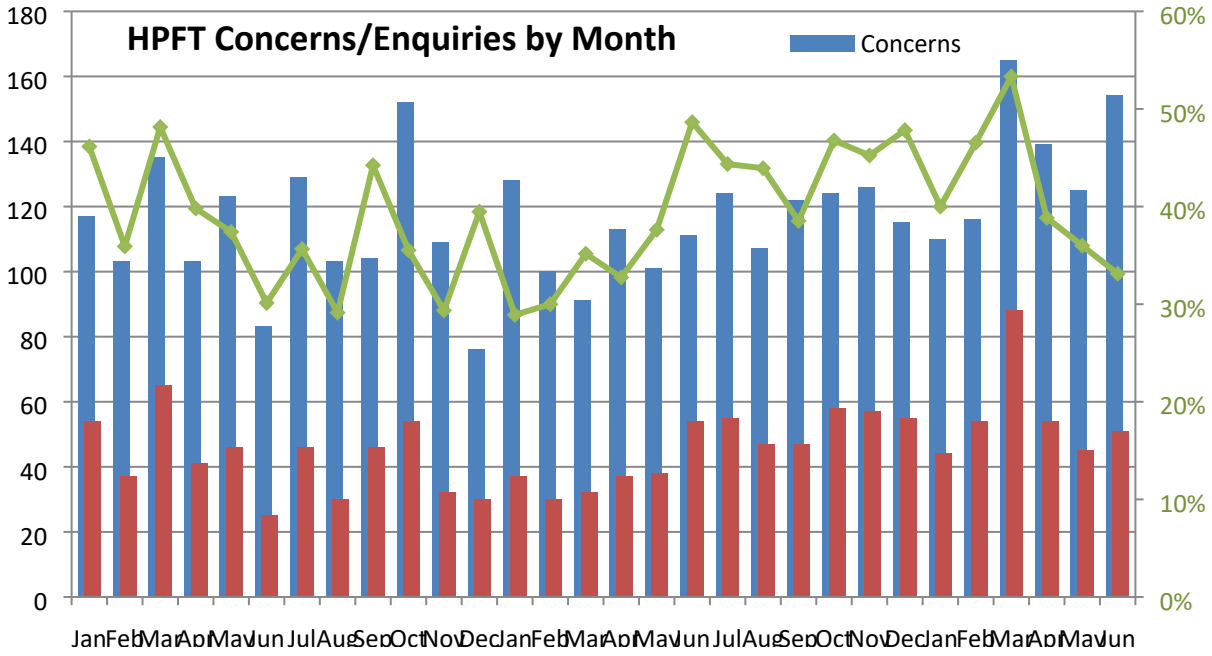
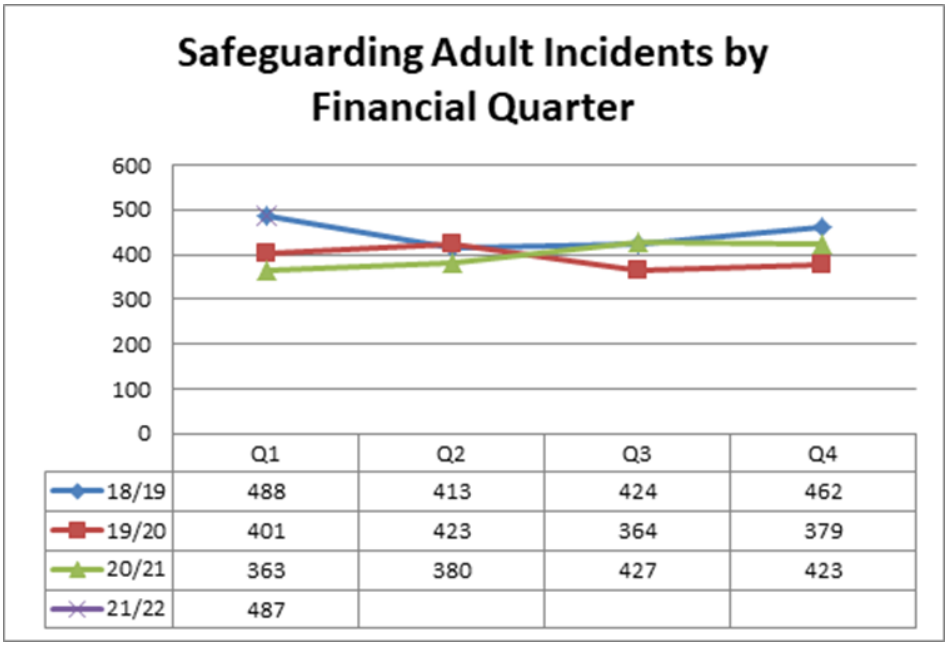


Figure 23

7.11 The number of Trust wide Safeguarding Adult incidents has risen significantly, with 487 recorded in this quarter (figure 24). It should be noted however that a separate audit of the Safeguarding dataset indicated an improvement in recording of Safeguarding incidents which suggests that the increase may be at least partly due to improved recording rather than an increased number of incidents



	Q1	Q2	Q3	Q4
18/19	488	413	424	462
19/20	401	423	364	379
20/21	363	380	427	423
21/22	487			

Figure 24

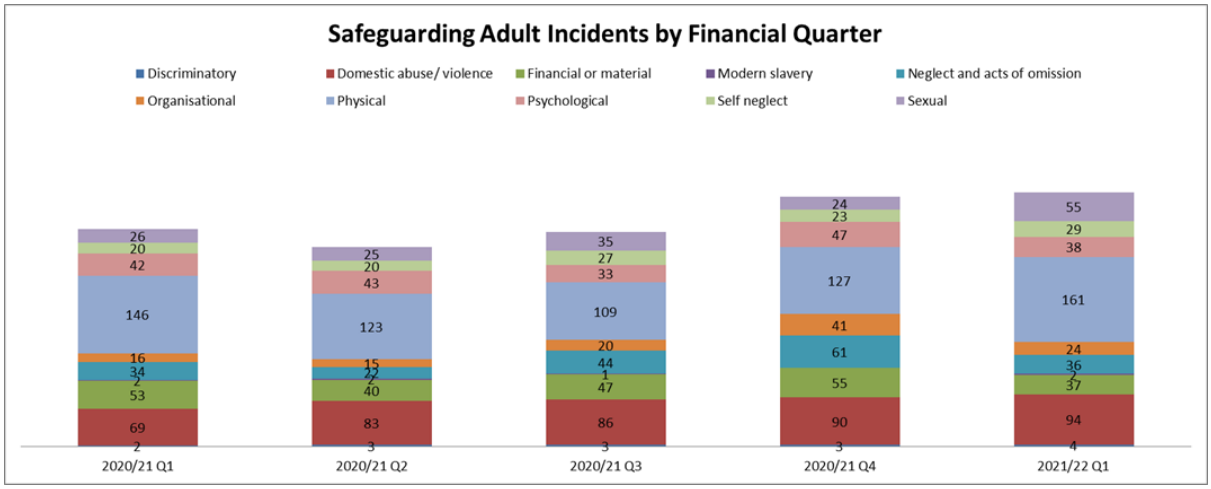


Figure 25

7.12 Domestic abuse continues to be one of the highest categories of abuse identified by staff in the quarter (figure 25); evidence from a currently ongoing re-audit of Safeguarding data suggests that this continues to be under reported and that the numbers continue to be higher.

7.13 Referrals for organisational abuse and neglect have noticeably decreased since the previous quarter and are now at similar levels to the same quarter last year.

7.14 The Trust has responsibilities to make decisions and investigate adult safeguarding concerns for individuals with a functional mental disorder in Hertfordshire. When an area of practice requires strengthening the team put in place an action plan.

7.15 The Trust is involved in a range of multiagency reviews in Hertfordshire, including 3 Domestic Homicide Reviews, in 2 cases the perpetrators had been briefly known to the Trust, and the third there was little involvement prior to the crime. There are currently 2 Safeguarding Adults Reviews ongoing, 1 focussing on a murder where both victim and perpetrator were known to agencies including the Trust, and the second is around the theme of 'cuckooing', gang related involvement and substance misuse. There are currently 2 Care Leaver Death Reviews ongoing.

7.16 The Trust made no referrals to Prevent in this quarter; however, individuals known to the Trust are frequently discussed at Channel Panel in Hertfordshire and the Trust is a key member of this panel, attending all meetings and working with our teams to ensure that they are engaged in any necessary actions resulting from the meeting.

7.17 Serious Violence Duty

The Trust and partner agencies are starting to prepare for the introduction of the new Serious Violence Duty which will commence once Police, Crime, Sentencing and Courts Bill is enacted. The bill has had its' second reading in the House of Commons and is currently at the committee stage. Royal Assent is planned for January 2022.

7.18 The Act will allow a public health approach to serious violence. The duty requires public bodies to work together to develop local strategies for reducing serious violence. Direct implications for mental health services and professionals at the front line are unclear at present, as this will depend on the approaches developed in their local area.

7.19 Sexual Safety

Sexual safety has been an area of focus for the Trust in the quarter with the reintroduction of the Sexual Safety Group, chaired by the Interim Head of Social Work and Safeguarding. The group is in it's infancy and is building on the work done by a previous Task and Finish Group which focussed on wards. The new group will have a broader remit looking at all aspects of sexual safety for service users, their families and staff. An action plan is being developed and progress will be fed back via Safety Committee and the Safeguarding Strategy Group.

7.20 Safeguarding Risk Register

There are currently 3 items on the Safeguarding Risk Register:

- Delays in sharing of information under the Children Act in Hertfordshire
- Levels 2 and 3 Safeguarding Children compliance
- Safeguarding reporting on SPIKE.

7.21 Safeguarding Children Referrals Audit

New quarterly audit commenced in the quarter by the Corporate Safeguarding Team, reviewing safeguarding children referrals, documentation and referral outcomes. 10 cases were randomly picked from each month (April- June 2021).

7.22 Findings:

- 53% (16/30) referrals were for emotional abuse
- 71% (17/24) of referrals had an open child safeguarding assessment (CSA) (6 teams do not use Paris)
- Referral outcome was known for 100% (30/30) cases. 97% (29/30) were accepted for some form of assessment or advice by children's services. 3% (1/30) had no further action taken.

7.23 Actions:

- Safeguarding team will continue to promote the use of the CSA
- Safeguarding team will continue to have oversight of all referral outcomes
- Safeguarding team participating in the Trust's Supervision CQI which will include standardisation of documentation of supervision on EPR.

7.24 Looked After Children (LAC) Quarter 4 2020-21 Audit

Ongoing LAC audit. In quarters 1 and 3 of each financial year, the audit reviews cases of LAC and CL discharges. In quarters 2 and 4, the audit reviews LAC/CL alerts, referrals in and referrals to other organisations.

7.25 Good practice:

- 100% (31/31) records had LAC/CL alert
- 18/35 cases (53%) discharge letter sent to LAC Health Team (increase from 22% in quarter 2)
- 23/35 (66%) discharge letter sent to social worker (Increase from 61% in quarter 2).

7.26 Areas of concern:

- 14/31 (45%) LAC health team informed of new referral (decrease from 56% in quarter 2)
- 11/13 (85%) CL offered priority appointment (decrease from 100% in quarter 2).

7.27 Actions:

- Non-compliant cases to be followed up
- Second LAC webinar scheduled for 14th September- for CAMHS only.

7.28 Safeguarding Adults Audits

2 main Safeguarding Adults audits were completed in the quarter:

- The Practice Audit and Clinical Effective (PACE) team conducted a re-audit of safeguarding enquiries undertaken by the mental health services for older people. There was some improvement in recording and decision making
- There was a second audit of the Safeguarding Data Set for adults to provide assurance that all documentation is being completed fully and in a timely manner. This demonstrated a clear improvement in recording since the previous cycle, although there is still work to be done around ensuring Datix is completed for all Safeguarding concerns and also that services are opening Paris forms appropriately.

8. Service Users Experience of Feeling Safe

8.1 The question "Overall, have you felt safe on the ward?" is asked on the Having Your Say Inpatient surveys, enabling an understanding of how safe service users feel whilst in inpatient care. This information is used to understand key areas of feeling safe, enhance physical support, privacy, dignity and respect, quality of treatment and care and equity which enables continuous improvement.

8.2 The feeling safe score Trust-wide decreased to 83% to compared to 84% in the previous quarter. The number of responses rose to 88 compared to 43. There was one survey response received from FHAU, however the service user did not respond to the safety question.

8.3 The feeling safe score for Acute 24/7 services was 77% (60 responses) compared to 90% (20 responses) in the previous quarter. In acute inpatient services, the feeling safe scores, which were above the 85% target, were Aston and Owl wards at 100%, however their response numbers were low. Those units below target were Robin ward (83%), the Section 136 Suite (75%) and Swift ward (25%). Thumbswood and Oak ward did not have any responses.

8.4 There were 27 responses to the feeling safe question in the Learning Disabiity and Foresnic services compared to 24 previously. Hampden House, Gainsford House, Astley Court, Astley Court (EATS) and Warren Court scored 100%. Dove Ward received 1 response which scored 0%.

8.5 Figure 26 shows the thematic emotional analysis for all comments given for Having Your Say and compliments. Any comment given related to "safety" are mapped as a positive or negative comment.

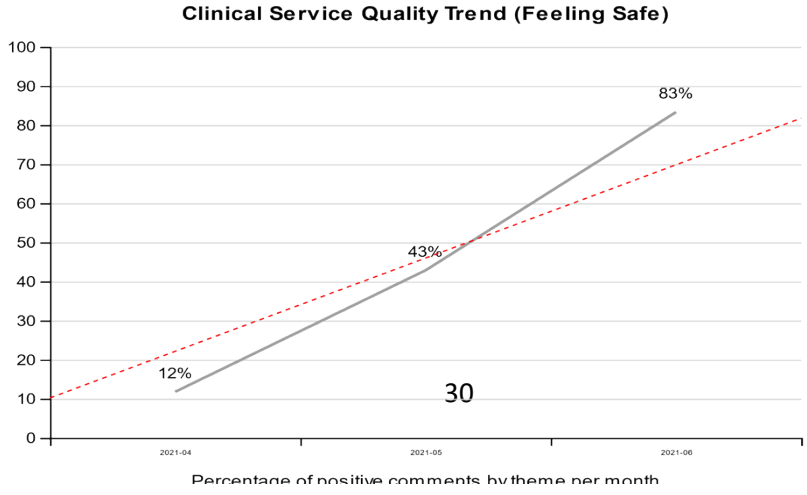


Figure 26

8.6 There were 627 compliments received Trust wide compared to 485 previously; 13 compliments mentioned the word “safe”, for example:

“My therapist was so helpful and was able to give me a lot of resources and teach me techniques that I'll be able to use throughout my life. They really connected with me and took a genuine interest in all aspects of my life which helped create a caring environment where I felt safe.”

8.7 There were 4 complaints where the description of the concerns contained the word “safe”, “unsafe” or “safety”. and 4 PALS enquiries recorded related to “safe”. Clinical practice was the subject for 2 PALS enquiries, one related to SPA and one to Oak ward. FHAU received an enquiry relating to systems and procedures.

8.8 The Peer Observation Project, a project to understand the experience of care and safety in older peoples’ inpatient services, is on hold and will be reviewed in September to determine whether Experts by Experience can return to visiting the wards.

9. Conclusion

9.1 Part B has provided an overview of incidents reported in quarter 1, demonstrating some improvements and areas requiring more increased focus in other areas during quarter 4, as detailed in Part C. There has been continued scrutiny and governance relating to LTS and other restrictive practice and providing increased support and guidance into the SBUs.

9.2 The number of unexpected deaths thought to be a result of suicide has increased in this quarter (16) compared to 9 in the previous quarter. A deep dive has been undertaken which has highlighted a concern around a potential changing risk profile. Actions in response to this concern have been taken but this work will continue into quarter 2.

9.3 The Trust has made progress with the SI recovery work, with further work required in quarter 2 regarding the outstanding action plans.

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

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

Part C Learning from Incidents and Changing Practice

1. Introduction

1.1. This part of the report summarises key actions and initiatives that have been identified for quarter 1, in consideration of the learning and the detail provided in part B. place in quarter 4. This is not a full account of the work that has taken place as our Continuous Quality Improvement (CQI) approach encourages and has resulted in many local initiatives.

1.2. Following the soft launch of the Trust's MOSStogether Strategy, continued implementation of the actions within the Strategy during with an increase in focus on some of the areas including SafeWards. The report concludes with the priorities for quarter 2.

2. Learning from Incidents

2.1. The monthly Adult Community Learning Events continued throughout the quarter facilitated by the Clinical Directors in East and North and West SBUs, enabling learning from Swarms, incidents and SIs including positive practice to be shared.

2.2. Actions taken in response to learning from SIs in the quarter have included:

- Learning from our serious incidents has informed the development of case scenarios for use in the risk simulation training for teams and has also informed the debriefing sessions. A launch day for the simulation faculty will be held on 22nd September 2021
- Learning around communication and joint working between the Trust and CGL for service users with a dual diagnosis has informed the refresh of the joint protocol and has highlighted a training need for staff around harm minimisation as part of the ongoing community transformation work
- A deep dive of suspected suicides was undertaken in the quarter which highlighted a potential change in risk profile of those presenting to our secondary mental health services. Guidance for front line workers when completing a risk formulation has been disseminated by the Executive Director for Medical Education
- A Clinical Summit on Violence and Aggression was held and work undertaken on use of Enhanced Risk Assessments supported by the Community Forensic Team
- An internal safety alert on raising awareness around the Potentially Dangerous Persons process has been disseminated
- A learning note on risk when changing brands of lithium and the importance of face to face assessments was produced
- The Transfer and Discharge policy was updated to include further clarity on actions required around the 48 hour follow up on discharge from wards, as this is a known time of risk
- Carer Essential Training has been developed and will be offered to teams via a virtual platform from quarter 2.

3. Suicide Prevention

3.1. The vision remains to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option. HPFT is continuing work around suicide prevention with system partners including Public Health, Mind, Samaritans, British Transport Police, Primary Care, and Network Rail as part of the Hertfordshire Suicide Prevention Strategy.

3.2. The Trust's Zero Suicide action plan is based on the principles of the *NCISH 10 Ways to Improve Safety* and progress is overseen by the Trust's Suicide Prevention Group.

3.3. Risk formulation refresher sessions have been delivered to teams Trust wide.

3.4. British Transport Police and Network Rail attend Trust reflective learning sessions, to support wider system learning around suicide on the railway.

3.5. GPs are asked to provide summaries of contacts and medications to inform our serious incident reviews. A copy of the serious incident reports are shared with GPs to support system wide learning and suicide prevention.

4. Harm Free Mental Health Care

Violence and Aggression and Least Restrictive Practice

4.1. Violence and aggression remain a high priority for the Trust. The close monitoring of the reported incidents of all levels and ensuring staff have the support, skill and training to respond is a discussion held regularly at the Safety Committee and the restrictive Practice Committee. This work will continue to ensure appropriate responsiveness.

4.2. Staff continue to be encouraged to report incidents of racial abuse; posters giving a stronger message that abuse of staff is not tolerated by the Trust have been approved by the Health, Safety and Security Committee for distribution/display.

4.3. Meetings with the Police have continued and an initiative at Warren Court has been put in place for police to meet and talk to staff on what is expected when staff are subjected to criminal acts by service users.

4.4. The Trust has invested in the training/development of a further 10 in-house Respect trainers across the Trust. A Respect Training Recovery plan is also implemented and further strengthened through the recruitment of two trainers through NMET funding.

4.5. The Dynamic Appraisal of Situational Aggression (DASA), a structured violence risk assessment used in a clinical ward setting to identify acute risk of service user aggression within 24 hours of the assessment, has been introduced to Oak ward and the Broadland Clinic for evaluation.

4.6. The Practice Development and Patient Safety Team has been meeting with senior clinicians from Lexden to offer ongoing support regarding one admission who was placed in LTS. Ad-hoc support has been provided to Astley Court when required and specialised advice given regarding the service user spitting at staff as part of their behaviour – goggles have been issued instead of visors due to the visors been deliberately targeted in order to knock them off.

5. CQC

5.1 The Care Quality Commission (CQC) Insight is a monitoring tool which tracks trends in quality (declining or improving) at provider, location and/or core service level to support decision making). CQC Insight aims to make it easier for inspectors to monitor their portfolio and identify potential changes in quality by having routine access to key information. It will also contribute to a shared view of quality across services.

5.2 The following was identified in the CQC Insight report dated 27th April 2021:

- The following was identified as 'worse' compared nationally
    - Central Alert Systems (CAS) alerts being dealt with in a timely way.

        - The Trust has a policy for the cascading of all safety alerts (including National Patient Safety Alerts). The Trust's Safer Care and Standards Facilitator is responsible, on behalf of the Trust, to confirm that they have received the alert on the CAS system and that it is being cascaded to all relevant areas within the Trust, as appropriate. There are deadline dates on all alerts by which the Trust has to confirm all necessary action has been completed, actions will be followed up and escalated by the Safer Care and Standards Facilitator.
        - All alerts are stored and updated on Datix, noting whether the alert is applicable or non-applicable to the Trust and any actions that need to be taken. Evidence of actions taken and compliance is saved on Datix as a contemporary record of the alert
        - Compliance with the implementation of alerts is provided with a quarterly report which is presented at the Trust's Safety Committee, Health and Safety Committee and Medical Devices Committee as appropriate to the type of alerts received. This will detail any alerts which are applicable to the Trust, actions being taken and any alert which are overdue for completion
        - The Trust has implemented an outlook reminder/flagging process for all alert completion deadline dates
    - Risk of under-reporting patient safety incidents to the National Reporting and Learning System (NRLS).
        - The Safer Care Team confirmed that all NRLS applicable incidents have been reported in the most recent time period.
- The following was identified as 'declined' compared nationally.
    - Proportion of patient safety alerts resulting in harm.
        - The level of harm and trends with regards to the level of harm is reported in the quarter 4 and Annual Integrated Safety Report. The number of incidents resulting in moderate or severe harm and death combined increased from 811 to 1,114 from 2019/20 to 2020/21
        - There was an increase in the total number of incidents reported overall and the proportion of incidents resulting in moderate or severe harm has therefore increased by 5.3%.

5.3 Changes from the April insight report reported in the June report are:

- Risk of under-reporting patient safety incidents to the National Reporting and Learning System (NRLS) – this is no longer listed as 'worse' compared nationally (Trust has improved)
- Proportion of patient safety incidents reported as resulting in harm (%) – this is no longer listed as 'declined' (Trust has improved)

6. Safeguarding

6.1 **Sexual Safety.** Sexual safety has been an area of focus for the Trust in the quarter with the reintroduction of the Sexual Safety Group, chaired by the Interim Head of Social Work and Safeguarding. In terms addressing specific areas of statutory Safeguarding concern, the group will look at specific learning from any cases, particularly learning which can be extrapolated and shared across a range of services. There will also be a focus on ensuring that inpatient areas respond appropriately to sexual safety incidents, including raising safeguarding concerns.

6.2 **Domestic Abuse.** The Corporate Safeguarding Team will continue with their planned rolling programme of domestic abuse training sessions. Additionally, work is underway

in Hertfordshire to reinstate the co-location of the Independent Domestic Violence Advisors into ACMHS teams.

6.3 **Child Safeguarding Assessment.** The child safeguarding assessment (CSA) has been updated on Paris. A tutorial has been recorded and is now available on YouTube. A guidance sheet has been completed and has been cascaded to all staff via Communications and Safeguarding Newsletters, Quality and Risk Meetings and direct emails to frontline staff, which includes the link to the video tutorial.

6.4 Following the completion of every safeguarding children Datix, or contact with the safeguarding team, staff are asked to complete a CSA. A quarterly audit on child safeguarding referrals, referral outcomes and completion of the CSA, will take place in 2021/22 (first due in July 2021). Training sessions on the use of the CSA are booked for 22nd July and 29th September 2021.

7. Priorities for Quarter 2

7.1 **Incident management.** The Incident and Serious Incident Reporting and Duty of Candour policies will be reviewed and updated. A learning note on incident reporting is to be disseminated. The Safety Dashboard will go live, and work will commence on the development of a Datix training webinar.

7.2 **Suicide Prevention.** The Samaritans' and the Trust's joint initiative to be piloted, this work will continue into 2021/22. World Suicide Prevention Day Conference for the Trust and Suicide Network partners will be held on 10th September 2021. Further work will continue introducing real time surveillance in Hertfordshire and improving postvention support and timely signposting to support for those affected or bereaved by suicide.

7.3 **Self-harming behaviour.** SBU West reports significant more self-harming behaviours than the other SBUs and further work is being undertaken to support service users with diagnoses of Emotionally Unstable Personality Disorders to further reduce self-harming behaviours.

7.4 The SBU continues to review and report their incidents of self-harming behaviours monthly to the Restrictive Practice Committee. All incident of self-harm within inpatient services are reported monthly to NHS Digital through the Mental Health Minimum Data Sets.

7.5 **Ligatures.** There continues to be a downward trend since quarter 3 2019/20 in ligature incidents with 59 reported ligature incidents within inpatient services in this quarter - a 5% decrease on the previous quarter of 62. Incidents involving items of clothing are the highest reported which is consistent with national guidance.

7.6 All incidents involving anchor points are investigated and reported. There were 3 anchor points in the quarter, all involving doors.

7.7 ANT, the review of environmental risk, has developed further over the year to improve assurance and evidence of reviews. This is being progressed into the community services for the next quarter.

7.8 **AWOL and Missing Persons.** There also continues to be an overall downward trend since quarter 3 2019/20, despite an increase in this quarter. All incidents of AWOL are reported monthly to NHS Digital through the Mental Health Minimum Data Sets.

7.9 **Restrictive Practice.** Recruitment to the vacant Respect Trainer post and requesting expressions of interest regarding future Respect train the trainer's course is a priority for the next quarter. Furthermore, to continue to implement and monitor the Respect training Recovery plan.

7.10 The development of Restrictive Practices Leaflets for service users, carers and relatives is also a priority and to commence a working group regarding staff experiencing 'spitting' as a weapon.

7.11 **Safeguarding.** Priorities for safeguarding for quarter 2 include continuing monitoring and support of investigating teams in Hertfordshire to ensure that the Care Act Safeguarding duties are being fulfilled and that service users are being kept safe.

7.12 The reinstatement of the Independent Domestic Violence Advisor into some teams will also support our approach to managing high risk victims. There will be a continued focus on ensuring that timely actions are being taken across all areas in response to SIs and high-profile cases.

8 Conclusion

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

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Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 9b
Subject:	Quarter1 Safer Staffing Report	**For Publication:** Yes
Author:	Bina Jumnoodoo, Interim Deputy Director of Nursing and Quality	**Approved by:** Jacky Vincent, Executive Director of Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director of Quality and Safety (Chief Nurse)	

Purpose of the report:

To give assurance to the Board in relation to safe staffing requirements for 2021/22.

Action required:

To Note.

Summary and recommendations to the Board:

This report updates the Board with regard to quarter one 2021/22 on the safe staffing across all SBUs within the Trust.

The report sets out that there has been a significant increase in staffing levels across services, owing to the level of acuity and complexity of service user, also impacting on the number and level of prescribed safe and supportive observations. During the quarter, both within the Strategic Business Units and Trust wide the staffing across areas continued to be monitored and managed.

In response to the increase in acuity certain wards were over established by recruiting newly Registered Nurses and HealthCare Support Workers, to ensure safe delivery of care.

Quarter two will see a new escalation process discussed at the Safer staffing Committee and the new Safer Care and E-Roster lead for the organisation will be starting.

Relationship with the Business Plan & Assurance Framework:

Relation to the Trust Risk Register:
Workforce: The Trust is unable to retain enough staff in key posts to be able to deliver safe services (Risk 657).
Workforce: The Trust is unable to recruit enough staff to be able to deliver safe services due to national shortages of key staff (Risk 215).
Relation to the BAF:

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

Summary of Implications for:

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

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

There are no implications arising from this report.

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

Seen by the following committee(s) on date:

Quality and Risk Management Committee 3rd September 2021 Integrated Governance Committee 16th September 2021

1. Introduction

1.1 This report provides the required assurance that Hertfordshire Partnership NHS University Foundation NHS Trust (the Trust) had safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage the demand. This report covers the reporting period for quarter 1 (April to June 2021). The report also includes measures to ensure preparedness and the health and well-being of staff throughout the pandemic.

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

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

2. Trust's Expectation

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

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

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

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

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

3. Summary of findings for quarter 1 nurse staffing data collection

3.1 Care Hours Per Patient Day (CHPPD) data submitted by the Trust, reflects the increased staffing utilised in many of the services because of increased acuity and the standalone units where CHPPD is high – see appendix 1

3.2 There are a few shifts which were over 120% and some which were below 80%. This was mainly at Forest House Adolescent Unit (FHAU), Swift, Aston and Oak wards, Lambourn Grove and Astley Court. The Heads of Nursing (HoN) are

continuing to focus their weekly scrutiny meetings on ensuring close monitoring and management of the skill mix and staffing levels.

3.3 An Eroster and SafeCare Lead has been appointed and is due to start at the end of September 2021. The post holder will work alongside the current clinical team to support the HoNs and Matrons with the daily staffing reviews. They will be part of operational meeting, reviews of nursing establishment with the HoNs and reviewing the use of the Health Roster and SafeCare systems

4. Safer staffing across the SBUs

West SBU.

4.1 In this quarter, the west SBU reported an increase in acuity which has continued to be a challenge with increased number of staffing on every shift in some units. There were 15 incidents that was reported relating to safer staffing during the quarter. In April 2021, there were a number of bank and agency staff who were cancelling shifts at last minute which was picked up by the Matrons and Bank Bureau manager.

4.2 Owing to the acuity and complexity of individual service users, there was an increase in the number of prescribed one to one safe and supportive observations. Despite cover being sought across SBUs, the shifts were not filled by bank/agency staff; Team Leaders and Matrons were therefore part of the numbers to support the wards.

4.3 Below is a list of priorities that has been set by the HoN:

- Continue with weekly scrutiny meetings
- Focus KPI and unfilled shifts as to whether these are still required, if not filled and not required, then these need to be cancelled
- Support the newly registered nurses and HCAs into their roles and to undertake some of their mandatory training, particularly RESPECT and Basic and Intermediate Life Support (BLS and ILS)
- Continue to work with the working group to ensure all vacancies are filled, where possible
- Continue with support for hot spot areas
- Team Leader and Matrons continue to review safe staffing daily with the overall aim of delivering safe services
- Continue with the new meeting structure
- Ensure timely production of rosters and monitoring of all KPIs in place
- All wards to ensure COVID-19 related costs are recorded as such on E-roster and reiterated in Roster Scrutiny meetings on a weekly basis
- Support staff to reduce/manage incidents of aggression including SWARMS, reflection sessions, and huddles
- Robust monitoring of sickness and support for staff
- Focus on Personal Development Plans (PDP) for all staff
- Organisational Development work in 2 wards and Continuous Quality Improvement (CQI) with another ward.

East and North.

4.4 This quarter also reported an increase in acuity across inpatient services, owing to young onset dementia whose presentation was challenging. Also owing to an

increased number of service users presenting with an Eating Disorder and acuity at Forest House Assessment Unit (FHAU) where acuity and complexity remained significantly high. Owing to a lack of Psychiatric Intensive Care Unit (PICU) and Low Secure Unit (LSU) beds nationally, some young people were prescribed higher levels of safe and supportive observations in consideration of their clinical presentation; this was compounded by the increase in staff not available to work.

4.5 The Team Leaders attended a session with the SBU's Management Accountant for the units to explore how to manage budgets. Budgets are also discussed weekly at the Matron and Team Leader meetings to ensure ownership and engagement with the wards and their budgets.

4.6 Supervision rates were high and the Matrons and Team Leaders are looking at how to ensure this is maintained.

4.7 Safety huddles have commenced on Wren ward, to ensure staff are able to discuss the level of risk and safety of service users in a timely manner and prevent any delay in the care and treatment of service users.

4.8 There were 5 incidents reported regarding safer staffing.

Essex and IAPT.

4.9 The SBU reported challenges during the quarter at Lexden due to an emergency hospital admission and 2 services users prescribed continuous safe and supportive observations.

4.10 Support from the community services was in place, as a contingency to manage the safer staffing levels. Staffing continued to be a challenge, mainly due to the high level of Registered Nurse (RN) vacancies, high levels of safe and supportive observations and staff sickness.

4.11 Contingency planning across the service to support inpatient services was I place, which included the Enhanced Support Team from the Community working in inpatient services.

4.12 Within the unit, there were 3 service users who were prescribed 2:1 safe and supportive observation and 2 on 1:1.

4.13 There is a workforce strategy to recruit staff and the local teams working with universities, to support local Learning Disability nurse training.

Learning Disability and Forensic SBU.

4.14 The weekly e-roster scrutiny meeting continues to take place which is well coordinated and well attended as well as monthly safer staffing meetings where all Key Performance Indicators (KPI) are discussed and analysed.

4.15 There is a significant number of overfilled rates in Astley Court, The Beacon, Dove and Broadland Clinic, owing to acuity and complexity of service users. There were 13 incidents reported at Broadland Clinic for this quarter.

5. Finance

5.1 The Safer Staffing Committee is seen as a key enabler in being able to control pay spend across the Trust and ensure financial grip on pay spend. As a result of this, the finance team, in conjunction with other partners, have evaluated the pay position and looked to identify the key drivers of pay and areas that need specific focus to maintain financial grip.

5.2 Analyses of the pay spend, and the impact of Covid is discussed on an ongoing basis at the Safer Staffing Committee within the SBUs and in several other forums. The SBU's Managing Directors have been reviewing bank and agency use with a view to further understand the drivers behind changes and this work will continue to move forwards and be developed in line with pay related reporting to HoNs and individual SBU Safer Staffing meetings.

5.3 Changes in pay spend have been steadily increasing across the year, both including and excluding Covid related spend. However, in areas of relatively stable establishment, there have also been increases and further increases are expected in line with further investment. This is due to expansion of some services, for instance

5.4 The SBUs receive regular analysis of bank and agency usage as detailed in Figure 1, to ensure the focus is on the area that can be most influenced.

	Trust position
Vacancies	385.45
Bank Usage	509.37
Agency Usage	152.09
Over/(Under) establishment	276.01
Reasons for over establishment	
Observations	261.25
Aspirant nurse's supernumerary	26
Sickness	36.07
HCSW awaiting RESPECT training/not started shifts	51.93
Other/Vacancies unfilled	-83.27

Figure 1

5.5 Figure 2 shows the increasing pay spend across the Trust over the last 14 months.

Figure 2

5.6 There is an increasing trend, particularly within community teams, in a delay in the reporting of worked hours within E-Roster, owing to the delay in staff inputting the information on e-roster. All managers are now finalising the e-roster on a weekly basis.

5.7 Agency spend was at the highest level for 15 months in both inpatient and community teams. As a result, the HoNs and Finance Business Partners have been proactive in ensuring there are no Loss Contracted Hours and plan to review staffing and skill mix establishments.

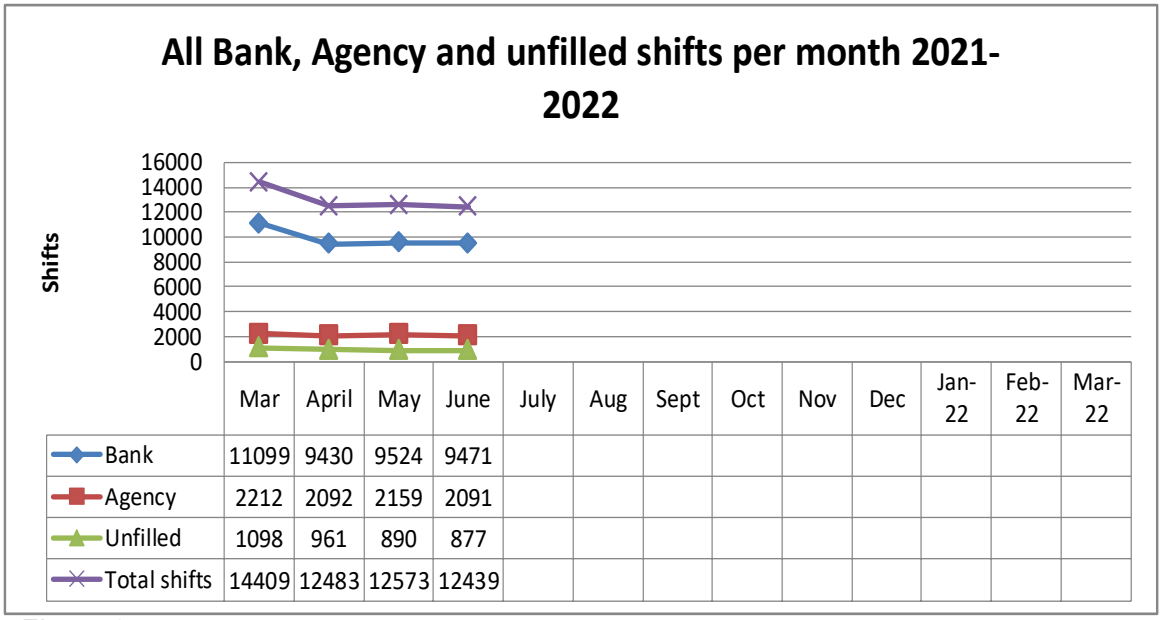
5.8 A Continuous Quality Improvement (CQI) project is in progress regarding safe and supportive observations, to identify areas of development in consideration of effectiveness, efficiency and quality and safety, led by one of the HoNs. The aim of the project is to review the local and national policies and make changes that will support the need of service users using the least restrictive method

6. Bank and agency

6.1 Reasons for variances in the fill rate against the number of shifts that were required are discussed at the SBU's Quality and Risk Meeting. The reasons with the most impact included vacancies and short-term and long-term sickness absence.

6.2 Figure 3 illustrates all bank, agency, and unfilled shifts for the quarter for a monthly comparison.

6.3 A review of the quarterly Safer Staffing Committee (Trust wide), the monthly SBU Safer Staffing Group meetings, the weekly Eroster Scrutiny meetings and daily SafeCare management was implemented during the quarter to increase the governance of safe staffing, including the use of bank and agency.



	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-22	Feb-22	Mar-22
Bank	11099	9430	9524	9471									
Agency	2212	2092	2159	2091									
Unfilled	1098	961	890	877									
Total shifts	14409	12483	12573	12439									

Figure 3

7. Recruitment and retention

7.1 There are several forums where recruitment and retention are discussed, both at a local level and by the workforce team.

7.2 The Trust has placed 70 student nurses who been offered a post in the Trust. Additionally, the Trust is recruiting 10 international nurses to work in the Learning Disability and Forensic SBU and 5 to work in Child and Adolescent Mental Health Services (CAMHS) services. Since April, there has been an increase of 160 staff on the bank.

7.3 Appendix 2 shows the retirement profile and status of RNs and HealthCare Assistants (HCA)s across the Trust as of 30th June 2021. A reduction in vacancies for the community teams, and an increase across the inpatient wards, in comparison to quarter 4. The Essex and IAPT SBU had a significant reduction in vacancies for both RNs and HCAs.

7.4 The Trust has also financially supported Health Care Supported Workers (HCSW) with Health Education England (HEE) funding and will continue to support them with OSCE preparation and to take their OSCE.

7.5 At the time of the report, there are 173.5 new starters in the external pipeline. Work continues to expand the number of bank workers, with 160 new recruits since April 2021.

8. Conclusion

8.1 This quarter has seen significant pressure within the SBUs to ensure safe staffing levels are maintained and an increase int eh use of bank and agency.

8.2 Quarter 2 will focus on the following key areas to ensure the safe and effective management of staffing, including:

- To embed the escalation procedure for safer staffing across all inpatient services
- To review the staffing skill mix and establishment for each inpatient service
- To implement the outcomes from the Matron consultation
- To implement self-rostering across all inpatient services
- To embed robust scrutiny and monitoring of the electronic rostering and SafeCXare, led by the appointed Eroster and Safe Care Lead.

Appendix 1

April 2021

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	Only complete sites your organisation is accountable for	Day				Night				Allied Health Professionals	
SBU	Service	RN Fill Rate (Day)	NRN Fill Rate (Day)	RNA Fill Rate (Day)	NRNA Fill Rate (Day)	RN Fill Rate (Night)	NRN Fill Rate (Night)	RNA Fill Rate (Night)	NRNA Fill Rate (Night)	R AHP Fill Rate	N R AHP Fill Rate
	Total	**111%**	**137%**	**100%**	**100%**	**105%**	**155%**	**100%**	**100%**	**-**	**-**
LD & F	Gainsford House	110%	97%	-	-	100%	103%	-	-	-	-
	Hampden House	100%	106%	-	-	100%	100%	-	-	-	-
	Astley Court	100%	157%	-	-	159%	79%	-	-	-	-
	Warren Court	94%	95%	-	100%	99%	100%	-	100%	-	-
	4 Bowlers Green	94%	106%	-	-	97%	100%	-	-	-	-
	Beech	137%	86%	-	-	101%	115%	-	-	-	-
	Dove	97%	130%	-	-	98%	150%	-	-	-	-
	The Beacon	8.3	111%	140%	-	-	110%	264%	-	-	-
	Broadland Clinic	114%	222%	100%	100%	117%	217%	-	-	-	-
	SRS	95%	97%	100%	-	100%	100%	100%	-	-	-
West	Albany Lodge	103%	120%	-	-	98%	141%	-	100%	-	-
	Aston	104%	279%	-	100%	97%	261%	-	100%	-	-
	Swift	142%	164%	100%	-	104%	232%	-	-	-	-
	Robin	140%	178%	-	-	97%	206%	-	-	-	-
	Owl	112%	172%	-	100%	98%	176%	-	-	-	-
	Oak	97%	284%	-	-	89%	282%	-	-	-	-
	Thumbswood	199%	127%	-	-	100%	160%	-	-	-	-
Essex and IAPT	Lexden	97%	116%	100%	100%	94%	108%	-	100%	-	-
East and North	Logandene	126%	102%	100%	100%	106%	149%	-	-	-	-
	Wren	103%	117%	-	-	105%	136%	-	-	-	-
	Lambourn Grove	147%	99%	-	100%	119%	119%	-	100%	-	-
	Seward Lodge	108%	82%	-	-	100%	108%	-	-	-	-
	Forest House	148%	206%	-	-	136%	249%	-	-	-	-
	Victoria Court	103%	104%	-	-	102%	110%	-	-	-	-

May 2021

Hospital Site / SBU	Service	Day				Night				Allied Health Professionals	
		RN Fill Rate (Day)	NRN Fill Rate (Day)	RNA Fill Rate (Day)	NRNA Fill Rate (Day)	RN Fill Rate (Night)	NRN Fill Rate (Night)	RNA Fill Rate (Night)	Average fill rate - Non-Registe	R AHP Fill Rate	N R AHP Fill Rate
	Total	**107%**	**128%**	**100%**	**100%**	**105%**	**148%**	**100%**	**100%**	**-**	**100%**
LD & F	Gainsford House	104%	100%	-	-	100%	113%	-	-	-	-
	Hampden House	100%	107%	-	-	100%	103%	-	-	-	-
	Astley Court	110%	212%	-	-	196%	103%	-	-	-	-
	Warren Court	99%	104%	-	100%	101%	102%	-	100%	-	-
	4 Bowlers Green	85%	118%	-	-	130%	90%	-	-	-	-
	Beech	118%	98%	-	-	98%	118%	-	-	-	-
	Dove	114%	125%	-	-	98%	159%	-	-	-	-
	The Beacon	104%	128%	-	-	107%	257%	-	100%	-	-
	SRS	96%	97%	100%	100%	100%	100%	-	100%	-	-
	Broadland Clinic	100%	99%	100%	-	99%	131%	-	-	-	-
West	Swift	130%	213%	100%	-	106%	272%	-	-	-	-
	Aston	101%	233%	-	100%	100%	218%	-	100%	-	-
	Albany Lodge	102%	119%	-	100%	104%	139%	-	100%	-	-
	Robin	129%	177%	-	-	102%	201%	-	-	-	-
	Owl	106%	167%	-	100%	100%	159%	-	-	-	-
	Oak	86%	247%	-	-	90%	222%	-	-	-	-
	Thumbswood	193%	124%	-	-	100%	135%	-	-	-	100%
Essex and IAPT	Lexden	100%	119%	100%	-	98%	129%	-	-	-	-
East and North	Logandene	98%	107%	100%	100%	100%	130%	100%	-	-	-
	Albany Lodge	102%	119%	-	100%	104%	139%	-	100%	-	-
	Seward Lodge	117%	76%	-	-	102%	116%	-	-	-	-
	Victoria Court	102%	103%	-	-	100%	111%	-	-	-	-
	Forest House	133%	236%	-	-	144%	295%	-	-	-	-
	Wren	103%	103%	-	-	102%	123%	-	-	-	-
	Lambourn Grove	116%	93%	-	-	101%	127%	-	100%	-	-

June 2021

Hospital Site / SBU	Service	Day				Night				Allied Health	
		RN Fill Rate (Day)	Average fill rate - Non-	Average fill rate - Register	Average fill rate - Non-	Average fill rate - Register	Average fill rate - Non-	Average fill rate - Registere	Average fill rate - Non-	Average fill rate - registere	Average fill rate - non-
	Total	**106%**	**125%**	**100%**	**100%**	**102%**	**147%**	**100%**	**100%**	**-**	**-**
LD & F	Gainsford House	100%	126%	-	-	101%	130%	-	-	-	-
	Hampden House	100%	100%	-	-	101%	100%	-	-	-	-
	The Beacon	104%	155%	-	-	99%	461%	-	100%	-	-
	Broadland Clinic	95%	117%	100%	100%	112%	131%	-	-	-	-
	Warren Court	97%	106%	-	100%	97%	106%	-	100%	-	-
	4 Bowlers Green	89%	100%	-	-	100%	101%	-	-	-	-
	Beech	125%	89%	-	-	96%	102%	-	-	-	-
	Dove	106%	122%	-	-	90%	155%	-	-	-	-
	Astley Court	111%	234%	-	-	230%	104%	-	-	-	-
	SRS	92%	99%	100%	100%	100%	101%	100%	100%	-	-
West	Aston	100%	181%	-	100%	100%	172%	-	100%	-	-
	Swift	121%	169%	100%	-	100%	289%	-	-	-	-
	Robin	130%	198%	-	-	100%	219%	-	-	-	-
	Owl	113%	140%	-	-	98%	148%	-	-	-	-
	Oak	87%	189%	-	-	90%	174%	-	-	-	-
	Thumbswood	169%	99%	-	-	100%	108%	-	-	-	-
Essex and IAPT	Lexden	111%	187%	100%	100%	84%	209%	-	-	-	-
East and North	Lambourn Grove	112%	101%	-	100%	100%	152%	-	100%	-	-
	Wren	99%	99%	-	-	102%	121%	-	-	-	-
	Forest House	144%	175%	-	-	125%	221%	-	-	-	-
	Logandene	97%	103%	-	100%	93%	147%	100%	-	-	-
	Albany Lodge	112%	136%	-	100%	100%	165%	-	100%	-	-
	Seward Lodge	111%	84%	-	-	100%	114%	-	-	-	-
	Victoria Court	88%	97%	-	-	99%	102%	-	-	-	-

Appendix 2 Recruitment profile at 30.6.21

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex & IAPT	13.00	9.29	3.71	29
Learning Disability & Forensic	186.21	146.43	39.78	21
East & North	124.51	107.78	16.73	13
West	125.66	103.94	21.72	17
Total	**449.38**	**367.43**	**81.95**	**18**
Unregistered Nursing				
Essex & IAPT	17.80	21.63	-3.83	-21
Learning Disability & Forensic	219.21	195.27	23.94	11
East & North SBU	202.01	171.16	30.85	15
West SBU	139.99	118.25	21.74	16
Total	**579.01**	**506.31**	**72.70**	**13**

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 9c
Subject:	Public Sector Equality Duty (PSED) compliance and Equality Delivery System 2 (EDS2) Grading update report 2020/21	**For Publication:** Yes
Author:	Sam Slaytor, Equality and Diversity Lead and Clive Saunders, Equality and Diversity Lead. Andrew Nicholls, Consultant Clinical Psychologist Clinical Director of Psychological Services	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

The purpose of this report is to provide the Board with assurance of compliance with the Public Sector Equality Duty (PSED) for 20/21.

Action required:

The Board is asked to approve the report and then progress to publish the annual compliance as required by the PSED.

Summary and recommendations

- The Trust is required to comply with both the general duties and the specific duties of the PSED and is mandated to publish the results of exercises in relation to the EDS2
- Trust compliance with the general duties is given in the form of some narrative regarding key pieces of project work, as detailed in this report. Following this, data is published on workforce and service users/carers as part of the Trust's compliance with the specific duties
- The EDS2 reporting is given in the form of grades from our previous grading. All EDS2 grading is required to be completed by Trust stakeholders (rather than self –assessed) based on evidence supplied
- The Trust is required to publish one or more equality objectives covering a four-year period, in the context of the EDS2. However the Trust is awaiting National guidance from the Equality and Diversity Council (EDC) on EDS3 so a partial re-grading took place as EDS3 has not been implemented due the need for all NHS trust to work from BCP as their heightened response to COVID-19
- The Trust Equality Plan outlines all Trust targets and strategic objectives until 2022. This is available online at www.hpft.nhs.uk
  It is recommended that this report is approved so this can be published on the Trust website.

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

The programme of work supporting compliance with the PSED and EDS2 links to the following annual plan priorities for 2020/21:

Great Care, Great Outcomes

2. We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy

Great People

4. We will continue to create a more empowered and engaged workforce through developing a culture of collective leadership
5. We will strengthen the capabilities and capacity required to deliver our plans by developing our leadership base

Great Networks and Partnerships

We will be recognised as system leaders having successfully driven and delivered on key system priorities.

Summary of Financial, IT, Staffing & Legal Implications:

The PSED and EDS2 Annual Report support the Trust in achieving its requirements set within the NHS standard contract in relations to WRES, WDES, AIS and EDS2. It also pays due regard to the Equality Act 2010 and associated Public Sector Equality Duty as well as commissioners targets (Service user Ethnicity data).

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

This paper shows compliance with the PSED and the EDS2 which both contribute to meeting legal responsibilities under the Equality Act 2010. Service user and carer data has been included in the report and will be circulated through our service user and carer councils.

Evidence for 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

Integrated Governance Committee 16th September 2021

Public Sector Equality Duty (PSED) compliance and Equality Delivery System 2 (EDS2) Grading update report 2020/21

1. Introduction/Executive Summary

1.1 The purpose of this report is to provide assurance of compliance with the Public Sector Equality Duty (PSED) for 2020/21 for Hertfordshire Partnership University NHS Foundation Trust (the Trust) as well as an update concerning NHS Equality Delivery System 2.

1.2 The PSED requires the Trust to ensure that all of its functions are carried out in a way that does not disadvantage anyone from a protected group. This is part of the Trust's overall compliance with the Equality Act 2010.

1.3 The Equality Delivery System 2 Grading (EDS2) is an improvement tool used by NHS providers to focus on one or more areas/functions of compliance annually to track improvements to services and employment. This is to be replaced by EDS3 and the implementation has been suspended due to Covid-19 pandemic.

1.4 The Trust is required to comply with both the general duties and the specific duties of the PSED given the size of the organisation. The EDS2 is a mandated part of the NHS standard contract for providers.

1.5 Sections 2 and 3 provide an overview of PSED compliance followed by section 4 which provides an overview of EDS2 compliance.

1.6 This report also contains a narrative pertaining to our compliance with the general duty and key pieces of project work, as detailed in this report). Following this, data has been published on workforce as part of Trust compliance with the specific duties, as detailed in appendix 1.

2 Reflections from last year.

2.1 A summary of past year's activities, that have contributed to both PSED and EDS2 compliance, included:

- Monthly Staff inductions with EDI as a core component
- Consistent involvement with the Trust's Disciplinary Review panel
- Monthly joint Meetings of the Mental Health and Diversability (Disabled) Staff networks
- Monthly meeting of Women's Staff network
- Monthly Outlook (LGBTQ+) Staff Network meetings
- Monthly/twice monthly Spirituality Staff Network meetings
- Monthly meetings of Carers Staff Network
- Twice Monthly meetings of BAME staff network consisting of a business meeting and a personal development meeting (#strongertogether)
- At least monthly live events with Members of the Executive regularly feature equality and diversity issues
- Consultation with staff across the business focusing on COVID-19 and its differential impact on some demographic groups (ethnicity, age groups, over 28 week pregnant).
- COVID-19 Risk Assessment developed and implemented incorporating demographic consideration
- Attend CNO BME Strategic Advisory Group south/east and south/west Region on 14th May 2020
- Learning Disability and Forensic Equality Group meeting monthly

- BAME Support Line Established
- NHS BAME Staff Webinars
- Schwartz Rounds for Inclusion – 'Let's Talk About Race' session, starting in June-November 2020
- Development of Microaggression Poster in July 2020
- Health inequalities webinar in July 2020
- Launch of the National Mapping of BAME Mental Health Services August 2020
- Establish Ambassadors Programme July 2020
- Big Listen Session on Staff networks September 2020
- Black History Month 2020 events throughout the month
- West SBU establish Equality Group October 2020
- Reverse Mentoring programme and associated Community of Practice set up
- International Day for Disabled People December 2020 – virtual event held
- Disability Staff Network – Chairs Webinars NHS England January 2021
- Spirituality and BAME Network events to encourage COVID-19 vaccine take up 2021
- LGBT History Month programme of activities February 2021
- International Women's Day event on March 2021
- Inclusion Webinar on March 2021
- Monthly unconscious bias training for staff
- Mental Health Awareness Week May 2020
- Equality and Human Rights Promotion Day May 2020
- Equality, Diversity and Human Rights week May 2020 and launching Schwartz Rounds themed on Race Equality.
- IDAHOBIT Day May 2020- Trust message for Staff and comms to raise awareness
- LGBT+ Partnership meetings that took place in December 2020 and February 2021 hosted by the Trust with 17 partner organisations discussing health and wellbeing including our voluntary sector partners.

2.2 Challenges from the past year have included:

- Issues around trust and confidence have emerged from staff networks and through consultation as being an area of weakness for the organisation
- Career Progression has been highlighted as an area for staff improvement to create an environment where there is seen to be equitable access to opportunities
- Access to staff networks- there has been continuing concern from staff who are finding it difficult to secure release to participate in staff networks
- Reasonable Adjustment practices remains inconsistent and there have been barriers to access, logistics and timeliness. This has an adverse impact on staff moral and staff effectiveness.
- Consistent management practice has been a challenge in relation to the creation of an equitable working environment for all staff across the protected characteristics
- Making improvements to the Trust's WRES data and ensuring that the experiences of BAME staff improve in relation to equality and diversity. There is still work to shift the culture at the Trust to a just and learning culture so that the experience gap between BAME and white staff closes
- During 2020/21, the Trust has continuously worked in and out of our Business Continuity Plans (BCP) as a response to coronavirus. This has been a real challenge and has heavily impacted some of the EDI workstreams and we are still unclear as to any longer lasting impact.

2.3 Compliance with the EDS2 is given in the form of the last partial regrading in 2019. Owing to the unanticipated impact of COVID-19 and the delay in the roll out of EDS3, the Executive expressed a view to defer regrading in anticipation of EDS2. The last regrading was therefore 2019 and that data is what is used in this report. It is anticipated that there will be a regrading for 2022 on either EDS2 or EDS3.

2.4 Appendix 2 provides an overview of the Trust's requirements in relation to the Public Sector Equality Duty and requirements under the EDS2.

3 PSED - Summary of Key Performance Areas regarding General Duties

3.1 The general duty of the PSED requires the Trust, in relation to all protected groups[1], to ensure it is working to:

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it.

4. Overview/narrative to eliminate unlawful discrimination

4.1 *NHS Workforce Race Equality Standard (WRES)* - The Trust has continued implementation of their WRES programme focusing on identifying and addressing the inequalities within Trust workplaces. The WRES data can be found on the public website.[2] We have also seen enhanced activity locally within services to proactively engage with BAME staff to understand their experiences of working in the Trust in the form of SBU BAME Ambassadors programme and SBU Equality Group meetings.

4.2 *NHS Workforce Disability Equality Standard (WDES)* – The Trust also has a duty to report on the WDES and this was submitted in July 2019. The report and action plan is published on the Trust website and the WDES data can be found on the public website.[3] Part of the work plan focused on the Trust's Employee Staff Records (ESR) and Reasonable Adjustments. The training with DWP and Jobcentre plus on Employment and Disability was parked during 2020/21, owing to implications from responding to COVID-19 working in the Business Continuity Plans. During the pandemic, the Diversability network and the Staff Mental Health network have been instrumental in providing a health and wellbeing support to staff that are engaged with these networks.

5. Overview/narrative to advancing equality of opportunity

5.1 Ambassadors/champions programme. Launched in quarter 2 to support becoming a more inclusive organisation; the first cohort are BAME Ambassadors who work across their SBU supporting the work on Race Equality. As the Trust developed its approach, it will commence Diversity and Inclusion Champions programmes in quarter 3. These sit alongside Ambassadors working in each of the Strategic Business Units (SBU). Together, they have a role to identify grass root issues to enable changes to be

[1] Age, Disability, Gender identity/reassignment, Pregnancy and maternity (employment only), Race/Ethnicity, Religion/Beliefs, Sex (gender), Sexual orientation, Marriage & Civil Partnership (employment only)

[2] https://www.hpft.nhs.uk/about-us/equality-and-diversity/nhs-workforce-race-equality-standard-wres/

[3] https://www.hpft.nhs.uk/about-us/equality-and-diversity/nhs-workforce-disability-equality-standard-wdes/

identified and action taken. The Ambassador and the Champions programmes will remain a focus for 2021-22 to support culture change.

5.2 *Stonewall Workplace Equality* Index (WEI). Suspended during 2020-21. The Trust has renewed its membership as a Stonewall Diversity Champion for 2021-22 and have access to additional resources via an online Diversity Champions portal. Stonewall will recommence with the WEI for 2021-22.

5.3 *Staff Networks.* The Trust recognises the relevance and importance of staff engagement and has one of the most extensive arrangements for staff to come together to provide mutual support and to contribute to overall organisational development. The Trust supports seven staff networks:

- LGBT Staff Network
- Black, Asian & Minority Ethnic Staff Network (BAME)
- Diversability Staff Network
- Staff Mental Health Network – Aimed primarily at staff with a lived experience of mental health
- Women's Staff Network
- Staff Carers Network
- Spirituality Staff Network.

5.4 With the impact of COVID-19, the networks were critical for supporting the wellbeing of staff and this has been invaluable. The networks work closely together and help to identify issues and to foster good relations between the Trust's diverse workforce. The networks have all contributed to identifying issues and areas for improvements, including access to reasonable adjustments and equality in access to opportunities for career progression. They were also critical in the development of the COVID-19 risk assessments. Staff fed back that some would have struggled with the isolation through COVID-19 if it was not for having the networks.

5.5 *Rainbow Lanyards and Rainbow Badges.* The Rainbow Lanyard and Rainbow Badge schemes were launched in 2019. The lanyard signifies that the person is committed to equality, diversity and inclusion for all. The Rainbow Badge signifies a commitment to champion LGBT Equality. Over a third of Trust staff have now signed up for the Rainbow lanyards (over 1,300). Approximately 300 members of staff have signed up for a rainbow badge. The badges are not suitable for every working situation particularly in inpatient settings and, as such, the capacity is lower. The number of requests during the last year has significantly reduced, and a promotional campaign will be held during 2021-22 to highlight the importance of these schemes.

6. Overview/narrative to foster good relations

6.1 The focus over the past year has been to use key events to bring a diverse range of people together to focus on a particular area of quality improvement. This has enabled both celebration of diversity and awareness around inequalities that require attention in order to remove barriers and further promote social inclusion. These have included:

- *International Women's Day (IWD) Programme 2021* – An exciting programme was held for IWD on 8th March 2021, led by our Women's Staff network to which all staff were invited. The theme for the day was 'Women in leadership: Achieving an equal future in a COVID-19 world' the diverse panel of speakers for the event included the Trust's Chair, former Deputy Assistant Commissioner at the Metropolitan Police, one of the Reverse Mentors and the Head of Organisational Development. The event was chaired by the Executive Sponsor of the Network and approximately 60 people attended the day. Alongside the days event the network has also arranged for a

series of events to take place reflecting the interest and concerns of women in the Trust

- *LGBT History Month 2021* – LGBT History Month was held in February 2021 and, in conjunction with other stakeholders, a number of activities took place. These included, screen savers celebrating the event running throughout the month, a meeting of the Outlook staff network, a book club event and a meeting of the Hertfordshire LGBT partnership
- *Carers week in June 2020* - The Trust hosted events virtually based on the theme #MakingCaringVisible and supported staff in reaching out to Carers making sure each contact counts. Reports from the event were generated and many of key stakeholders managed to engage
- *Black History Month* Race Equality - Stronger Together - Influencing Change. In October 2021, the Trust hosted its seventh Trust wide event to mark BHM. The programme was launched on 2nd October with a virtual event attended by approximately 100 staff. A full range of events were organised to celebrate Black History Month including the following:
    - West SBU: PATH - BHM discussion on 7th October
    - Big Listen: Race Equality Schwartz Rounds - Theme: Woken by my Whiteness also on 7th October
    - BAME Staff Network Business Meeting on 14th October 2020
    - Celebrating History on 19th October
    - Voices of Influence - An event for all 11 Trusts across Hertfordshire and West Essex ICS on 20th October
    - Career Planning and Progression session on 21st October
    - Book Club: Facilitated by the Trust's Chief Nurse and Executive Sponsor of BAME Network featuring a review of Black and British: A Forgotten History by David Olusoga on 27th October
    - Learning Disability and Forensics SBU Black history event, featuring activities for service users and staff on 29th October
    - Essex and IAPT SBU Event - Open discussion around anti-racist resources, and racial identity in the workplace on 29th October
    - East and North SBU Event - How your BAME ambassadors can support you; on 29th October 2021.
- Pride Month – June 2020. An extensive programme for pride was initially planned, however, COVID 19 changed what was possible and instead we organised a month of activities that included:
    - Sharing information about pride and LGBTQ+ equality information on the Hive
    - Sharing a message from the new Stonewall CEO
    - A book club and review that took place over the whole month
    - An article from the Trust's LGBT+ Unison Representative
    - Promoting the rainbow lanyard and badge programmes and informing colleagues about their relevance
    - Participating in the #NHSVirtualPride on Friday 26th June.

7. PSED - Specific Duties

7.1 **Overview of requirements.** The Trust is required to comply with the specific duties in the following ways:

- Publish information to demonstrate compliance with the general duty - this report has been written and published to ensure compliance with this element of the duty
- Publish data on the make-up of the workforce - this is provided in Appendix 1
- Publish data on those affected by Trust policies and procedures - this is provided in Appendix 1 (service user data).

- Publish one or more equality objectives - the Trust's Equality Plan was published in September 2018 detailing strategic objectives for the Trust over the next four years. The plan is available online at https://www.hpft.nhs.uk/about-us/equality-and-diversity/our-equality-plan-2018-2022/. The strategic objectives of the Equality Plan are:

  1. People have equity of access
  2. People have equity of outcomes
  3. People's human rights are promoted
  4. People have equally good experiences
  5. The impact of the plan is monitored for effectiveness.

In addition to the above the plan includes focused work on improving understanding of intersectionality and the need to remove systemic barriers that can cause inequality.

7.2 **Observations against the Trust data.** Appendix 1 details data for employment and for service provision by protected group. The following observations have been made from this along with our WRES and WDES data – available at https://www.hpft.nhs.uk/about-us/equality-and-diversity/
There has been overall good progress on the Trust's data quality for service users and carers over the past year. The biggest improvement is around the data set for age. There are some concerns over the data set for Ethnicity which is below the 90% target for service users. The Trust needs to improve our data quality and quality improvement for sexual orientation, disability, religion/belief and ethnicity throughout 2021/22.

7.3 The Age demography of our Service Users has remained the same and under 20s are the largest group using Trust services (23.5%) followed by the over 65s (19.5%). Both these services sit in one SBU so the Trust could look at an additional business plan to support accessibility of these operational services.

7.4 The Trust's Workforce Race Equality Standard (WRES) Data for 2020-21 has showed some improvements in relation to workplace culture, as reported through the 2020 staff survey for the Trust. However, appointments following shortlisting are still an area for concern at the Trust and will look at some focused work around this. There has been a decrease in BAME staff entering the formal disciplinary processes.

7.5 The metric 3 for 2020-21 is 0.77, which is a decrease of 0.26 which the lowest figure calculated for the Trust since WRES reporting began. The Second Decision Making Panel process was removed in 2020 and COVID-19 has impacted the numbers of staff entering the formal disciplinary processes across each quarter. There are also hotspots in the trust which will require triangulated work to unpack the narrative with our Operational Teams, Human Resources, Organisational Development and People Team and Inclusion and Engagement Team understanding the differential experience based on Staff Surveys, 'Having Your Say', 'Friends and Family Test' and 'Feeling Safe scores'.

7.6 There is 29.7% of the workforce that have not declared their religion and/or belief, which is an improvement of 6.3% compared to last year's data. This is not currently mirrored across people applying for roles (10.1%). The Trust will continue with its programme of work to encourage staff to amend their staff records aiming to reduce the proportion of data missing for staff records providing a better quality of workforce intelligence.

7.7 The Disability rate of employed staff has risen to 5.33%. There is 23.7% of staff who have no data recorded on the disability field of their staff record. The Trust will ensure it has focused work during the year to improve its data quality for Disability, which is also part of the WDES work plan.

7.8 The year we have seen a shift in applications and have received more from those aged 20-29 (43.8%); this is not mirrored in the workforce where this age group is underrepresented. The Trust will undertake a deep dive to look at age groups and employment.

7.9 36.3% of employees are from an ethnic minority background, which is a 2.4% increase on 2019-20 figures (where those who did not state their ethnicity are removed from figures). This is not currently reflected evenly across the workforce, which is a key evidence base for the WRES having been implemented. There are professional groups in which the Trust has underrepresentation of employees from an ethnic minority. The Trust will be coordinating work around talent mapping to have more equity in the workforce across different professional groups.

8. EDS2 – partial regrading of activity

8.1 The EDS2 requires providers to select one or more EDS2 outcomes to re-assess on an annual basis.

8.2 EDS2 grades should be agreed by the Trust's 'local interests' (stakeholders) through the provision of range of evidence showing the Trust current position.

8.3 The EDS2 has four grading options:

- Red – Under-developed (i.e. no evidence of activity for protected groups)
- Amber – Developing (i.e. evidence of activity (often good) but not for all protected groups)
- Green – Developed (i.e. good evidence of activity for most protected groups)
- Purple – Excelling (i.e. good evidence of activity for all protected groups).

8.4 The last regrade was completed in May 2019 and, at that time, the Trust had anticipated that EDS3 would have been in place for 2020. However, owing to the ongoing impact of COVID-19 EDS3 has not yet been ratified by the Equality and Diversity Council (EDC). Furthermore, the Executive had taken the decision to defer any further regrading for EDS3.

8.5 It is unclear when EDS3 will now be adopted and become operation and, as such, the Trust will consider to regrade under EDS2 once there is clarity about the future or to wait for more clarity about EDS3. In the light of the current environment, it is the intention of the Trust to complete a full EDS grading as soon as circumstances makes it possible.

8.6 In May 2019, the Trust chose to re-grade ten outcomes as agreed with the Trust Equality, Diversity and Inclusion Group (EDIG), as detailed in table 1.

Goal	Outcome	January 2018	May 2019	July 2021

Goal	Outcome	January 2018	May 2019	July 2021
1. Better health outcomes	1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	Not re-graded	Not re-graded	Not re-graded
	1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways			To re-grade
	1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.			Not re-graded
	1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	Not re-graded		Not re-graded
	1.5 Screening, vaccination and other health promotion services reach and benefit all local communities.			Not re-graded
2. Improved patient access and experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds			Not re-graded
	2.2 People are informed and supported to be as involved as they wish to be in decisions about their care.			Not re-graded
	2.3 People report positive experiences of the NHS.			Not re-graded
	2.4 People's complaints about services are handled respectfully and efficiently.			To re-grade
3. Empowered, engaged and well-supported staff	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.			To re-grade
	3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.			Not re-graded
	3.3 Training and development opportunities are taken up and positively evaluated by all staff.			Not re-graded
	3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.			Not re-graded
	3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives.			Not re-graded
	3.6 Staff report positive experiences of their membership of the workforce.			Not re-graded

Goal	Outcome	January 2018	May 2019	July 2021
4. Inclusive leadership	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond			Not re-graded
	4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed.			Not re-graded
	4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.			To re-grade

Table 1

8.7 EDS2 objectives from 2019-20 position:

- Develop and implement plan to diversify engagement mechanisms such as Carer Council, Service User Council and Youth Council
- Improve the collection of demographic data particularly for sexual orientation and disability for staff and service users
- Identify and develop mechanisms to capture and report demographic data concerning the safety of service users and staff.
- Develop action plan emerging from gender pay gap reporting and put in place arrangements for ethnicity and disability pay gap monitoring and reporting
- Explore the rationale for the significant inequality identified with the workforce race equality standard results and identify solutions
- Identify and develop arrangements to monitor use of informal flexible working arrangements and identify any differential impact by demography.
- Review approach to reasonable adjustments to ensure that there is a consistent approach across the Trust
- Provide training and information on reasonable adjustments for all middle managers.

9. Challenges and Opportunities for the coming year

9.1 The Trust is aware from the staff survey results that a number of challenges remain, with respect to equality and diversity. Foremost amongst these, is a need to deal with the extent of bullying and harassment of staff particularly from service users.

9.2 An ongoing challenge relates to improvement in WRES scores for staff appointments and staff experience. The Trust will be introducing BAME representatives at interview panel. The representatives will undertake training and have support in place to equip them in this new initiative and this is the main objective set by BAME staff Network for 2021-22.

9.3 The Trust's reverse mentoring programme has been impacted by COVID-19 and there remains much to do to roll out the programme to a wider demographic and to review its impact.

9.4 There is a need now to review the policy, procedure, operation and impact of the disciplinary panel on disciplinary cases coming forward and to create an equal

environment for all diverse staff by opening the pool of staff that sit and make decisions through the process.

9.5 To continue to build on the rainbow lanyards and NHS rainbow badge schemes. The former focused on improving awareness and commitment from staff to equality, diversity and inclusion. The latter focused on staff and team commitment to creating safe spaces for LGBT people to disclose their sexual orientation and explore their gender identity and receive specialist signposting and information. There is a need to promote both initiatives to engage more of the new staff to the Trust.

9.6 To shape the work on the Trust's Equality, Diversity and Inclusion Plan, to have a bigger focus on experience and culture change. Also, to strengthen our work between all NHS equality standards. It is recognised by the Trust that improving data quality will help improve understanding in relation to equitable access to services and employment and the Trust will continue to build on data quality throughout 2021-22.

9.7 To work on the development of a new Trust Equality, Diversity and Inclusion Plan/Strategy to replace to plan that ends in 2022.

9.8 During COVID-19, the Trust invested more time and resources into the development of staff networks via virtual platforms. During 2021-22, the Trust will look to combine face to face work, where appropriate, whilst continuing to develop our virtual spaces for discussion and debate.

9.9 Reinvest work into the Trust's targeted action planning to address the gender pay gap, through improving the experiences of women in the workforce, learning from best practice and challenging inequality and inequity.

9.10 Further develop the Ambassador and Champions Programmes. The Trust will continue to take specific positive action on Race and Disability as part of its requirements to address issues arising from the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). The Ambassador and Champions programmes were affected during the COVID-19 pandemic, so have an opportunity to prioritise these programmes focusing on intersectionality and integration. The full Ambassador and Champion programmes will be embedded by March 2022.

10. Conclusion

10.1 This report has provided an overview of the Trust work towards meeting the Public Sector Equality Duty, with respect to both the general duties (in the form of narrative) and the specific duties (with respect to the Trust's Equality Plan and data in Appendix 1).

10.2 Whilst there is work to be done, the Trust is able to show that it is linking its work into meeting the general duties and identifying areas for improvement.

10.3 The past year has seen a number of successes for the Trust in relation to advancing the Equality, Diversity and Inclusion agenda, including events for Black History Month, International Women's Day, Disability Awareness Day, LGBT History and also Pride Month.

10.4 There is a need to strengthen the Trust's governance structure for Equality, Diversity and Inclusion, ensuring all areas of work reported effectively.

10.5 However, there remain some challenges for the Trust, most notably in relation the WRES and improving data quality across both employment and service provision. Targeted work began in 2019 has begun to yield results around some of this in relation to the WDES and the WRES and this will remain a priority over the coming year.

10.6 Throughout 2020/21 there were a number of projects launched including the Reverse Mentors programme, the Ambassador programme and the Champions programme. The Trust will continue to ensure inclusion is in the spotlight during 2021/22.

10.7 As aforementioned we will undertake a full EDS2/3 regrade with our stakeholders to ensure we have the right systems and processes in place and will put in to place an agreed set of Equality objectives.

11. Recommendations

11.1 A need to further analysis the data to look at variation and patterns across service user, staff and carer demography data.

11.2 A request to add data around COVID-19 including percentage demographic spread of risk assessments.

11.3 It is recommended that, once this report is approved to proceed for Board approval, so this can be published on the Trust website as part of the Trust's Public Sector Equality Duty.

Appendix 1 – Workforce & Service User Data

Data tables for staff and service user equalities data for 2020/21.
The % listed in the tables relates the following numbers:

Applicants between 01/04/20 – 31/03/21	5702
Staff in Post at 31/03/21	4537
Leavers between 01/04/18 – 31/03/20	592
Staff with a current Professional Development Plan (PDP)	3130
Service Users as of 31/03/20	48418
Carers as of 31/03/20	2753

AGE

	Employed staff	Leavers	Current PDP
16-20	0.5%	0.5%	TBC
21-25	10.6%	10.6%	TBC
26-30	14.7%	14.7%	TBC
31-35	9.8%	9.8%	TBC
36-40	13.3%	13.3%	TBC
41-45	9.1%	9.1%	TBC
46-50	11.5%	11.5%	TBC
51-55	9.6%	9.6%	TBC
56-60	9.6%	9.6%	TBC
61-65	5.6%	5.6%	TBC
66-70	4.4%	4.4%	TBC
71 & above	1.3%	1.3%	TBC

	Applicants	Service Users	Carers
Under 20	1%	23.5%	0.8%
20 - 24	25%	9.5%	1.96%
25 - 29	18.8%	8.4%	3%
30 - 34	13.5%	7.9%	3.7%
35 - 39	9.9%	6.8%	4.7%
40 - 44	9.1%	5.55%	7.3%
45 - 49	6.2%	5.1%	7.4%
50 - 54	6.3%	5.2%	11.4%
55 - 59	4.8%	4.9%	12%
60 - 64	2.3%	3.7%	10.5%
65+	0.54%	19.5%	21.3%
Not stated	2.56%	0.03%	15.94%

GENDER

	Applicants	Employed staff	Leavers	Current PDP	Service users	Carers
Female	78%	73.3%	77%	TBC	54.2%	65.7%
Male	21.2%	26.7%	23%	TBC	45.6%	32.1%
Did not disclose	0.8%	-	-	TBC	-	-
Not recorded	-	-	-	TBC	0.13%	2.14%

Our systems currently do not monitoring non-binary genders but this will change as part of our data improvement plan.

ETHNICITY

	Applicants	Employed staff	Leavers	Current PDP	Service users	Carers
A White - British	44.3%	50%	53.8%	TBC	55.2%	24.4%
B White - Irish	1.2%	2.2%	3.2%	TBC	1%	0.8%
C White - Any other White background	10.4%	6.7%	5.9%	TBC	2.9%	1.02%
D Mixed - White & Black Caribbean	1.3%	0.9%	0.67%	TBC	0.9%	0.33%
E Mixed - White & Black African	0.8%	0.48%	0.34%	TBC	0.31%	-
F Mixed - White & Asian	0.79%	0.79%	0.67%	TBC	0.45%	0.14%
G Mixed - Any other mixed background	1.37%	1%	1.01%	TBC	1.04%	0.25%
H Asian or Asian British - Indian	8%	5.02%	5.7%	TBC	0.76%	0.58%
J Asian or Asian British - Pakistani	3%	1.6%	1.18%	TBC	0.6%	0.25%
K Asian or Asian British - Bangladeshi	1.4%	0.48%	0.17%	TBC	0.25%	0.29%
L Asian or Asian British - Any other Asian background	3.3%	3.6%	2.8%	TBC	1.05%	0.58%
M Black or Black British - Caribbean	2.7%	2.5%	2.2%	TBC	0.45%	0.25%
N Black or Black British - African	14.3%	15.2%	16.2%	TBC	0.66%	0.29%
P Black or Black British - Any other Black background	0.93%	1.56%	0.84%	TBC	0.83%	0.47%
R Chinese	0.68%	0.64%	0.67%	TBC	0.15%	0.07%
S Any Other Ethnic Group	2.6%	2.5%	1.5%	TBC	0.77%	0.47%
Z Not Stated	3.8%	4.83%	2.8%	TBC	32.68%	69.8%

SEXUAL ORIENTATION

	Applicants	Employed staff	Leavers	Current PDP	Service users	Carers
Gay or Lesbian	1.33%	1.2%	TBC	TBC	0.8%	0.18%
Bisexual	7.1%	2.3%	TBC	TBC	0.85%	-
Heterosexual	86.6%	69%	TBC	TBC	41.4%	17%
Refused	4.4%	27.3%	TBC	TBC	2.6%	0.3%
Other	0.33%	0.1%	TBC	TBC	1.4%	0.14%
Not recorded	0.24%	0.1%	TBC	TBC	52.9%	82.3%

DISABILITY

	Applicants	Employed staff	Leavers	Current PDP	Service users	Carers
Yes	6.8%	5.33%	4.9%	TBC	33%	4.4%
No	90.9%	70.8%	74.1%	TBC	-	-
Refused	2%	0.17%	0.17%	TBC	-	-
Not recorded	0.3%	23.7%	20.8%	TBC	67%	95.6%

RELIGION & BELIEF

	Applicants	Employed staff	Leavers	Current PDP	Service Users	Carers
Atheism	23.7%	13.3%	TBC	TBC	1.3%	0.7%
Buddhism	0.84%	0.62%	TBC	TBC	0.16%	0.04%
Christianity	42.7%	40.1%	TBC	TBC	15.2%	6.1%
Hinduism	4.4%	3.1%	TBC	TBC	0.36%	0.4%
Islam	7%	3.9%	TBC	TBC	1.1%	0.5%
Jainism	0.1%	0.08%	TBC	TBC	0.004%	-
Judaism	1.06%	1%	TBC	TBC	0.63%	0.2%
Sikhism	0.86%	0.5%	TBC	TBC	0.01%	0.04%
Other	8.9%	7.5%	TBC	TBC	2.6%	0.6%
None	-	-	TBC	TBC	9.4%	1.6%
Rather not say	10.1%	29.7%	TBC	TBC	2%	0.3%
Not recorded	0.34	3.3	TBC	TBC	67.2%	89.5%

MARRIAGE & CIVIL PARTNERSHIP

	Applicants	Employed staff	Leavers	Current PDP
Civil Partnership	2.4%	TBC	TBC	TBC
Divorced	4%	TBC	TBC	TBC
Legally Separated	0.43%	TBC	TBC	TBC
Married	30%	TBC	TBC	TBC
Single	57.7%	TBC	TBC	TBC
Unknown	4.87%	TBC	TBC	TBC
Widowed	0.6%	TBC	TBC	TBC

	Service Users	Carers
Married/Civil Partnership	5.3%	2.8%
Divorced	1.2%	0.4%
Legally Separated	0.57%	0.18%
Single	19.8%	2%
Unknown	71.2%	94.4%
Widowed	1.9%	0.18%

Appendix 2 – Overview of Trust requirements re: Public Sector Equality Duty

In October 2010, the Equality Act 2010 came into effect. Prior to this time there had been over 100 pieces of legislation covering equalities protections and – with them – three associated public duties for race, gender and disability.

The Equality Act 2010 has brought with it a new – legal – public sector equality duty (PSED) requiring public bodies to declare their compliance with the duty on an annual basis. This means that HPFT must show compliance with both the general and specific duties of the PSED. This includes:

For the general duty showing how we have due regard to the need to:

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it
- **Foster good relations** between people who share a protected characteristic and people who do not share it.

Protected characteristics – in the context of the PSED – are defined as:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race – this includes ethnic or national origins, colour or nationality
- Religion or belief – this includes lack of belief
- Sex (gender)
- Sexual orientation

It also applies to marriage and civil partnership in respect of the requirement to have due regard to the need to eliminate discrimination.

For the specific duty HPFT must:

- Publish information to demonstrate compliance with the general duty
- Publish data on the make-up of the workforce
- Publish data on those affected by HPFT policies and procedures
- Publish one or more equality objectives.

This document outlines how HPFT is currently complying with the PSED and working at maintaining a level of excellence in equality & diversity. Much of our evidence of PSED compliance is detailed through Trust Equality Delivery System 2 (EDS2) approached.

The PSED is a legal framework which requires the Trust to be compliant across **ALL** functions in meeting the needs of those with a protected characteristic.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 10
Subject:	Annual EPRR report	**For Publication:** Yes
Authors:	Caroline Mills/ Fiona McMillan Shields	**Approved by:** Sandra Brookes, Executive Director of Service Delivery and Experience/Chief Operating Officer
Presented by:	Sandra Brookes, Executive Director of Service Delivery and Experience/Chief Operating Officer	

Purpose of the report:

To provide the Board with an overview of the Trusts performance in relation to the EPRR Core Standards monitored by NHSE/I for 2021/22 and assurance regarding the Trust's annual position statement for EPRR.

Action required:

To note the self-assessment of the Trust position against the EPRR Core standards and the annual EPRR Statement of conformity submitted.
To note the focus of the EPRR Board during 2021.

Summary and recommendations:

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical, and business continuity incidents whilst maintaining services to patients.

The process is in four stages and this report details the outcomes of the first stage of a 'self-assessment'.

The NHS Core Standards for EPRR are the minimum requirements commissioners and providers of NHS funded services must meet.

These core standards are the basis of the EPRR annual assurance process. Commissioners and providers of NHS funded services must assure themselves against the core standards.

The applicability of each core standard is dependent on the organisation's function and statutory requirements. Each organisation type has a different number of core standards to assure itself against.

For the Trust this report demonstrates that all 58 mental health provider core standards and the 1 deep dive standards have been reviewed. The deep dive standards do not contribute to the overall assurance rating for the trust. [This year the deep dive is about Piped Oxygen which is not used within HPFT sites].

Following review of the standards we will be submitting a rating of Fully Compliant in the assurance process with all systems and processes remaining effective.

Following the submission of the self-assessment the Accountable Emergency Officer will be invited a to a review meeting with CCG colleagues before final submission at end of Q3.

Recommendation

For the Board to accept the Statement of EPRR Conformity and note the Trust self-assessment of the 2021 NHS Core Standards for EPRR.

To consider the need for a Non-Executive Director to EPRR

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

Relation to the Trust Risk Register:

978-**Quality and safety:** The Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff.

Relation to the BAF:

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

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

The Civil Contingencies Act 2004 and the NHS Act 2006, as amended by the Health and Social Care Act 2012, underpin EPRR within health. Both Acts place EPRR duties on NHS England and the NHS in England.
Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS funded services to comply with NHS England EPRR guidance.

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

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

Seen by the following committee(s) on date:

IGC 16 September 2021

Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2021-22

1. Introduction

1.1 The purpose of the EPRR annual assurance process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR core standards.

1.2 Due to demands on the NHS, the 2020 process was much reduced and focused on learning from the first COVID-19 wave and the preparation for future waves and winter.

1.3 The 2021 EPRR assurance aims to return some of the previous mechanisms to the process, but also acknowledges the previous 18 months and the changing landscape of the NHS.

1.4 The Trust was assessed last year as 'green' and substantially compliant in the assurance process of 2020/21 and following local commissioner assurance meetings this final rating was confirmed by NHS E/I. The main actions taken by the Trust following last year's assurance process include the review and consultation of the Trust approach to On-Call arrangements and a review of the training needs of the senior leadership team including the Executive directors.

2. Compliance with the Core Standards

2.1 NHS England/NHS Improvement has a statutory requirement to assure itself of NHS EPRR readiness including through individual provider trusts. This is actioned through the EPRR annual assurance process. Assurance is a four-stage process.

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

2.2 There are 58 core standards that apply to mental health trusts in 2021/22. The table below demonstrates self-assessment of compliance for the Trust for 2021/22. The latest version with the detail for submission is appended to this report.

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

Compliance level	No of Standards
Not compliant	0
Partially compliant	0
Fully compliant	58

2.3 As well as the EPRR Core Standards there is an annual 'deep dive', however as this year's deep dive focuses on Piped Oxygen systems, which are not present within HPFT sites, the deep dive is not applicable to the Trust.

2.4 In addition to the self-assessment submission a refreshed 'decant' or evacuation plan has been requested this year and this has been updated to include Elizabeth Court as the main option for decant of inpatient settings.

3 EPRR statement

3.1 All NHS funded organisations are asked to provide evidence of their compliance and for their Board to issue a *Statement of EPRR Conformity* to their commissioners. This report provides evidence for this purpose.

3.2 The EPRR annual statement is appended to this report for this purpose.

4 Identification of learning from Covid-19 Pandemic

4.1 Over the past year the Trust has undertaken a series of debriefs regarding the incident management of the Covid19 pandemic. The themes have been considered and incorporated into the Trust EPRR action plan and used to shape the ongoing response.

4.2 Due to the length and protracted nature of incident some senior staff have changed roles, and EPRR training has been completed with further training booked to further prepare new staff for Incident Management.

4.3 The need to establish an Incident Command Centre which has been has been able to flex up and down, in line with the waves of the pandemic, to meet the needs of the Trust. Positive feedback has included how individual site and business unit business continuity frameworks worked well. There was good visible leadership throughout the incident and reported improvements in the way the business units work together. For many of the operational and tactical commanders this has been their first initiation into incident management and has provided them with a broader understanding of the management of the Trust's business beyond their immediate sphere.

4.4 Information Technology, digital platforms, automated reporting through Spike, once established, all contributed to the development of new ways of working including remote working and virtual meetings, which have enabled and facilitated the range of participation and rapidity of response as required including staff from across Trust settings and sites, promoting inclusion and breadth of coverage.

4.5 Other areas of learning that have been actioned include identifying skills gaps and providing further training, and ensuring that health, wellbeing and practical support is in place for staff. Areas for further consideration include the approach to management of redeployment in any future large-scale, long-lasting incidents.

5. Incident Command

5.1 The Trusts Incident Command Centre (ICC) team has had to address other stressors on the Trust's business throughout the past year including several small Information Management and Technology (IMT) / digital incidents. A digital exercise is planned for the end of September 2021 to reflect on IMT incidents and prioritise further learning for the Trust. In the past week we have had to respond to a bomb threat at a unit in Hertfordshire that was managed and contained through a robust incident approach.

5.2 ICC was stood up to oversee and co-ordinate response to increasing pressures on clinical services, with a focus on Trust-wide bed flow, staff resources, and system

wide pressures throughout August. A new internal Incident Management Framework was quickly established to support and prioritise operational services along with new reports and SitReps mobilised to promote the timely flow of management information to monitor the incident and aid timely recovery.

5.3 A hot debrief is already being planned in September to feedback learning from this incident and to identify the issues that will need taking forward to improve bed flow and response to activity surge.

6. Working with Partners

6.1 The Trust has continued to be responsive and support local Hertfordshire and wider organisation system calls and meetings. We have responded to the local tactical health response for Covid 19 and more recently for Quarantine Hotels and Afghan repatriation.

6.2 The Trust continues to contribute to the Local Resilience Forum to access training and have also used the Public Health England training.

6.3 The Trust has offered Mutual Aid to partners, including providing Infection Prevention Control advice to independent providers where HPFT had placed service users. We have also benefitted from the Mutual Aid provided by partners, including acquisition of Lateral Flow Devices.

7. EPRR Group focus

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

7.2 The EPRR group also coordinates and commissions EPRR focused training and exercises.

7.3 A system exercise, “Exercise Starlight” is a communication exercise planned some time during September 2021. The objective of the exercise is: -

- To confirm that NHS England and NHS Improvement can contact CCGs via their on-call contact number.
- To confirm that CCGs can contact Providers via their on-call contact number.
- To ascertain that CCGs and Providers can respond to messages via their on-call contacts.
- To review and amend, as necessary, Incident Response Plans or contact directories to ensure lessons are learnt.

8. Winter Planning

8.1 The winter plan provides a framework with which to identify the deployment of additional resources, surge capacity and support for staff. Winter Planning encompasses support for the system, including response to surges in demand and changes in capacity alongside improved use of technology. The organisation adverse weather policy is also included.

8.2 Winter planning this year will include the Covid-19 Booster vaccine being provided to staff along with the Flu vaccination programme.

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

9. Recommendation

9.1 For the IGC to accept the *Statement of EPRR Conformity* and acknowledge the Trust self-assessment of the 2021 NHS Core Standards for EPRR.

9.2 For the Board to consider the need for a Non-Executive Director link to EPRR

APPENDIX

Hertfordshire Partnership University NHS Foundation Trust

Emergency Preparedness Resilience Response Policy Statement

The Civil Contingencies Act (2004) is a national legislation which places the highest priority on all organisations to ensure adequate emergency planning and preparedness, as well as robust business continuity planning.

The Hertfordshire Partnership Foundation Trust (HPFT), under the Civil Contingencies Act 2004, is required to respond as a Category 1 responder and has a duty to protect and promote the health of the economy in partnership with the wider NHS, the emergency services and local authorities and through the Local Resilience Forum (LRF). We have a central role in planning for and responding to any incident with major consequences for health or health services.

Every member of staff plays a vital role in ensuring there is a professional NHS response in a crisis. As such, it is essential that staff are familiar with how the Trust operates during such an event, what role staff may play and what other organisations the Trust will be working with.

An emergency, by its nature, is a stressful and uncertain situation. As such it is vital that staff feel supported by an effective emergency management team, who will work with staff to co-ordinate the response. There may be a need for staff to be flexible, work in unfamiliar environments or for extended periods and we rely on staff co-operation and support in order to manage any crisis effectively.

This policy statement sets out the framework for the Trust's approach to Emergency Preparedness, Resilience and Response (EPRR).

It is vital that the Trust is prepared and can respond to any major incident, providing a coordinated range of emergency-, mid- and long-term services to those involved, including patients, relatives and friends, and our own staff. As such, robust and comprehensive emergency planning is a priority for the Trust.

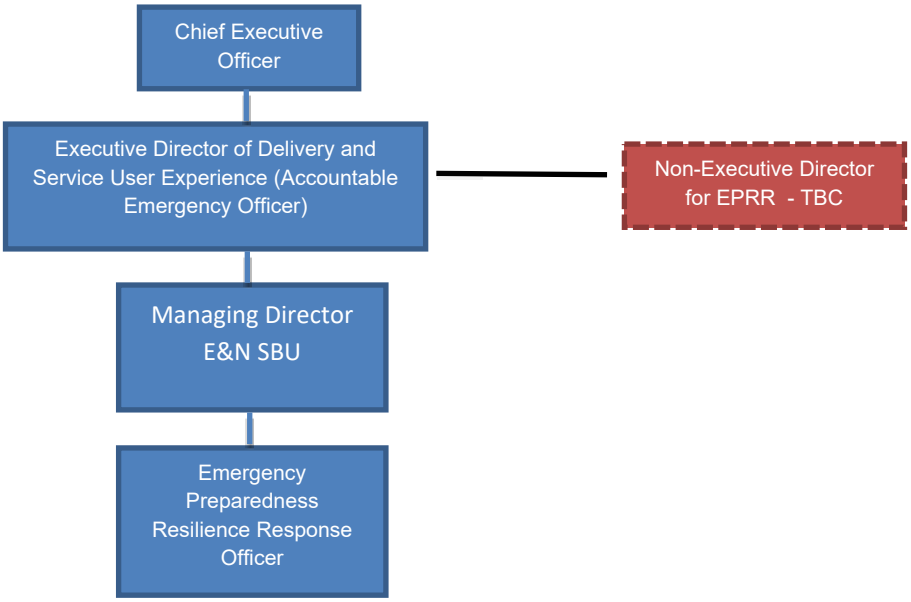
Within the EPRR group there is a work plan, which identifies actions internally and externally within the organisations. This also focuses on lessons learnt and ensuring we take away efficient actions to ensure this can be combined with other partnership organisations.

The EPRR groups Terms of Reference ensures accountability by ensuring that the group reports to the Quality and Risk Management Committee (QRMC). One of which will be a yearly report.

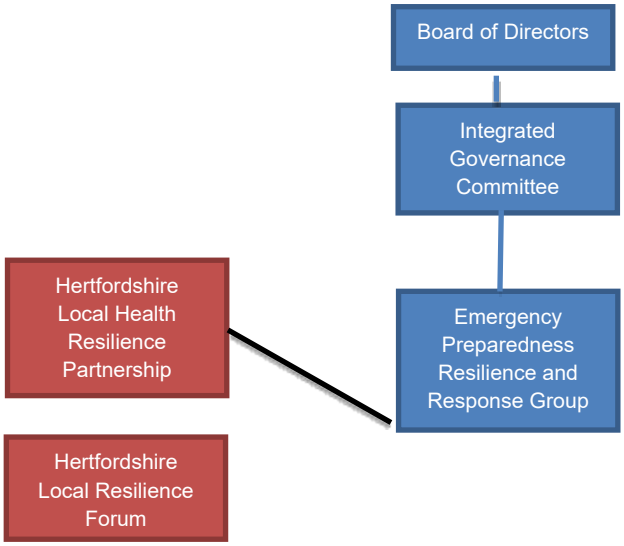
Within the trust there is collaboration working with partners which includes the Health, Safety and Security committee, this also extends to external groups such as the Hertfordshire Local Resilience Partnership (LHRP), The Sub LHRP group and The Local Resilience Forum (LRF)

We manage and identify incidents via Datix and Risk registers. This will then be presented within the EPRR group and populated accordingly for wider sharing. This ensures continuous improvement within our services and ensures regular meetings where this can be worked on and actioned accordingly.

Structure of Roles



Structure of Governance



Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 11
Subject:	Report from Finance & Investment Committees – held on 16 August 2021 & 22 September 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 meetings on 16 August 2021 22 September 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.

At the August meeting the Committee approved the purchasing of additional inpatient mental health beds making a recommendation to the Board for the case to be approved. It was agreed by board members to delegate approval of the proposal on their behalf to Trust Chair, CEO and Chair of FIC, to enable the Trust to enter into the contract in a timely why and therefore support delivery of high quality of care to service users.

Following FIC the Chair, CEO and Chair of FIC approved the case and the contract was signed.

At the September meeting the Committee agreed the business case for phase one of refurbishment of Oak Ward.

Recommendation:

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

a) Lexden Business Case
b) Transfer of Children's Learning Disability Services - Essex

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 22 September 2021.

1. Introduction

1.1 The Finance and Investment Committee (FIC) has met twice since the last report. It had an extraordinary meeting on 16 August 2021 and a further meeting on the 22 September 2021, they met in accordance with its terms of reference and were quorate.

2. Extra ordinary FIC meeting held 16 August 2021-

The meeting considered a single item relating to the purchase of an additional ten inpatient mental health beds for an initial period of 3-6 months. It was reported that discussions are underway with an NHSE Preferred Provider and negotiations completed on the service specification, contract and associated cost.

The Committee noted that with the additional beds the Trust will be able to manage service users more effectively and efficiently and there has always been a plan to reduce out of area placements in line with NHSE's target. The Committee were assured that the Beds will be managed in the same way as Trust internal beds including quality monitoring.

In response to a question Maria Wheeler confirmed that the contract included a small reduction against Spot Purchase but overall the costs are standard. Sandra Brooked added that SBU Senior Leadership Team will have oversight and will collate data looking at complaints, length of stay and will ensure that the levels of quality will mirror our own beds

The Committee approved the case making a recommendation to the Board for the case to be approved whilst noting it had been agreed by board members to delegate approval of the proposal on their behalf to Trust Chair, CEO and Chair of FIC. This was to enable the Trust to enter into the contract in a timely why and therefore support delivery of high quality of care to service users.

3. Committee held on 22 September 2021

3.1 Deep Dive – H2 Planning

The Committee received a presentation on latest understanding of the expected guidance for planning for H2. It included an assessment of the Trust's financial plan and the impact of the expected guidance. The Committee considered the current run rate and what this meant for 2021/22 as well as the brought forward elements.

The Committee noted the Transformation funding carried forward from 2020/21 including the progress that has been made with the transformation programme as well as the funding available in 2021/22.

It was reported that the detailed guidance for H2 was expected at the end of the month, some of the early indications are that pay award is funded and efficiency requirements were likely to be less that the Trust was planning for in H2.

Looking forward it is expected that the contracting processes will be up and running for 2022/23 and await guidance on the funding for the increased NI contribution announced by the government.

In response to David Atkinson's question Maria Wheeler confirmed that the forecast position included figures from the updated Delivering Value Programme. It was agreed that future FIC meetings in 2021/22 would receive a regular update on forecast year end position including management of provisions.

3.2 Digital Capital Investment Update

The Committee considered a report that provided an update on progress of the capital projects in the annual plan for the implementation of Our Digital Strategy. It was noted that nine out of the relevant projects in the portfolio are progressing as planned and are on track to deliver the year end aims.

The Committee received an update on the two remaining to projects: Right Tools for the Job and Care workflows. The Committee discussed the forecast overspend for one of the projects linked with an increase in unit prices and due to changes in requirements that there the other project had paused while there was a review of the scope of the project.

3.3 Future National Digital Funding

a) NHS X Guidance for Digitised Healthcare

The Committee considered a report that set out the recent publications from NHS X. These include: What Good Looks Like framework which outlines national digital success measures at ICS and organisational level; Unified Tech Fund prospectus which consolidates national funding for technology for 21-22 with a total of around £680m funding available across eight components and Who Pays for What proposal for the future of digital investment which proposes that ICSs are tasked to manage investment for digital from their own budgets (ICS and organisational) from 22-23 onwards.

The Committee welcomed the clarity provided by the new guidance noting that the Committee would be considering a separate report on implication of these changes on the Trust's Digital Aspirants programme.

In response to David Atkinson's question Hakan Akozek reported that the ICS Digital Partnership Board was still in its infancy but was a helpful forum to be involved in. He also confirmed that he would be part of the national CIO forum which had recently been set up. It was agreed that the Committee

would continue to keep the question of access to capital and implications for the Trust would be kept under review.

b) UTF Frontline Digitisation Application

The Committee received a report at the end of August 2021 which updated the Committee on the published guidance from NHS X regarding the Unified Tech Fund (UTF). It was noted that the fund consolidates national funding for digital initiatives under a single umbrella.

The Committee noted that the seed funding from NHS X in 2020-21 received by the Trust to develop a business case to seek contribution to the cost of implementing Our Digital Strategy as part of the Digital Aspirants programme had been superseded by the Frontline Digitisation component of the UTF. The report outlined that the Trust has made significant progress preparing a business case for the Digital Aspirants programme and is in a good position to meet the eligibility criteria for UTF funding in 21-22 whilst also noting that further work may be required to meet the exact requirements of the UTF. It was reported that the Trust has been encouraged by NHS England and Improvement East of England finance and digital teams to put forward an application with a view to finalise and approve the business case in collaboration with NHS X. The bid will provide funds for 21-22 financial year with indications that a successful bid for multi-year funding in 21-22 will put Trust in a better position to access funds in future years.

The Committee noted the intention to submit an application in line with the stated timescale asking that the coproduction work is clearly described within the application.

3.4 East of England Provider Collaborative

It was reported that good progress had been made with the Collaborative. The Committee considered the proposal that the Trust agree the sub-contracts with those organisations related to the provision of CAMHS tier four services across the East of England as well as a sub-contract with EPUT for forensic services.

The report provided a brief update on the progress to date and outstanding issues for resolution focusing on: Trust role as lead provider for Child & Adolescent Tier 4 Services; Trust as host of the Patient Flow Hub (bed management) for all service lines and Trust as a provider of Secure/Forensic, CAMHS and Adult Eating Disorder services.

It was noted that non-recurrent funding has been secured via the accelerated transformation fund to support the role out of LD community forensic services in Norfolk. Also, that the finance controls and reporting within the Provider Collaborative are being embedded and that there remain some challenges around the data quality. The Committee considered the month four finance position and the impact of the agreed risk arrangements.

In response to David Atkinson's question Sandra Brookes confirmed that work was underway to support providers with the transformation of CAMHs services to support reduced lengths of stay.

Anne Barnard provided an update on the recent Provider Board.

3.5 Commercial Update

The Committee received a report that provided an update on the contracting arrangements, noting that significant agreement has been reached on the items proposed with an overall contract value with commissioners. It was noted that there is will be potential opportunities for the Trust to receive further funding in addition that already agreed.

The Committee noted the successful bids by the Trust in 2021, including a joint business case with Commissioners for the Delivery of CYP Eating Disorders Medical Monitoring clinic to provide management of CYP with eating disorders. They also noted a number of bids in the planning stage, relating to development of HCC's Residential Strategy for Children Looked After (CLA) and CAMHS Liaison to General Acute Hospitals.

It was noted that later on the agenda the Committee would be considering a proposal with regard to Essex Learning Disability Partnership –Children's Learning Disability Services (CLDS).

Karen Taylor reported on the ongoing work regarding Norfolk Most Capable Provider (MCP) agreeing that a future Committee meeting would receive a specific update on this. The Committee noted the horizon scanning work relating to Sexual Assault Referral Service (SARS) and Sexual Violence Support Service (SVSS) in Hertfordshire and Pathfinders for adult victims and survivors of sexual assault and abuse with complex trauma related mental health needs.

a) <u>Children's Learning Disability Service (CLDS) - Essex</u>

The Committee considered a report setting out the proposal to transfer CLDS services, noting would be hosted within the Essex Learning Disability Partnership (ELDP) contract. It was noted that this proposal was part of the vision for the Essex Learning Disability Partnership.

The Committee considered the Due Diligence that had been completed in advance of the CLDS contract transfer. It was noted that it had considered the current operational and clinical risks; quality of the CLDS provision and any concerns and/or areas for improvement; workforce; finances and contract performance. It was reported that the process has not highlighted any risks that cannot adequately be mitigated.

The report detailed that the CLDS contract transfer holds three different elements each requiring a separate Contract Variation. When the contract is varied into the ELDP contract, the expiry date will become coterminous with the sub-contract end date 31 October 2025, although there is an option for a further two-year extension.

In response to Anne Barnard's question Maria Wheeler confirmed that the contract with EPUT would be block and Karen Taylor outlined that the quality assurance processes were in line w the ELDP and would be supported by regular quality visits.

The Committee supported the proposed transfer starting from 1 October 2021 recommending it to the Board for approval

3.6 Business Cases

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

a) Lexden – Refurbishment of the Assessment and Treatment Unit (ATU)

The Committee considered the business case for the refurbishment of Lexden Assessment and Treatment Unit. The business case includes: the provision of a safety suite (seclusion, LTS and de-escalation, secure garden); improvements to the reception and visitor area; improved line of sight/ supportive observation with removal of walls, placement of vision windows and creation of a safe courtyard garden. The Committee welcomed the business case noting that the refurbishment will create a safe environment for staff and service users, a fit for purpose facility to treat some of the most challenged service users the Trust treats.

The Committee noted that a Strategic Outline Case has been developed to create a 15 bedded ATU on the site in line with the ELDP contract and this is likely to be some years away from completion, meaning that a short term improvements are need to made to the facility. The Committee discussed in detail the pros and cons of investing in the site in the light of the longer term plans, concluding that it was an appropriate use of resources due to the quality issues and also uncertainly of the new unit being built.

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

b) Oak Ward

The Committee considered the Business Case for the for refurbishment of the Occupational Therapy (OT) Garden at Oak Ward Psychiatric Intensive Care Unit (PICU), Kingsley Green as the first phase in the project. It was noted that due to Health & Safety issues, the OT Therapy Garden has been closed and inaccessible to service users and staff.

The report set out that The PICU is part of HPFT's acute service provision for people with acute mental ill health and patients are compulsorily detained usually in secure conditions, often whilst in an acutely disturbed phase of a serious mental illness. Access to suitable outside space can be particularly important to the therapeutic process and to improving the quality of the general environment and experience for service users.

It was noted that is approved the project is expected to commence in October 2021 and completed in February 2022. The second and third phases of the project were currently being planned and final end date of quarter four of 2022/23.

The Business Case was approved.

3.7 Performance Report

The Committee received a report that detailed the performance of the organisation for quarter one 2021/22 with an update on trends in quarter two, against the 68 national, regional and local indicators. It was noted that critical KPIs including access into all services (in both crisis and referrals), safety and safe staffing remained strong. Additionally, several below target indicators have relatively small numbers (Community Eating Disorders 28 day waits, Learning Disability 28 day waits, urgent Community Referrals) and do not represent a significant drop in quality of service. The reduction in KPI performance reflects the current pressure from increased referral demands.

It was reported that performance in Quarter two remains strong against a challenging context. It was noted that there is expected to be a continuation of improvement in some of the longer standing challenges to performance such as risk assessment and CPA reviews.

The Committee were updated on the steps being taken in response including the sourcing of additional beds; expanding its recruitment and on-boarding support team to increase staffing, accelerating digital spend, and rescheduling non-priority work. Operationally there has been further investment in the Single Point of Access services to provide early interventions where possible and to increase onward referrals to partners where appropriate to do so.

It was highlighted that the Trust was using the triangulation of information to help better understand the whole picture across, finance, people and services.

The Committee received the report.

3.8 Finance Report.

The Committee considered the finance report for the period up to end of August 2021. It set out a positive finance position for year to date and for the forecast for 2021/22. The Committee considered the key variances within the yearend position. The report set out that income and expenditure are behind Plan for the month and for the year to date.

It was noted that the Trust expects to be on plan for Half 1 and has as relatively high level of confidence that will be on plan for Half 2, whilst noting was subject to details of the expected guidance. Detailed planning guidance is expected at the end of September which creates some uncertainty.

The Committee discussed the split of expenditure between bank and agency spend and the agency cap reporting requirements.

3.9 Delivering Value Efficiency Programme Update

The Committee received a report that provided an update on the Trust's Delivering Value Programme for 2021/22 including: the delivered savings in Quarter 1, the schemes identified to date, and the future work being undertaken to ensure delivery for the year.

It was reported that the programme target had been amended in the light of emerging guidance for H2 and reduced efficiency requirements. The importance of planning for the 2022/23 programme was discussed including the need to maintain momentum. It was agreed that would look into identifying resources to help support the QIA process prior to the start of 2022/23.

3.10 Capital Investment Programme Update

The Committee received a report that provided an update on the progress in delivering the Capital Plan for 2021/22. It was noted that the latest forecast incorporated a disposal programme of £4.7m which would give a gross spend of £20.8m.

The committee were updated that the programme comprises several elements: completion of FY21 schemes (covering 4 safety suites, Forest House HDU and Albany Lodge refurbishment); essential and routine works on estates and IM&T; the progression of the new inpatient facility; and six significant capital developments planned. Namely: major refurbishment of Oak ward, two further safety suites, the refurbishment of Lexden, the extension and upgrade of camera technology, the second year of the Digital Strategy roll out, and upgraded anti ligature windows and Kingfisher Court.

It was reported that the programme is largely on Plan and welcome the progress, noting the need for continued focus to ensure successful delivery. It was noted that the Trust had submitted an expression of interest to NHSE for funding for the inpatient unit in East and North Herts.

3.11 FIC Committee Planner

The Committee noted the updated planner which set out a rolling programme.

3.12 Any Other Business

The Committee noted Paul Ronald's retirement and was thanked for his significant contribution to the FIC and the work of the Trust.

4. Recommendation

To receive and note the report.

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

c) Lexden Business Case
d) Transfer of Children's Learning Disability Services - Essex

Board of Directors PUBLIC

Meeting Date:	30 Sept 2021	**Agenda Item:** 12
Subject:	Performance Update Report August 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 provide to the Trust Board an overview of the Trusts current performance as measured against the NHS Oversight Framework (NHSOF) targets, the Trust Key Performance Indicators and recent past trends.

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

Introduction

The attached report provides a summary of the performance of the organisation during August against 61 national, regional and local indicators across five key groupings. In addition, the report covers service demand in the context of new referrals and caseloads including a forecast of expected demand over the upcoming Quarter 3. It is an interim report with the full quarterly report to be provided to the October meeting.

August Performance Summary

Teams are continuing to work with great dedication and professionalism to maintain and improve performance whilst facing the continuing pressures from staff vacancy and turnover levels, the increase in demand for services and the acuity of service users:

- In July and August staff turnover reached 19% whilst vacancy rates over all were 13.6%. Beneath this there are some higher vacancy rates within certain staff groups – including nursing and AHPs
- The number of service users currently being treated in our services is at its highest levels with 2,000 more adults and 400 more children and young people than we treated pre-COVID.
- Service users are staying longer in our inpatient services as a result of increased acuity. Length of stay has increased from 35 days to 48 days with relatively high levels of people coming into services through Mental Health Act assessments. (57% adult inpatient admitted under the Mental Health Act)
- There are increased levels of violence and aggression in some LD&F and CAMHS inpatient services

Although our staff and services are under considerable pressure, all of our services remain fully open and we remain strong in:

- Our access standards (14 days, 28 days, and 18 week) are holding
- Our waiting time for treatment is also holding steady and we still benchmark favourably in comparison to other MHLD Trusts
- We are maintaining high standards of COVID-19 infection control and physical health checks
- Our staff tell us through the recent pulse survey that we are looking after their Wellbeing at this difficult and demanding time

Key performance indicators

Key Performance Indicators have improved slightly from last month. Of the 61 Key Performance Indicators monitored in August, overall performance is as follows:

- 31 (51%) are maintaining or exceeding performance levels (on target)
- 11 (18%) are almost meeting target performance levels (close to target)
- 17 (28%) are not meeting our performance standards (underperforming)
- 2 (3%) are currently monitored but no formal performance target set
- 5/6 targets on the NHS Oversight Framework are fully met, with the Out of Area placements of zero not being met. Under current bed demand and local acuity pressures this target is challenging to achieve.

The number of performance indicators that have been met has improved since Quarter 1 with critical KPIs including access into all services (in both crisis and referrals), safety and safe staffing remained strong. Additionally, several below target indicators have relatively small numbers (Community Eating Disorders 28 day waits, Learning Disability 28 day waits, urgent Community Referrals) and do not represent a significant drop in the quality of service.

The Trust has taken a number of steps in response including the sourcing of 10 additional temporary beds from the independent sector, expanding its recruitment & on-boarding support team to increase staffing, accelerating digital spend, and rescheduling non priority work. Operationally there has been further expansion the Single Point of Access services to provide early interventions where possible and to increase onward referrals to partners where appropriate to do so.

Net recruitment is a critical indicator of our ability to respond to demand increases, COVID-19 infection rate rises, and to deliver the changes we are driving forward. Net recruitment was positive in August. We will continue to report on progress in increasing net recruitment as the year progresses.

Following successful pilots there will be a phased increase in the use of data with SBUs, using the Modelling for Improvement Tool that demonstrates flow through services and are a useful indicator for forecasting and service modelling.

Service Demand Forecast

Referrals into the Single Point of Access Service in August saw a 10% increase on the same period in 19/20 with our forward looking forecast position for services for Q3 for referrals is:

- CAMHS referrals increase by 8% in Q3 when compared to our baseline (FY19/20);
- Adult referrals are 32% above our FY19/20 baseline in Q3, with an upward growth trend. This is slightly above national guidance of 10%-30% growth
- Older Adult referrals to continue a slight (2%) downward trend throughout Q3

- LD&F referrals to stay at the same levels as previous years

Looking ahead to winter workforce planning, overall workforce numbers are expected to increase with several new service developments progressing as well as from the current recruitment and retention plans.

Areas of Strong or Improved Performance

The following areas saw continued strong performance in August:

- Children and Young Persons referrals meeting the 4 hour waiting time standards in CRISIS was 99% (target 95%).
- People with a first episode of psychosis began treatment within two weeks of referral in 78% 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 100% 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%).
- People accessing our EMDASS service received their diagnosis within 12 weeks in 81% of cases for June (target – 80%).
- Across all our services 99% of people received treatment within the 18 weeks wait standard (target – 98%)
- Our service users told us that they would recommend our services to friends and family, if they needed them, in 89% of cases (target - 80%) and 93% of people said that they knew how to get support and advice at a time of crisis (target – 83%)

Areas of Concern/Focus

At the end of August, 30 (49%) of 61 indicators were below our performance standards.

The key areas of note for August were:

- Inappropriate out of area placements have increased over the quarter with a total of 834 out of area days against a target of 0. This equates to circa 27 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. An additional 10 adult acute beds have been procured from an independent sector provider in response to demand levels, however we will not be able to meet the target by the end of quarter 2 and so we are currently negotiating an extension to this with NHSI/E. We have continued to work on improving the bed flow and exploring options to digitalise the in-patient flow function to improve efficiency. Commissioners are considering commissioning of further crisis services to provide alternatives to admission and in addition we will work to review the community transformation programme to include more actions to manage the increasing caseloads which is impacting on demand for beds.

- 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 August. 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 86%in August (target – 95%). Performance dropped for the first time in August following a 6 month improvement trend throughout the year. We expect improvement in September

- The rate of service users with an up to date risk assessment has remained at 91% % against a target of 95%. The primary reason for underperformance is the large caseloads held by some of our medical staff. 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 82% (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.

- PDP and Appraisal rates improved in August, reaching 86% (target – 95%). A re- launch of the appraisal requirement backed by a revised and simplified form is expected to further improve performance during Q3

- Turnover rates have reduced marginally in August to 19% with a net increase in staff numbers of 25 following a period of net reduction. The implementation of a number of actions within the recently approved recruitment and retention strategy is expected to see this recover further over the coming months.

Conclusion & Recommendation

Overall, all of our services remain open to admissions, access and waiting times are holding and performance has remained relatively strong as reflected across principal KPIs. We are facing challenges through continuing high levels of demand and acuity in services, and high turnover and vacancy rates. We are confident that we will meet and overcome these challenges and continue to improve and transform our services to meet the needs of our service users.

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

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Performance Report Quarter 1 2020/21

Contents

1. Summary

1.1 Service Recovery New referrals

Overall, new referrals into the Trust both via SPA, trusted assessors and internal referrals, are 20% higher than in pre-COVID period (FY19/20).

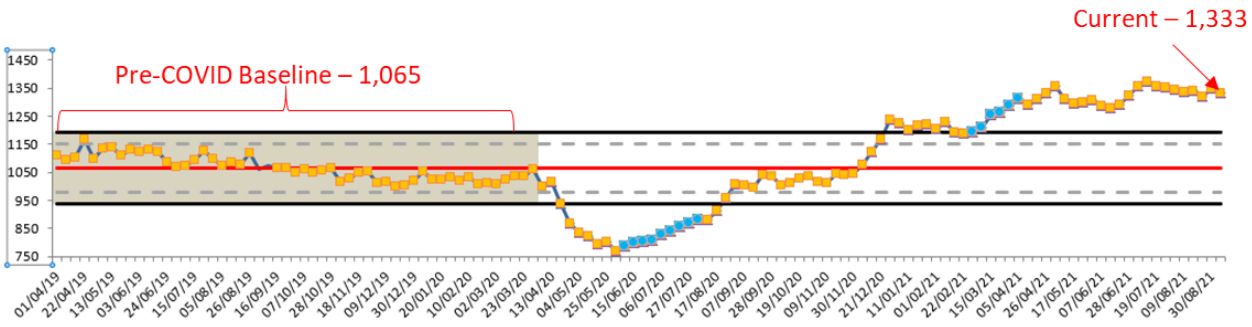


Figure 1 – Weekly Referrals into HPFT

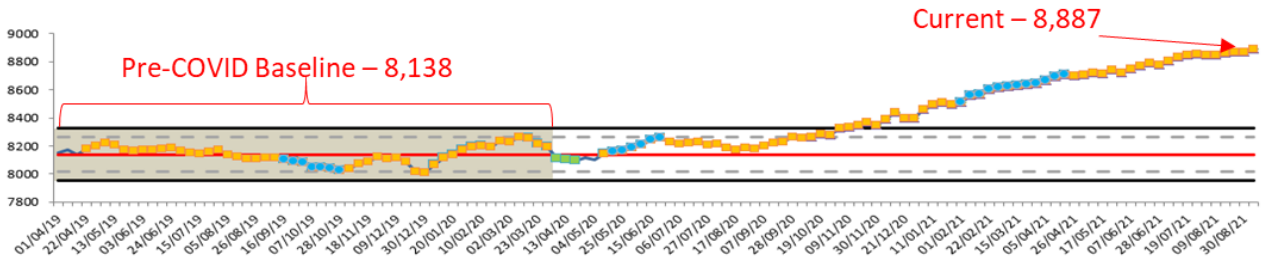
Referrals do not correlate directly with new demand for services. There is a high percentage of referrals that are discharged prior to treatment. Typically, people who are discharged prior to treatment are signposted to other services. The rates of people discharged prior to treatment are:

Services	Referrals that go on to treatment	Discharged from SPA	Discharged at IA
Adults	33%	40%	27%
CAMHS	37%	47%	16%
Older Adults	47%	23%	30%
LD&F	61%	0%	39%

* The rates of discharge prior to treatment has not changed significantly during the post-COVID period.

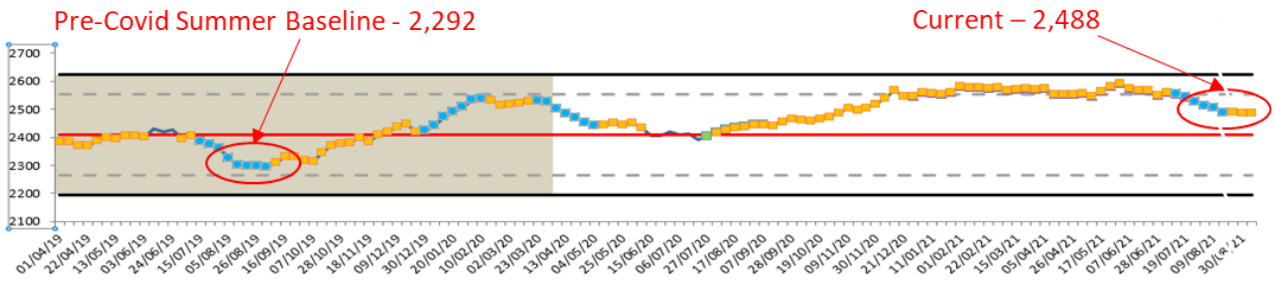
The net impact of changes in demand and acuity is most evident in the growth of our caseloads. Staff are reporting that it is challenging to meet new demand alongside high caseloads. High caseloads create additional pressure not only on direct care but also completing risk assessments, CPA reviews, physical health checks. We see the impact of high caseload pressures in a number of our Key Performance Indicators.

Adult Community Mental Health Services (Quadrant Teams)



The number of people in treatment in our Adult Community Mental Health services has increased consistently since September last year by almost 10%.

CAMHS Community (Excl ADHD)



CAMHS Service demand is more seasonal that other services due to the impact of school term time on referral and treatment patterns. Adjusting for these reveals a caseloads increase of 8%.

The rise in demand and acuity for CAMHS Eating Disorders was not specifically provisions in the Long Term Plan

1.1 Forecast

The forecasts below look to predict the number of referrals into HPFT services every week over the period of Q2 and Q3 2021/22.

The table shows:

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

Q3 Referral Demand Forecast

Services	Baseline (FY19/20)	Q3 Forecast (HPFT)	Planning Guidance (NHSI/E)
CAMHS	**184**	**217-240**	**215-254**
Adults	**212**	**300-325**	**248-296**
Older Adults	**120**	**116**	**No guidance issued**
LD&F	**9**	**9**	**No guidance issued**

CAMHS referrals have reduced since the start of the Summer Holidays, in line with normal seasonal patterns. However, as CAMHS referrals have been consistently high during Q1 and Q2, we are forecasting another increase in Q3. This increase is still in line with planning guidance from NHSI/E which is proving incredibly accurate across the year for CAMHS services.

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 has been at the higher end of that range. For Q3 we are forecasting new referrals to exceed the range in planning guidance from NHSI/E. We have forewarned SPA and Adult community teams of the potential increase and have started winter planning with these new referral volumes in mind.

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.

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.

1.2 Performance Overview

Overall performance in August is an improvement on July. We are facing significant challenges with high vacancy rates, high demand and increased acuity. In this context our performance is strong as all services remain open to admissions, access and wait times are in line with national standards, and we continue to improve and transform services.

We are, however, seeing the impact of current pressures on the number of met performance indicators. The main change has been in safe and effective indicators, including two days and seven-day follow-up post-discharge; Having Your Say Survey results, along with recording of key demographic information.

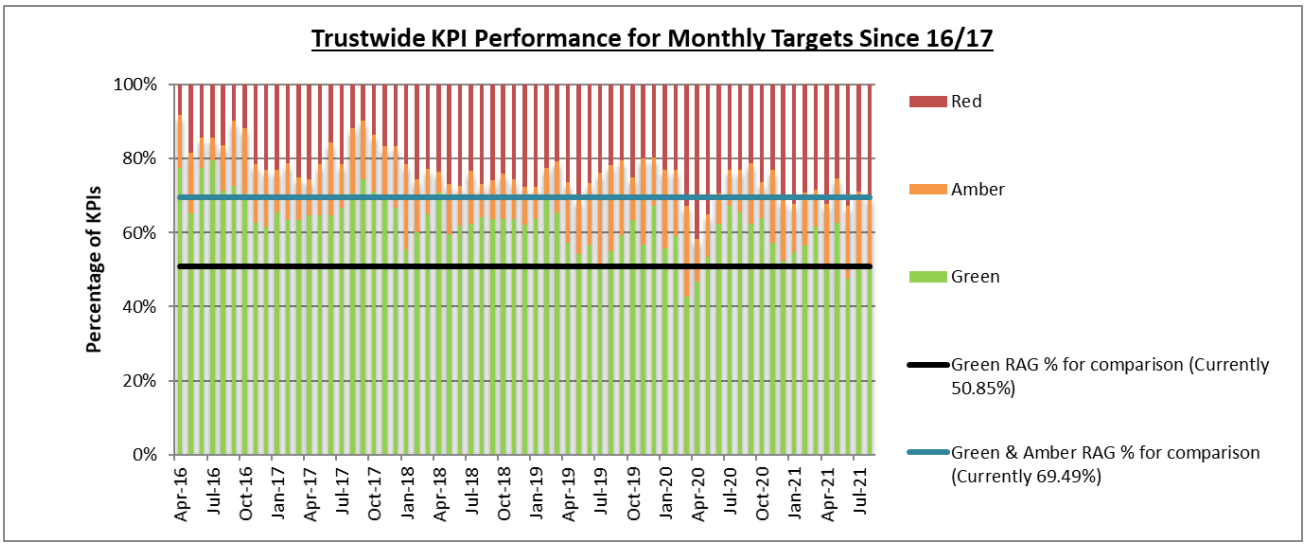
Furthermore, adult 28-day access has fallen below target and CYP indicators for Eating Disorders. IAPT cumulative access targets are not on track to recover during Q2 as previously reported.

Of the 61 Key Performance Indicators monitored in July, overall performance is as follows:

- 30 (51%) are maintaining or exceeding performance levels (on target)
- 11 (19%) are almost meeting target performance levels (close to target)
- 18 (31%) are not meeting our performance standards (underperforming)
- 2 (3%) are currently monitored but no formal performance target set

Referrals into the Single Point of Access in August 2021 (5,194) are circa 18% higher than for the same period in 2020/21 and 17% higher than 2019/20.

Table 4 – Comparison of Performance on KPIs by Month



2.1 Reporting Categories

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

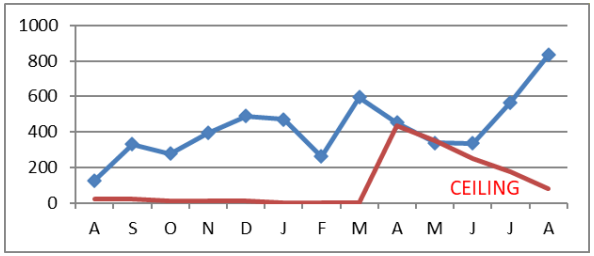
- NHS Oversight Framework - NHS Improvement
- Access to Services
- Safety and Effectiveness of Services
- Workforce Indicators
- Financial Indicators

3 NHS Oversight Framework

3. 1 Summary of Position

There are six Key Performance Indicators under this domain, five of these indicators are meeting the performance standard set:

- People with First Episode Psychosis receive treatment within 2 weeks of referral (84.62% target – 60%)
- Data Quality Maturity Index (97% target 95%)
- Improving Access to Psychological Therapies (IAPT) (18-week access – 100% target 75%)
- Improving Access to Psychological Therapies (IAPT) recovery (52% target 50%)
- IAPT waiting time to receive treatment (within 6 weeks – 98% target 95%)

KPI: NHSOF 5: Inappropriate Out of Area Placements	**August Performance: 834 Target = 80**	**RAG:**
Run Chart 	**History:** Performance against this target has been variable over the last 12 months, with placement days ranging from 500+ to under 100 per month. The trajectory for achieving 0 inappropriate out of area days by the end of 2021 was not met and a new trajectory was agreed with NHSE, shown below. **Cause:** Use of out of Trust placements remains a challenge for the organisation; the clinical and operational management before decision making is robust, however, the Trust is experiencing a high demand for beds, which we believe reflects the pressure on the community teams, and the growth in complexity and demand in the community, has resulted in increased length of stay. **Remedial Actions:** HPFT's acute pathway improvement plan focuses on 3 main areas for improvement; Alternatives to Admission, Treatment and Facilitating Discharge. **Alternatives to admission** Improved gatekeeping with a focus on ensuring alternatives to admission have been explored: -Standardised gatekeeping in place ensuring consistency and quality of gatekeeping including increased levels of consultant psychiatry and a strong focus on the reason for admission	

	-In partnership with third sector colleagues, explore what their provision can provide as support for the pathway and alternatives to admission e.g. Mind providing alternatives to admission, Reach Out providing time-limited volunteer support to people at risk of admission **Treatment:** Standardised acute processes to ensure consistency across the pathways and services, making services more efficient and improving communication across services including: -Consistent use of the audit checklist -Joint inpatient & community review of all new admissions within first 72 hours to understand barriers to discharge and gather information -Making Every Day Count -Review (& potentially increase) therapeutic input into the wards **Facilitating Discharge:** Implementation of an integrated discharge model moving away from a Bed Management model to an Integrated Discharge model with an emphasis on patient flow rather than managing beds, including: -Weekly review of out of area placements including joining ward rounds with direct input into care plans to ensure a service user's stay is no longer than necessary and community & crisis teams are involved to repatriate into a local bed or facilitate early discharge from the OAP. -Weekly internal bed meetings with each of the wards -Daily Demand and Capacity calls with senior clinicians and managers -Weekly DToC meetings -Working with partners to support discharge (e.g. Housing Worker via Herts Young Homeless)
	Recovery Timescale:
	Trajectory in place to have 0 placements by the end of Q2 is to be revised

4 Access to Services

4.1 Summary Position

In August the Trust met 13 out of 24 targeted access indicators and dipped marginally in comparison to July where we saw 15 of the access indicators being met.

The main changes to the access indicators in August were routine referrals to community eating disorders and routine referrals to community mental health teams not meeting the 28 day wait standards. However, a number of access standards were maintained and improved further in August including CAMHS Crisis referrals and referrals meeting the 18 weeks' treatment start timescales.

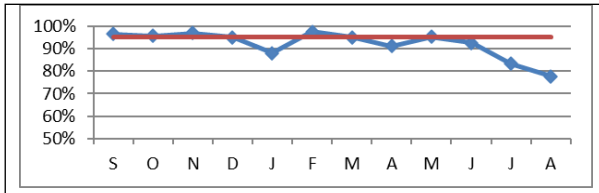
4.2 Areas of Strong/Improved Performance

- People accessing routine Learning Disabilities Services were seen within the 28-day target in 100% of cases in August
- Children and Young People needing urgent assessment were seen within 7 days in 100% of cases (target – 75%)
- Children and Young People needing social worker contact within the 14-day target were seen in 100% of cases (target 85%) and children needing assessment in the targeted service were seen within 28 days in 90% of cases (target 85%)
- An alternative to inpatient admission was sought by the CAT Team in 100% of adults who went on to be admitted.

4.3 Access Indicators currently underperforming

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

KPI: A4 Routine referrals to community mental health team meeting 28 day wait	**August Performance: 77.78% (189/243) Target = 95%** **West: 66.39%** **E&N 89.26%**	**RAG:**
Run Chart	**History:**	
	Target has a history of being met during 20/21.	
	Cause:	
	Capacity issues in the North, NW and SW Quadrant have affected performance and are likely to continue to fail to meet target until these issues are addressed. NW continue to experience a deficit in medical staffing, whilst North have nine WTE vacancies for care coordinators and SW is holding high vacancy levels of all staff. Teams are having difficulty in securing locum medical staff at capped rates. In addition to	



capacity issues, the inability to meet target has been impacted by SPA not being able to pass on referrals within their agreed timescales.

Remedial Actions:

In the North quadrant the following actions have been agreed:

- SUs are being prioritised based on complexity and risk.
- The Additional IA clinics on weekends are to be reinstated as of the end of October. The weekend clinics have been postponed since August as the staff were becoming overwhelmed.
- Agreement for agency staff has been given and recruitment is underway.

In SW the following actions have been agreed:

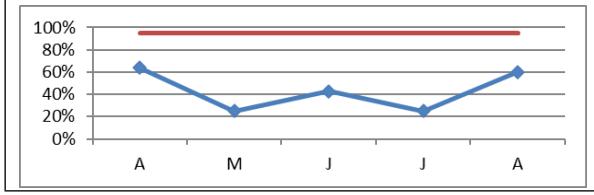
- Review all referrals currently booked to breach to identify any that have already had a robust assessment.
- Looking at the practice around brief assessment and how it can be implemented within the current pathway and Consider with commissioners assessing its impact on the 28 day KPI.
- Identified a staff member to undertake brief assessments for all ADHD / ASD referrals - which are noted to be increasing causing strain on initial assessment availability.

Recovery Timescale:

Immediate recovery is unlikely and further slippage is expected but with the recruitments initiatives within the North and SW we should begin to see an improving position.

KPI: A19 CAMHS Eating Disorders - Urgent referrals seen within 7 days	**August Performance: 80.00%% (4/5) Target = 95%**	**RAG:**

Run Chart



History:

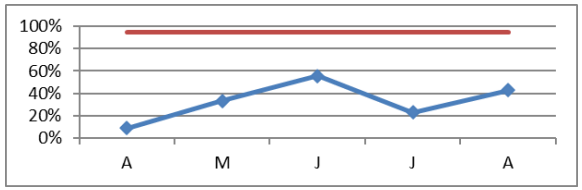
This target had a history of being met until July 2020, when performance began to drop.

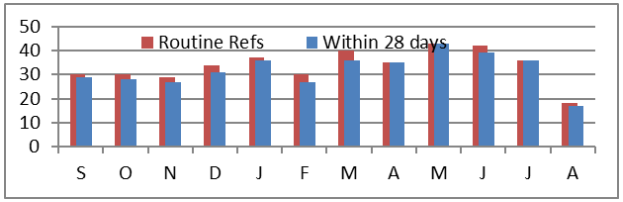
Cause:

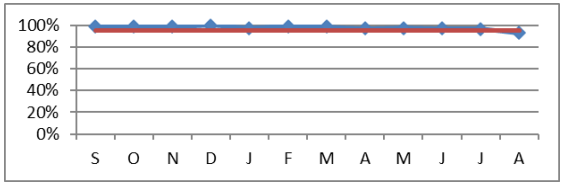
Increase in referral numbers, starting in July 2020. Average monthly referrals have risen from an average of 22 per month to 45 – 50 per month after the Covid epidemic. More of the children and young people on the service caseload have become more acutely unwell and this has impacted on the capacity of the team to see urgent referrals.

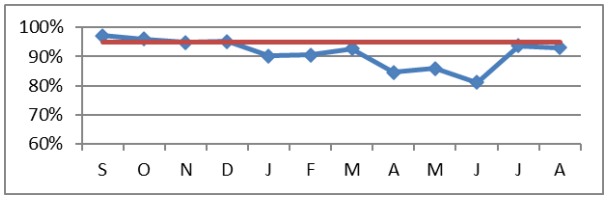
Remedial Actions:

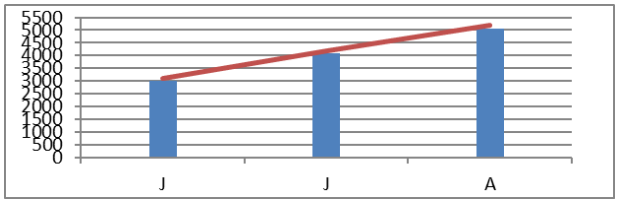
	An additional 200k has been made available in 21/22 on a one year, non-recurrent basis, to support CYP ED service. The plan is to recruit an additional 5 staff to support children on the waiting list with meal plans and support at mealtimes where necessary. Recruiting into posts is proving difficult but interviews are planned for end of September.
	Recovery Timescale:
	TBC – in line with recruitment

KPI: A20 CAMHS Eating Disorders meeting routine 28 day wait	**August Performance: 42.86% (3/7) Target = 95%**	**RAG:**
Run Chart 	**History:** This target had a history of being met until January 2021, when performance began to drop. **Cause:** Increase in referral numbers, starting in July 2020. Average monthly referrals have risen from an average of 22 per month to 45 – 50 per month after the Covid epidemic. More of the children and young people on the service caseload have become more acutely unwell and this has impacted on the capacity of the team to see urgent referrals. **Remedial Actions:** An additional 200k has been made available in 21/22 on a one year, non-recurrent basis, to support CYP ED service. The plan is to recruit an additional 5 staff to support children on the waiting list with meal plans and support at mealtimes where necessary. Recruiting into posts is proving difficult but interviews are planned for end of September. **Recovery Timescale:** TBC – in line with recruitment	

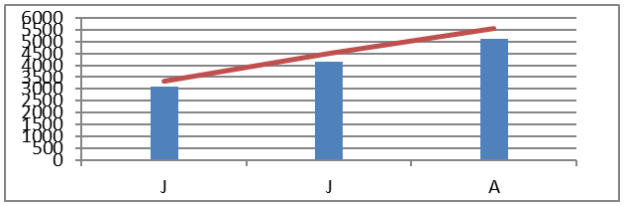
KPI: A2 Routine referrals to community eating disorder services meeting 28 day wait	August Performance: 94.44 % (17/18) Target = 98%	RAG:
Run Chart 	**History:** Target has been met for April, May and July in 2021/21. **Cause:** Although the number of service users seen in August was the lowest for the year, A build up on the waiting list has created a backlog of referrals. August performance dipped to below 98% due to one service user who was seen on 35. An appointment had been scheduled beforehand and within the timescales however it was cancelled due to the unavailability of clinical staff. **Remedial Actions:** 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. **Recovery Timescale:** TBC – in line with recruitment	

KPI: A17: CAMHS Routine Wait 28 day wait	August Performance: 92.96% (66/71) Target = 95%	RAG:
Run Chart 	**History:** The CAMHS 28 day target has a history of being met consistenltly during 20/21. **Cause:** 5 breaches occurred in August of which all were subsequently seen. Some late pass ons from SPA and a booked to breach appointment resulted in a dip in performance in August. **Remedial Actions:** This is being monitored on a weekly basis as part of the reinstated weekly performance reporting regime. SPA process for passing on children to the CAMHS Tier 3 services are being reviewed with the focus being around clear channels of communications for referrals that are to be passed to the CAMHS Tier 3 services to ensure childrend and young people are assessed within a timely manner. **Recovery Timescale:** Recovery expected by the end of Q2.	

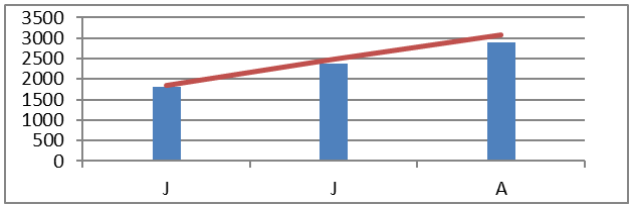
KPI: A21 SPA referrals with an outcome within 14 days	August Performance: 93.09% (2,615/2,809) Target = 95%	RAG:
Run Chart 	**History:** This target had a long history of being met, until November 2020. **Cause:** KPI has been impacted by three changes, 1st is a 15% rise in referral volumes; the second is introduction of Brief Intervention service in SPA which holds cases longer; third is new ways of working with primary care(GP Plus, Enhanced Primary Care service, Additional Roles Re-imbursement Scheme). Reporting now changed to take account of Brief Intervention Service and improvement of 13% seen. **Remedial Actions:** Continue to fund 24x7 advice and support line (SPA and First Response) Planned joint review with commissioners and system partners of SPA processes has been rescheduled to commence in September for 3 months and by December with recommendations to be part of the 22/23 contract discussions. **Recovery Timescale:** Expected to recover by the end of the quarter.	

KPI: A23: IAPT Access – E&N CCG	August Performance: 5044/5183 (139 behind target) 97.3% of YTD target.	RAG:
Run Chart 	**History:** E&NH CCG IAPT services have previously had difficulty meeting both access and waiting times due to funded staffing levels. This has been adjusted in 2021/22 **Cause:** Insufficient GP and self-referrals coming into the service to achieve access levels during the pandemic. Referrals and engagement have dipped in line with changes to lockdown measures in July, alongside the seasonal dip seen each summer. Current referral levels are rising and are expected to return to sufficient levels in Q3. **Remedial Actions:**	

	Discussions have taken place with the EoE regarding promotion of IAPT services, as this pattern is the same across the region. Regular monthly communications are sent to local stakeholders. Plans are in place for targeted service promotion in the Autumn, although an increase in referrals has been seen in the first 2 weeks of Sept.
	Recovery Timescale:
	Currently on track for the Q2 trajectory. Expected achievement of access target as follows: Q1: 96.60% achieved Q2: 98% Q3: 100% Q4: 100%

KPI: A24: IAPT Access – Herts Valleys	**August Performance: 5121/5552 (431 behind target)** **92.4% of YTD target**	**RAG:**
Run Chart 	**History:**	
	HVCCG IAPT services have a long history of meeting their access targets, before the COVID emergency.	
	Cause:	
	GP and self-referrals are approx. 200 fewer each month than are needed to achieve access.	
	Remedial Actions:	
	Bi-weekly access meetings have been reinstated to focus the teams on improving engagement with the service. Exam stress workshops have been set up for Oct/Nov and contact made with retirement villages to target older people. Stakeholder updates are circulated monthly to promote the service.	
	Recovery Timescale:	
	August access was 91.89% of trajectory. Expected achievement of access target as follows: Q1: 93.31% achieved Q2: 95% Q3: 97% Q4: 100%	

KPI: A25: IAPT Access - Mid Essex	**August Performance: 2,893/3,088 (193 behind target)** **96% of YTD Target**	**RAG:**
	History:	

Run Chart 	Mid-Essex last met its access target in Q3 of 2019/2020 before covid 19 impacted significantly on referrals to the service.
	Cause:
	Insufficient GP and self-referrals coming into the service to achieve access levels. Referrals and engagement have dipped in line with changes to lockdown measures in July, alongside the seasonal dip seen each summer.
	Remedial Actions:
	Discussions have taken place with the CCG, ICS and EoE regarding promotion of IAPT services, as this pattern is the same across the region. A CCG funded promotional campaign took place in July, with no discernible impact. Plans are in place for targeted service promotion in the Autumn, although an increase in referrals has been seen in the first 2 weeks of Sept.
	Recovery Timescale:
	Access in August was 84.27% of monhtly trajectory. Expected achievement of access target as follows: Q1: 98.06% achieved Q2: 100% Q3: 100% Q4: 100%

5 Safety and Effectiveness of Services

5.1 Summary Position

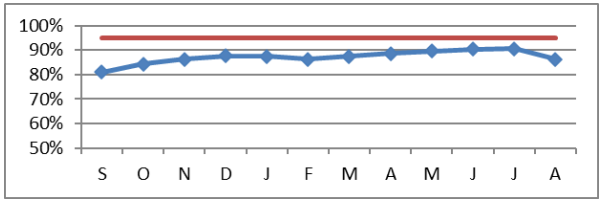
There are 23 Safety & Effectiveness Key Performance Indicators of which 9 have been fully met, 6 were almost met, and 8 where further improvement is required.

5.2 Areas of Strong/Improved Performance

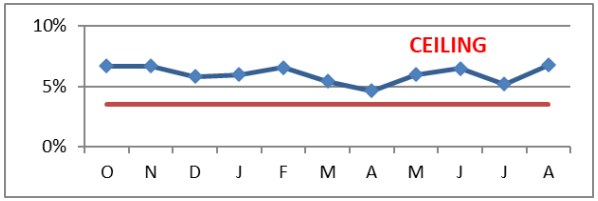
- Our service users told us that they felt they would recommend our services to friends and/or family if they needed them in 89% of cases (target – 80%)
- They also told us that in 92.8% of cases they knew how to get support at a time of crisis (target – 83%)
- They told us that in 84% of case they are treated in a way that reflects the Trust's values (target – 80%)
- Inpatients feeling safe has improved to 85% (target – 85%)

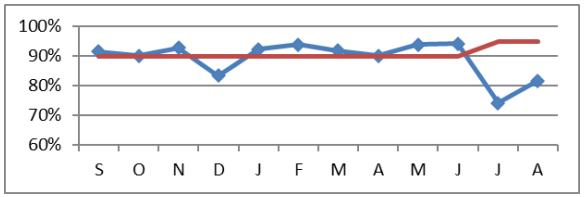
5.3 Underperforming Indicators

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

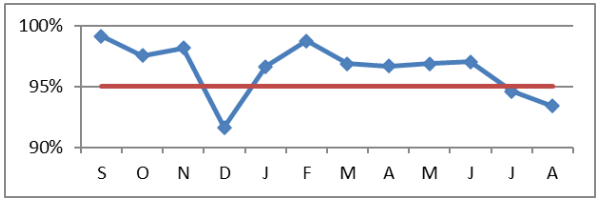
KPI: SE1: Care Programme Approach (CPA) Reviews	**August Performance: 86.30% (1,493/1,730)** **Target = 95%**	**RAG:**
Run Chart 	**History:** CPA review performance has been below target since February 2020. **Cause:** E&N SBU require an additional 37 CPAs to meet target and West SBU require an additional 115. Problems in the East and West include capacity issues due to staffing deficits. High caseloads and service users without a care co-ordinator are impacting the West in particular. **Remedial Actions:** E&N individual teams have low numbers of overdue reviews with the exception of SMHTOP East (11) and ACMHS Welwyn and Hatfield (18). Work is underway on scheduling appointments, with a focus on overdue reviews. West SBU have a higher number of reviews overdue, with the main areas for improvement being Borehamwood and Watford. The SBUs has set recovery trajectories for each team. **Recovery Timescale:** E&N SBU expected to recover by end of Q2 however now have missed target by 37 CPAs due to a couple of teams having a large number of overdue reviews. West SBU have not been able to sustain	

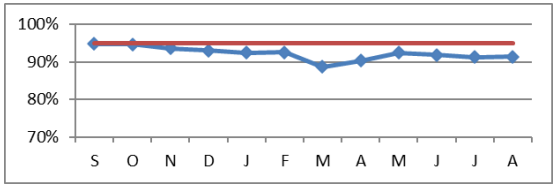
	the 1-2% monthyl increase and have fallen by 4% in August. Underlying capacity issues in teams will need to be addressed for this indicator to be reliably met.

KPI: SE2: Delayed Transfers of Care	**August Performance: 6.75% (797/11,801) Target = <=3.5% (No more than 5 people by end of Q2)**	**RAG:**
Run Chart 	**History:** This target has not been met since the end of 17/18 when the threshold changed to 3.5%. In 2018/19 Adult DTOC days lost as a %age of OBDs were in the upper quartile at 13%, MHSOP were upper quartile at 16% (source NHSBN reporting) **Cause:** 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. **Remedial Actions:** Implementing recommendations of joint HPFT / Regional review of practice, including better community and acute engagement through the clinical review meetings. Daily monitoring of delays via Acute Dashboard at Tactical Command. **Recovery Timescale:** 13 people currently delayed – trajectory is to have no more than 5 by the end of Q2 – looks unlikely to be met.	

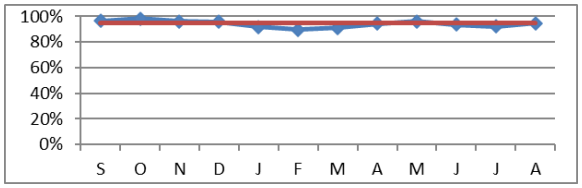
KPI: SE4: Follow-ups within 48 hours of discharge of inpatient care	**August Performance: 86.92% (62/76) Target = 95%**	**RAG:**
Run Chart 	**History:** This 48-hour indicator has replaced the previous 72-hour indicator as part of our Quality Account commitment. Historically the 72 hour indicator was met for most of 20/21 **Cause:** Inpatient units facing recording issues whereby discharges are being not being recorded on time. Late discharges on PARIS have been the reasons for 9 out of the 14 breaches. **Remedial Actions:** Referred to Tactical Command.	

	Recovery Timescale:
	Immediate.

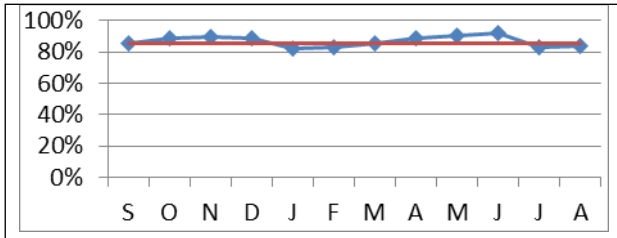
KPI: SE3: Followed up within 7 days of discharge from psychiatric in-patient care	**August Performance: 94.73% (72/76) Target = 95%**	**RAG:**
Run Chart 	**History:** This target has been achieved for the last year, with the exception of December 2020. **Cause:** Changes to ways of working due to the COVID emergency have impacted on performance in March and April. Performance against the 7-day follow-up target has not seen a similar decline, indicating that people have still been seen following discharge, but between day 4 and day 7. **Remedial Actions:** All reminder and escalation processes have been reinstated and this indicator is part of the weekly performance reporting and monitoring. **Recovery Timescale:** Indications through weekly monitoring show that performance has improved and the target should be met in May.	

KPI: SE5: Rate of Service Users with an up to date risk assessment	**August Performance: 91.40% (15,938/17,438) Target = 95%**	**RAG:**
Run Chart 	**History:** Following a long period of being slightly below target, the 95% target was met since April 2020, but has fallen below in August and has not recovered since. Some improvement seen in August after a decline in June and July 21. **Cause:** 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. **Remedial 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 fix.
	Recovery Timescale:
	TBC

KPI: SE14: Rate of Service Users saying staff are welcoming and friendly	**August Performance: 94.74% (54/57) Target = 95%**	**RAG:**
Run Chart 	**History:** This target has a history of being met. **Cause:** Current response rate is low. **Remedial Actions:** • Mutual Help Meetings are being restarted onwards. • IAPT services are recruiting recently discharged service users for involvement groups, i.e. understanding the experience. • Welcome APP has been launched. • Peer support workers being employed in EPMHS to support service users. **Recovery Timescale:** Expected to recover by end of Q2	

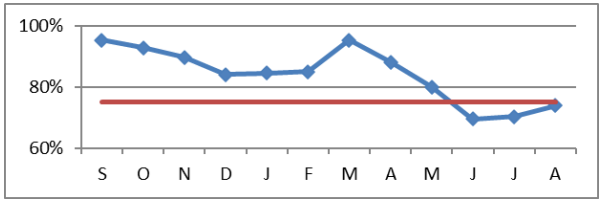
KPI: SE16: Have you been involved as much as you want to be in discussions about your care	**August Performance: 83.93% (47/56) Target = 85%**	**RAG:**
Run Chart	**History:** This target has a history of being met. **Cause:** Current response rate is low. **Remedial Actions:** OT team in West SBU starting “plan your day sessions” with service users to look at activities, appointments.	



Recovery Timescale:
Expected to recover by end of Q2

KPI: SE17: Rate of carers that feel valued by staff	August Performance: 73.91% (17/23) Target = 75%	RAG:

Run Chart



History:

This target has a history of being met.

Cause:

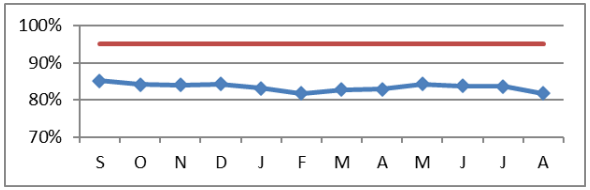
Current response rate is low.

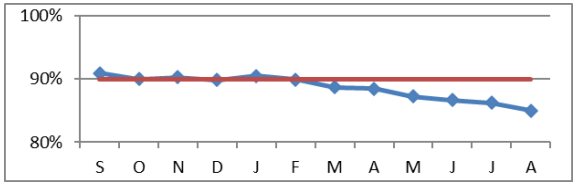
Remedial Actions:

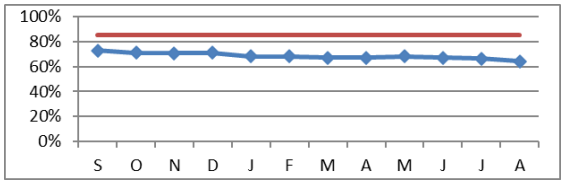
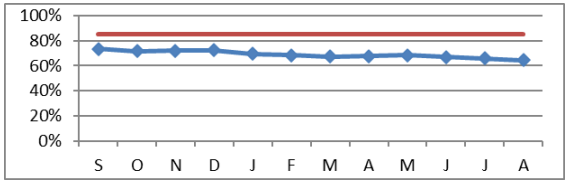
- Carers surgeries and meetings are being reinstated in older peoples' services which provide support on discharge, pathways, expectations and support for family members and peer support.
- Carers Awareness Training is being restarted for staff
- Essex LD inpatient services are seeking views from carers and family members on their experience, this will happen one month after discharge. Feedback being sought about what information would be helpful on the website.
- LD&F SBU have commissioned Inclusion Unlimited to run a focus group involving service users and carers to improve meaningful engagement.
- West SBU introducing a Carers Feedback Group to improve communication with carers and service users on admission, transfer and discharge.
- CRHTT doing piece of work around issues carers experience when loved ones go on leave from the ward.

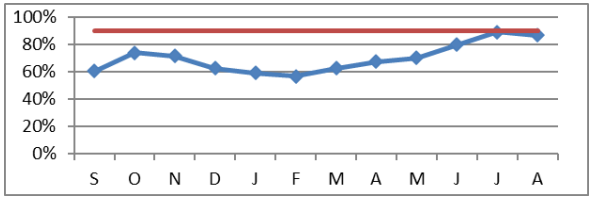
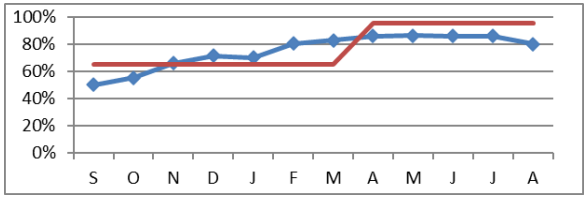
Recovery Timescale:

Expected to recover by end of Q2

KPI: SE20: Percentage of Eligible Service Users with a PBR Cluster review	August Performance: 81.71% (8,726/10,679) Target = 95%	RAG:
Run Chart 	**History:** This target was last met in August 2017. **Cause:** As focus on PBR clustering declined so did performance and was not currently seen as a priority – it has, however, stayed relatively stable. **Remedial Actions:** Improvement actions in the short term will be covered by the CQUIN work for Paired HoNOS. Longer term solution is underway with outcomes work on SPIKE with a variety of outcome measures available on-line. **Recovery Timescale:** Trajectory for recovery to target to be set	

KPI: SE21: Ethnicity Recording (MHSDS)	August Performance: 84.97% (22,203/26,130) Target 90%	RAG:
Run Chart 	**History:** This target has a history of being met until December 2020. **Cause:** Possible decreased focus on data quality during the COVID emergency **Remedial Actions:** 1)The digital support and information team to conduct a targeted drive in October with the services to recover and reposition MHSDS in the short term. 2)The Inclusion, Involvement and Experience Team will lead a longer term piece of work with the SBUs and their PG Leads to raise awareness of the personal, cultural and organisational value of recording comprehensively. **Recovery Timescale:** On track to reach year end trajectory: Q1: 85% Q2: 90% Q3: 95% Q4: 95%+	

KPI: SE23 a) Employment and b) Accommodation	August Performance*:* Employment: 64.09% (11,453/17,870) Accommodation: 65.84% (11,540/17,870) Target = 85% (Q2 – 75%)	RAG:
Run Chart a)  b)  	**History:** 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. **Cause:** Historically unable to see when reviews were due on Paris. SPIKE dashboards now give this information on team and individual dashboards. The recording of these indicators has decreased due to the COVID emergency and less face to face contact. **Remedial Actions:** 1)The digital support and information team to conduct a targeted drive in September with the services to recover and reposition MHSDS in the short term. 2)The Inclusion, Involvement and Experience Team will lead a longer term piece of work with the SBUs and their PG Leads to raise awareness of the personal, cultural and organisational value of recording comprehensively. **Recovery Timescale:** On track to reach year end trajectory: Q1: 70% Q2: 75% Q3: 80% Q4: 85%	

KPI: SE24: Cardio-metabolic checks for people with psychosis	August Performance: RAG: FEP: 86.40% (489/566) Target = 90% Community CPA: 80.11% (737/920) Target = 95%* changed as part of Annual Plan 21/22 from 65% Inpatient: N/A
Run Chart - FEP  **Run Chart – Community CPA**  	**History:** Previously a CQUIN, these three measures are now part of the Herts Contractual reporting requirements. **Cause:** Underperformance has been caused in part by inconsistent recording practices across quadrants & teams. A steady increase in performance has taken place since June 2021 with a slight dip in August which can be recovered in September with greater focus in Community Teams on carrying out health checks. Community teams have reached 80.11% against an increased target of 95%, whilst FEP has improved steadily to 86.40% against a target of 90%. **Remedial Actions:** FEP: Individual action plans for PATH Teams, supported by CDs. CPA: E&N currently at 86.2%. West at 73.1%. Both SBUs have seen significant improvement over last year with additional clinics and dedicated clinicians to carry out the checks. **Recovery Timescale:** FEP: Recovery by September for PATH Teams. CPA: E&N need an improvement of 1.8% in order to meet Q2 milestone, West need an improvement of 15% in order to meet it. Quarterly Improvement milestones: Q1 85% Q2 88% Q3: 92% Q4 95%

6 Workforce

6.1 Summary position

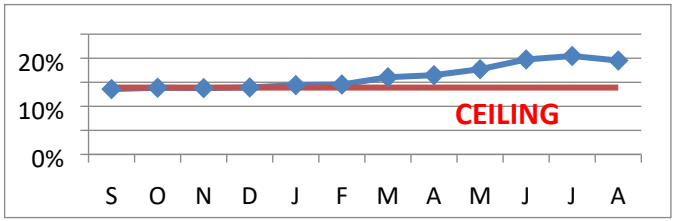
There are 4 Key Performance Indicators routinely monitored in August. Three were unmet and one was almost met.

6.2 Underperforming Indicators

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

KPI: W9: Turnover	August Performance: 19.52% Target = 13.9%	RAG:

Run Chart



History:

The Trust turnover rate has been increasing since the start of Q1 and is currently 19.52%, this is a slight improvement to last month (20.47%)

Cause:

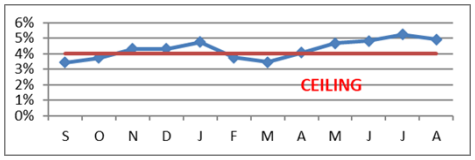
Whilst our overall turnover reduced slightly in August, our unplanned turnover increased to 10.96% in August (from 10.62%). We saw more staff leave us (43.6WTE) than join us in July (26.4WTE). However, this situation changed in August, with a net recruitment gain. The top reasons for leaving the Trust are: relocation; retirement; work/life balance; and promotion.

Remedial Actions:

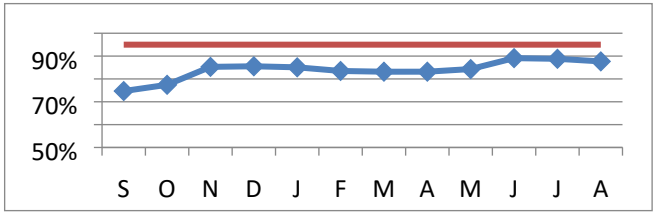
A detailed action plan aligned to our new recruitment and retention strategy has been developed. The plan sets out our short-, medium- and long-term actions in relation to recruitment and retention, focussing on our top voluntary reasons for leaving: relocation; retirement; work/life balance; and promotion. A number of immediate short term actions were taken during August to address retention. In particular: (i) All staff were encouraged to take time for rest and recuperation; (ii) We held our first Summer Wellbeing Festival across all our sites, providing food, massages, goody bags and wellbeing offers; and (iii) we successfully applied to be part of an NHSE/I supported project to further increase our flexible working offer and culture. In addition to this, we are reviewing our flexible, self-rostering offer with a view to rolling this out across the Trust and we continue to run our successful retire and return scheme.

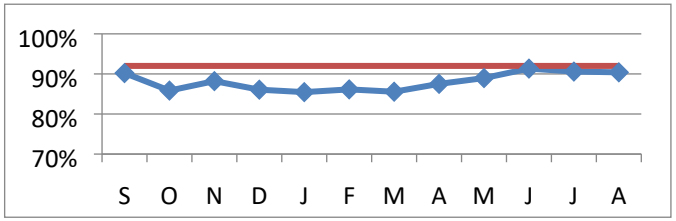
As part of our refreshed Recruitment and Retention Strategy and action plan, immediate actions have been taken, as follows in relation to recruitment (i) The recruitment team resource was temporarily expanded as part of a CQI project to trial a new model of recruitment. As a result of this work, the number of people who started by 6 September increased from 25.1 WTE to 58 WTE; (ii) the Bank team proactively over-booked Bank/agency staff at sites such as Kingfisher Court to enable people to be deployed across the site as needed and mitigate against the risks of unexpected absence and staff shortages. Bank incentive schemes were also introduced and the Bank has been proactively recruiting and expanding the Bank pool of staff; (iii) 106 former clinical staff and 66 former non-clinical staff who had retired were contacted to offer the opportunity to return to us; (iv) we are appointing two nurses recruited from oversees and already working within the ICS on a 4 – 8 month rotation (v) 60 newly qualified nurses have been placed within the Trust, with a further 11 possible appointments; (vi) Two Advisory Appointment Committees (AACs) took place in August, from which two consultants were appointed and further AACs are

	taking place September; (vii) 12 staff who are registered nurses overseas, but working with us in a non-registered capacity are being supported to have their registration recognised in the UK. Targeted attraction campaigns are focussing on hot spot areas to ensure further recruitment gains in Q3.
	Recovery Timescale:
	Net recruitment returned to positive (+10) in August and expected to continue in September, with full recovery expected in Q3.

KPI: W8: Sickness	**August Performance: 4.91%** **Target = 4%**	**RAG:**
Run Chart  	**History:** Sickness levels have dropped slightly this month to 4.91% from 5.23% last month and had been increasing month on month since the start of Q1. **Cause:** The primary known reasons for current sickness absence is mental ill health, followed by gastrointestinal reasons and back/musculoskeletal problems. From direct engagement with staff, we know that our people are tired and some are experiencing burnout or at risk of doing so. **Remedial Actions:** The following actions have been taken: • Significant work continues across the Trust regarding health and wellbeing to promote self-care and support staff to keep mental ill health levels as low as possible, including focussed support from the Here for You service, including to prevent burnout amongst our people and we held our first Summer Wellbeing Festival. • We have a fast track physio service available to all staff. However, in order to increase uptake, we are developing a system to provide immediate advice and support to managers on managing musculoskeletal absence as soon as they record any such absence on eRoster/Spike. We are also working with the ICS in developing an expanded fast track physio service offer to be launched in Q4. • DSE training and risk assessment was relaunched in July 2021 to ensure that all staff's training on self-support was up to date and that they have the correct equipment and support in place to avoid musculoskeletal issues.	

	• Absence can no longer be recorded as "unknown" on eRoster or Spike to improve our intelligence in relation to absence reasons. • Our flu and Covid-19 booster vaccination campaigns are planning and launching by the end of September to mitigate the risk of increased flu/Covid absence into Q3. The People and OD Group continues to oversee our health and wellbeing activity and ensure that work is focussed on the current needs of our staff.
	Recovery Timescale:
	Sickness absence reduced in August, although remains above target and is expected to remain above target into Q3. Recovery to target levels is anticipated in Q4.

KPI: W6: PDP and Appraisal	**August Performance: 87.68% Target = 95%**	**RAG:**
Run Chart 	**History:**	
	Since the launch of our strengths based appraisal, rates have been increasing following the significant negative impact of the pandemic experienced during the first half of 20/21.	
	Cause:	
	Whilst significant recovery since H1 of 2020/21 has taken place, operational pressures and leave have impacted compliance in July and August.	
	Remedial Actions:	
	The new strengths-based appraisal will be relaunched in Q3 in order to continue promoting the value of appraisal and therefore to increase compliance. The HRBPs are proactively working with their SBUs to assist with continuing the previous increase in compliance to attain the target rate of 95%. Monthly reporting including exception reports are being received in order to help target hot spot areas. Currently, the only areas below 90% are West SBU and Corporate, albeit that both have made significant improvements since the start of Q1 and are the areas which are most improved. LD&F SBU's compliance is over target at 96%.	
	Recovery Timescale:	
	Recovery is expected in Q3.	

KPI: W7: Mandatory Training Rate	August Performance: Statutory – 90.40% Essential – TBC% Target = 92%	RAG:
Run Chart 	**History:** There has been significant focus on recovery following the impact of the pandemic on mandatory training, achieving compliance at 1.6% under target. **Cause:** The coronavirus pandemic resulted in: a) a reduction in the ability of staff to take time to complete their training; and b) pauses in and restrictions to face to face training. During the Summer, annual leave has impacted our improving compliance **Remedial Actions:** Reminders are being sent to staff and managers via Discovery and staff are actively booking themselves onto courses. Monthly compliance and exception reports are sent to management teams. Whilst much of our mandatory training is available via eLearning, compliance with training that must be carried out face to face remains the area of lowest compliance. Respect training has been a particular focus, with additional trainers having been trained, additional venues sought and weekend training being run. Communications regarding available courses has been sent out Trust wide. This has seen us train 488 staff since the beginning of June 2021 with aAn additional train the trainer course has been arranged for November. In addition, additional ILS/BLS trainers and manual handling trainers have been trained. This has increased ILS/BLS training provision and once the manual handling trainers are signed off as competent to train, they will be undertaking additional sessions during Q3. **Recovery Timescale:** Recovery is expected in Q3.	

7 Finance

7.1 Finance Overview

The Trust has reported a position on Plan for the month of August and the year to date, at break-even for the month and a surplus of £85k for the year to date. As part of this position, £4.4m of COVID-19 income has been received. Both income and expenditure are behind plan for the month and year to date. Financial pressure areas continue to be; secondary commission costs and staff bank and agency costs to meet the current demand and acuity levels.

Ref	Financial Indicator	Target	Current Period Numbers (August 2021/22 UNLESS	Current Period (August 2021/22 UNLESS STATED)	Previous Period (July 2021/22 UNLESS STATED)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (September 2021/22)
F1	To Achieve Surplus in year (not including PSF)	0k (break even)	£0k (break even)	£0k (break even)	£0k (break even)	-£XXk	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		255	283		Figures as per NHSI weekly submission. Figure based on full weeks that contain days in the reporting period. Current period figure includes weeks commencing; 02/08/21 09/08/21 16/08/21 23/08/21	↔
F4	Delivering Value (cash releasing efficiency savings in Financial Year)	£7,000k savings target	Current estimate of savings requirement for the year is £5,383k	Current savings programme totals £5,383k for the year	Current savings programme totals £6,548k for the year	Reduction in estimate £1,165	Further work being completed to close the gap and identify further savings	↔

8. Conclusion

Services are under significant pressure due to high vacancy rates, high demand and high acuity levels amongst inpatients. Notwithstanding, although our staff and services are under considerable pressure, we remain strong in:

- All services are all open to admissions
- Our access standards (14 day, 28 day, and 18 week) are holding
- Our waiting time for treatment is also holding steady and we still benchmark favourably in comparison to other MHLD Trusts
- We are maintaining high standards of COVID-19 infection control and physical health checks
- Our staff tell us that we are looking after their Wellbeing at this difficult and demanding time

We will continue to work towards improving our performance and providing the best services for our service users.

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 13
Subject:	Financial Position for Month 5 2021/22	**For Publication:** Yes
Author:	Sam Garrett, Interim Deputy Director of Finance and David Flint, Head of Financial Planning & Reporting	**Approved by:** Maria Wheeler, Executive Director of Finance
Presented by:	Maria Wheeler, Executive Director of Finance	

Purpose of the report:

The report sets out the financial position to 31st August 2021 with an indication of the expected position 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

The Trust has reported a position on Plan for the month of August and the year to date, at break-even for the month and a surplus of £85k for the year to date. As part of this position, £4.4m of COVID-19 income has been received.

Overall income and expenditure figures are shown below:

Financial Position to 31st August 2021 £000	August Plan	August Actuals	August Variance	YTD Plan	YTD Actuals	YTD Variance
Income incl. COVID-19	**23,706**	**23,370**	**(336)***	**119,473**	**118,406**	**(1,064)***
Expenditure	**23,706**	**26,664**	**336***	**119,388**	**118,321**	**1,064***
Surplus / (Deficit)	**0**	**0**		**85**	**85**	

*NB the Income and Expenditure for the Provider Collaborative are not shown in the above and are separated in the below report

Both income and expenditure are behind Plan for the month and for the year to date, for the following reasons:

- Income is behind Plan for the year due to some delays on new or expanded services meaning that income has not been released for them but has been held to match expenditure, similarly deferred income planned to be released against expenditure has been less than planned.

- Pay costs are behind Plan for the year for the same reason, although exceptional high levels of bank and agency usage above Plan has closed the gap, with substantive pay remaining below Plan.
- Secondary commissioning costs are above Plan for the year due to exceptionally high usage of external beds particularly Acute and PICU external placements.

- Overheads and other Non-Pay are below Plan for the year due to the delays in new and expanded services as outlined above

Block payments from the Trust's main commissioners have been uplifted by inflation and continued in 2021/22, with revised guidance due imminently for Half 2. For Hertfordshire contract discussions have continued and are almost completed with c. £17m additional funding in year including MHIS, SDF and SR funding.

It remains fully expected that the Trust will report on Plan for Half 1 at break-even. Half 2 remains less certain, with a 5% reduction in COVID-19 funding expected (c. £45k per month reduction for the Trust) and additional efficiencies. A separate planning presentation is being made to the Executive Team with further detail. An overall break-even position is still expected.

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 15th September 2021
FIC 22nd September 2021

1. Summary

1.1. The Trust has reported a position on Plan for the month of August and the year to date, a break-even position for the month and a surplus of £85k for the year to date. As part of this position, £4.4m of COVID-19 income has been received.

1.2. Accounting for the Provider Collaborative (PC) commenced in Month 4, these figures are reported separately in Section 3 and are excluded from the main figures below.

1.3. Main figures and variances for the month and year to date excluding Provider Collaborative (PC) are shown below:

Financial Position to 31st August 2021 £000	August Plan	August Actuals	August Variance	YTD Plan	YTD Actuals	YTD Variance
Income incl. COVID-19	23,706	23,370	(336)	119,473	118,406	(1,067)
Pay	15,562	15,780	(218)	78,789	78,619	170
Sec Comm.	2,819	3,161	(342)	14,161	14,720	(559)
Non-Pay & Overheads	5,324	4,429	895	26,434	24,984	1,450
Total Expenditure	23,706	23,370	336	119,388	118,321	1,061
Surplus / (Deficit)	**0**	**0**		**85**	**85**	

1.4. The table shows a break-even position in month and surplus of £85k for the year to date, with individual variances to Plan as follows:

1.4.1. Income is behind by c. £1.1m due to income not needing to be released to match expenditure, both relating to deferred income which had been planned, and also to delays in new and expanded services getting started.

1.4.2. Pay costs remain behind Plan for the year by c. £170k but were above Plan in month by c. £220k, due to both bank and agency costs being above Plan; substantive pay remains below Plan.

1.4.3. Secondary commissioning costs remain above Plan for the year by c. £560k due in particular to exceptionally high Acute and PICU activity.

1.4.4. Non-pay and Overheads remains below Plan by c. £1.5m again largely due to the same investment areas having been delayed;

Further detail on these areas is included in Section 4 on expenditure.

2. Provider Collaborative

2.1. Accounting for the Provider Collaborative (PC) commenced in Month 4, and though this has had no net impact to date, it does represent a potential risk area, both in terms of the Trust's own position, and shared responsibility within the collaborative for the position as a whole. This is not perceived as currently high risk with the overall position break-even, but will continue to be monitored. Figures

for HPFT are as follows, showing income and expenditure of £3.3m in month and £6.6m for the year to date:

£m	August	Year to Date
Income	**(3,294)**	**(6,588)**
Expenditure	**3,294**	**6,588**
Difference	**0**	**0**

3. Income

3.1. Half 1 has seen the continuation of the COVID-19 contracting and funding arrangements adopted during 2020/21, with block contracts having been uplifted for inflation, and some changes made to payments reflecting additional services in Norfolk and Buckinghamshire, as well as reductions in Essex IAPT services.

3.2. Contract values with Hertfordshire commissioners are expected to be completed imminently, with SDF and SR monies to be added as the CCGs receive them; only those amounts currently being spent are reported within the current position.

3.3. CQUIN has been included for the year to date at 100% with no penalties, this position is likely to continue for the full year 2021/22, though CQUIN is now being actively discussed with Commissioners and it is expected that 2022/23 will see a return to full contracting processes.

Having carried forward some SDF (Transformation) monies to spend in 2021/22, there are several other items of carried forward income which are being spent in year. These include IAPT Chatbots (£243k, now in place), Digital X Aspirant (£250k, being progressed), and the Staff Wellbeing Hub (£186k, in place).

4. Expenditure Position including Key Variances

Pay

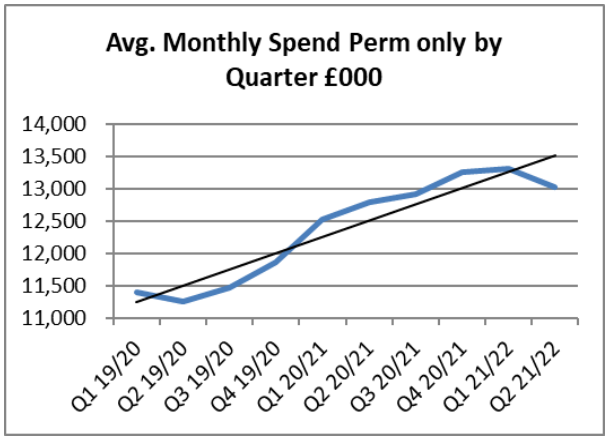
4.1. Pay reports below Plan by £170k for the year to date overall, however there is some variation within this:

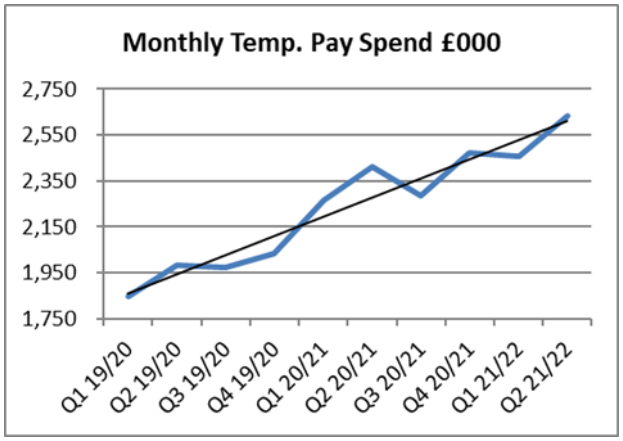
4.1.1. Substantive Pay is below Plan by c. £2.2m for the year to date, this is due both to a delayed start to a number of new or expanded services (where income is also not released), and to difficulties in general recruitment currently, with ftes overall in year either reducing or only increasing by small numbers.

4.1.2. Bank Pay is above Plan by c. £550k for the year to date, and Agency Pay similarly by c. £750k, due to exceptionally high levels of demand and acuity, above average rates of annual leave being taken over the summer, vacancies in substantive staffing, and continued impact of COVID-19. All these factors have led to the Trust needing to over-book staff at times,

and pay to grade at times, in order to secure safe staffing levels. Additionally there have been several particularly unwell service users who have needed high levels of support and in some cases this has been funded or part-funded by commissioners – this has applied in Essex, in Norfolk, and in Adult Hertfordshire services.

4.1.3. The graphs below show the average monthly spend by Quarter for Permanent Substantive Pay and for Temporary (i.e. Bank and Agency) Pay respectively; this shows the former decreasing slightly in recent months and not continuing its upward trend, and the latter continuing to increase.





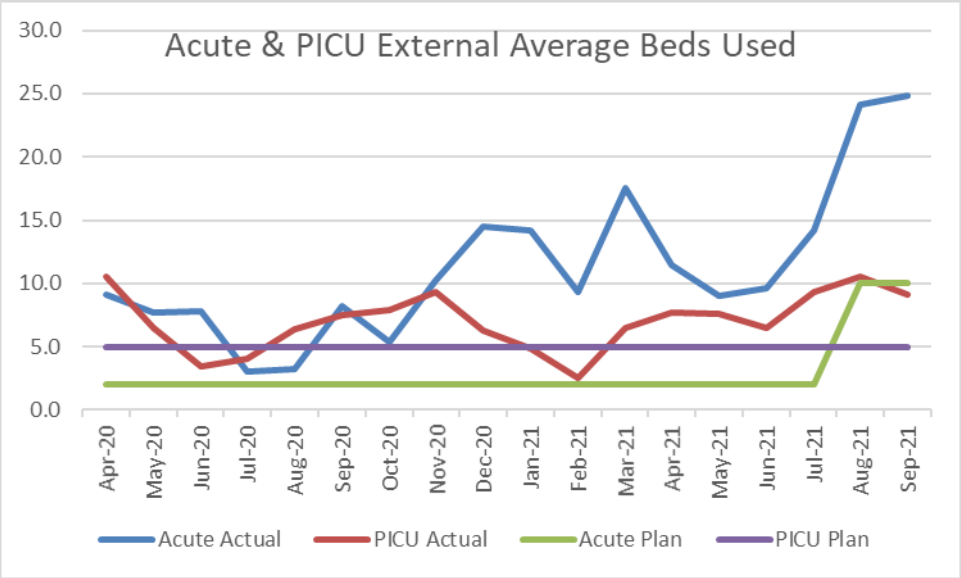
4.2. Recruitment continues on a proactive basis with currently c. 200 individuals having start dates or offers awaiting confirmation of start date, the recruitment team has been boosted in numbers in order to increase throughput and ensure start dates are booked as soon as possible. Support has been given to ensure the current cohort of newly qualified nurses are secured for HPFT roles where at all possible. A current CQI project is looking at the best way to run recruitment in order to deal with these busy periods.

Secondary Commissioning

4.3. Secondary Commissioning reports above Plan for the year to date by c. £550k, and in month by c. £300k. There has been a particular increase in recent months due to exceptional demand for Acute and PICU external placements, and high acuity requiring high levels of observation costs which are charged as an additional cost. Other areas are more stable with some reduction in Social Care spend in line with the Connected Lives programme.

4.4. Activity is shown in the following graph as the average number of beds purchased in any month, based on the bed day data, and compared to the figure that the Plan allows for. In August 2021 the Trust made an agreement with Kneesworth Hospital to purchase 10 additional beds each

month due to the increased activity; this will allow service users to be treated closer to home and in a consistent setting. These are within the "Acute" figure in the graph, and the Plan figure has been uplifted to allow for the agreement to purchase, as this number of beds would bring HPFT closer to the national average and is the longer term plan with the East & North proposed development.



Overheads and Non-Pay

4.5. Other Direct costs and Overheads are below Plan by c. £1.5m for the year, this is due to a number of non pay costs associated with new and expanded services which have not yet flowed through in line with the Plan. Within this there is also 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.

5. COVID-19 Income and Expenditure

5.1. For Half 1 there continues to be a flat rate of income to cover COVID-19 costs of £885k per month, which is expected to reduce by c. 5% in Half 2. Current areas of spend against this are as follows:

5.1.1. Pay costs particularly relating to Incident Command, junior doctors on-call, and weekend cover.

5.1.2. 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.

5.1.3. Additional external bed provision / secondary commissioning costs.

5.2. A number of these costs had reduced but did increase again during August and September when Incident Command was stepped back up again; overall though they remain within the amount of income received.

5.3. 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. It is expected that this will continue until end of March 2022 at the earliest.

6. Delivering Value Programme

6.1. The Trust had originally planned for a target of £7.0m savings delivery in year, based on a number of factors including a known saving requirement of 0.28% for Half 1 and a higher amount expected (possibly as high as 3%) for Half 2.

6.2. Although planning guidance has yet to be received, it is now expected that the requirement for Half 2 will be 0.82%. This would mean that the requirement for the full year is lower, at £4.6m.

6.3. Current delivery is forecast at £5.5m, this is within the new target but is lower than previously expected due to the exceptional demand faced by the Trust currently, which has led to removing or delaying several programmes around reduction in external beds, or reduction in agency costs driven in part by reduction in observation levels. These elements are not currently possible because they would have an adverse quality impact.

6.4. In the light of the current requirement and forecast delivery, the programme remains on track with some head room for later in the year. Focus continues on delivery this year and also on plans for 2022/23; many of the schemes being progressed are multi-year and will achieve significant amounts next year.

7. Capital

7.1. The capital allocation for 2021/22 was confirmed at £16.1m of the ICS total allocation of £69.5m, and the Trust has requested a further £2.5m in a later bid, though this has yet to be confirmed. There is Board approval for a provisional Plan of £18.0m. There is also a disposal programme currently forecast at £4.8m which would allow gross spend available of £20.9m, excluding the additional CDEL bid for

7.2. Expenditure to date is £5.5m, with the full amount forecast to be spent at the yearend.

7.3. There is a further £420k of revenue spend year to date, £40k in the month. This primarily relates to the running costs for empty buildings and the dilapidation costs for Trust leased buildings, as well as revenue costs associated with the large capital projects.

8. Summary and Forward Look

8.1. 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, particularly bank and agency, and continued pressure against secondary commissioning costs, particularly external acute and picu placements, including the 10 beds recently purchased from Kneesworth Hospital.

8.2. Expenditure has increased fairly significantly in August and September, reflecting the high activity and acuity particularly for both HPFT's own inpatient services, and external beds purchased.

8.3. Going forward, cash block payments continue, full planning guidance is due later in September for Half 2. Likely impact is as follows:

8.3.1. COVID-19 income allocated at £885k per month in Half 1 to reduce by 5% in Half 2, c. £45k per month and £266k in total for 6 months;

8.3.2. An increase in efficiencies from Half 2 at c. 0.82%;

8.3.3. Pay award at 3% likely to be funded above the level already included in inflation;

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

This may be partially mitigated by an increase in new income from SDF and SR monies by Half 2, though with some additional costs against this.

8.4. The Trust continues to expect to report on Plan for Half 1; Half 2 is less certain with revised planning currently being carried out but the Trust expects to be able to achieve Plan.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 14
Subject:	Interim People and Organisational Development Report (July – August 2021)	**For Publication:** Yes
Authors:	Louise Thomas, Deputy Director of People and OD	**Approved by:** Janet Lynch, Interim Director of People and OD
Presented by:	Louise Thomas, Deputy Director of People and OD Louise Thomas, Deputy Director of People and OD	

Purpose of the report:

For information

Action required:

To receive this report

Summary and recommendations:

The Board is asked to receive the attached report on the Trust's performance against the key people and organisational development metrics and activity as set out in the Annual Plan. This report sets out the position for July and August as an interim briefing, pending the end of Quarter 2 report, which will be received in October 2021.

Whilst a number of our people and OD activities are on plan, of particular concern is recruitment, retention and wellbeing. The key data relating to these areas is as follows:

- Vacancy rate - the vacancy rate has further increased from 11.74% at the end of Q1 to 12.52% in July and 13.57% in August, significantly above our target rate of 10.5%. The two main areas of concern are our AHP (27.51%; 50.7 posts) and registered nurse vacancy rates (23.16%; 213.66 posts).
- Turnover - our turnover rate has continued to increase, in line with the new trend we saw emerge in Quarter 1, which ended at 19.74% total turnover and 10% unplanned turnover. Our unplanned turnover increased to 10.62% in July (20.47% total turnover rate) and 10.96% in August (19.52% total turnover rate).
- Absence - The sickness absence rate rose to 4.54% at the end of Quarter 1 and again to 5.23% in July (significantly higher than our target of 4%). The August data is now available and shows a reduction to 4.91%. Analysis of the absence data shows that the top two known reasons for absence are mental ill health and musculoskeletal issues. Absence levels reduced across all the top reasons for absence in August, save for gastrointestinal related absence, which increased slightly.

The attached report sets out the actions being taken to recruit to our vacancies at pace and the headline activities in relation to retention, including our significant work in relation to health and wellbeing, increasing morale and engaging with our people.

Recruitment and retention and health and wellbeing support to our people will remain our areas of focus for the remainder of Quarter 2 and into Quarter 3.

The Board is asked to note the current 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.

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

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

N/A

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

N/A

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

N/A

Seen by the following committee(s) on date:

IGC September 2021

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Interim People and Organisational Development Report
July – August 2021

1. Introduction

The purpose of this report is to update the Board on 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.

This report sets out the position for July and August as an interim briefing, pending the end of Quarter 2 report, which will be received in October 2021.

2. Context

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 comprises 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 NHS People Promise, which was refreshed nationally in July 2021:

Our HPFT people and OD priorities for 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. July/August performance

3.1 Vacancies

The vacancy rate at the end of Q1 had increased to 11.74%. This increased further in July to 12.52% and in August to 13.57%%. This remains above our target rate of 10.5%.

Whilst the creation of new posts in our CAMHS trailblazer team that have not yet been recruited to accounts for 14.40WTE posts and our establishment increased again in August by 54 WTE, there are 521.03 vacant posts in total.

The level of vacancies remains a concern and continues to be a priority. Of particular concern are our AHP (27.51%; 50.7 posts) and registered nurse vacancy rates (23.16%; 213.66 posts). For the first time in over a year, we saw more staff leave us (43.6WTE) than join us in July (26.4WTE).

During July and August, staffing levels were of significant concern and immediate action was taken, as follows:

a) Pace and model of recruitment
There is currently a recruitment pipeline of 284.4 WTE, of which 195.5WTE are external candidates. A further 266.79 WTE posts are in the advertising/interview stages of recruitment. Since the start of August, we focussed on confirming start dates for the 62 staff who were ready to start, undertaking personal contact outside of the usual automated email process to move the 112 new joiners we had at that time forward in the pipeline to finalise their checks and start date. The recruitment team resource was temporarily increased in order to do this and a CQI project set up to assist in reviewing our model of recruitment going forward. Weekly sit rep reporting was devised to monitor progress through the Trust Tactical Command structure. As a result of this work, the number of people who started by 6 September increased from 25.1 WTE to 58 WTE, with 1.33 WTE more new staff with start dates after this point. An additional 39.76 WTE have now completed their pre-employment checks and will be assigned start dates shortly and we are proactively managing the pre-employment checks for a further 79.81WTE.

b) Bank/Agency cover
The Bank team proactively over-booked Bank/agency staff at sites such as Kingfisher Court to enable people to be deployed across the site as needed and mitigate against the risks of unexpected absence and staff shortages. In order to further ensure safe staffing levels, it was agreed via Tactical Command and in partnership with Staffside representatives to pay Bank staff

at grade for a short period and to extend the existing bank incentive scheme to all areas of the Trust.

c) Contacting retirees
106 former clinical staff and 66 former non-clinical staff who had retired in recent years were contacted to offer the opportunity to return to us in some capacity to support, for example, supporting with activities on wards, in an administrative capacity, on the Bank or on regular hours. Three staff have so far made contact to re-join HPFT.

d) Retaining staff on fixed term contracts
All managers who had staff on fixed term contracts were contacted to determine how we can ensure that we retain them, where appropriate.

e) International recruitment
We appointed two nurses recruited from oversees and already working within the ICS on a 4 – 8 month rotation. These registered nurses are taking up post in our Older People's Services. We are actively recruiting a further 10 overseas nurses.

f) Recruitment of newly qualified nurses
We fast-tracked recruitment of the 2021 cohort of 59 newly qualified nurses to bring them into teams early wherever possible, for example, supporting teams by engaging service users in activities on wards. All newly qualified nurses have been booked into mandatory training, including respect training, to ensure that they are ready to start work immediately.

g) Bank expansion
We have been actively expanding the Bank, including the admin Bank, with 33 new HCAs, 2 new nurses, 1 new social worker and 4 new admin staff starting in August. In addition, 57 HCAs, 11 admin staff, 3 registered nurses and 2 social workers were appointed and commenced the required pre-employment checks during August. Since April 2021, 160 staff have been recruited to the Bank.

h) Medical recruitment
Two Advisory Appointment Committees (AAC) took place in August, from which two consultants were appointed and a further AAC is taking place in the week commencing 6 September.

i) Overseas registrants
We have identified 11 staff who are registered nurses overseas, but working with us in a non-registered capacity. We are supporting these staff to have their registration recognised in the UK, the first step of which is to pass English language exams, which all staff will have sat by the end of September.

A detailed action plan aligned to our new recruitment and retention strategy was developed in partnership with SBUs, the R&R Group and TMG. The plan was approved by the People and OD Group on 2 September 2021 and sets out our short, medium and long-term actions in relation to the following three pillars in our refreshed R&R Strategy, which is set out below:

3.2 Turnover

Our turnover rate has continued to increase, in line with the new trend we saw emerge in Quarter 1, which ended at 19.74% total turnover and 10% unplanned turnover. Our unplanned turnover increased to 10.62% in July (20.47% total turnover rate) and 10.96% in August (19.52% total turnover rate). For the first time in over a year, we saw more staff leave us (43.6WTE) than join us in July (26.4WTE).

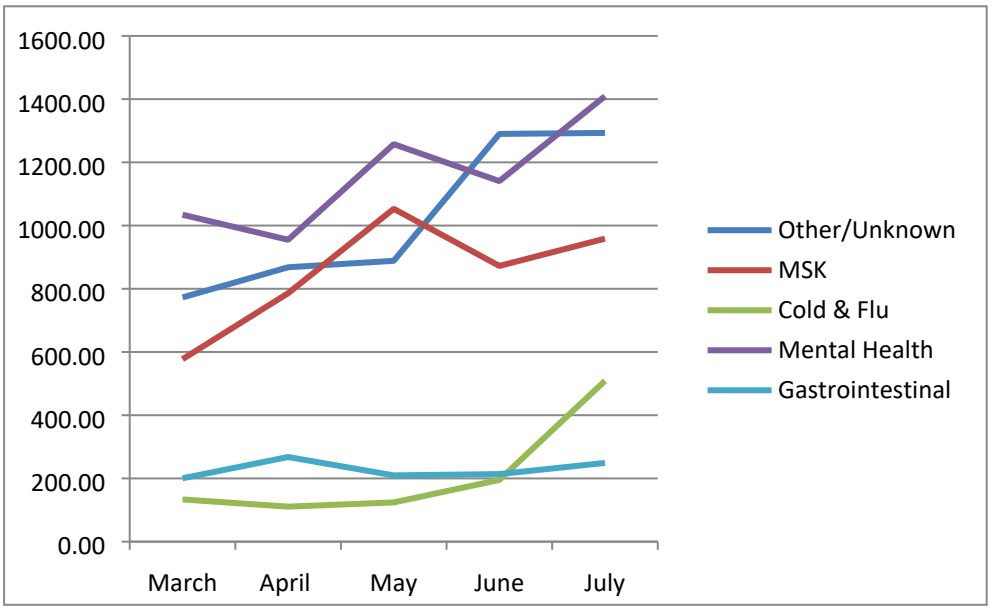
Our top voluntary reasons for leaving us are: relocation; retirement; work/life balance; and promotion. Whilst we already have a well-used retire and return policy to retain retirees in some capacity and ratings of flexible working opportunities in our annual staff survey are high (72%, compared to 66% nationally and 68% in 2019), in August 2021, we successfully applied to be part of an NHSE/I supported project to further increase our flexible working offer and culture. Our recruitment and retention action plan includes our intention to explore relocation and retention incentives, as well as increasing our development offer and better communicating our development pathways and internal transfer opportunities.

3.3 Sickness Absence

The sickness absence rate rose to 4.54% at the end of Quarter 1 and again to 5.23% in July (significantly higher than our target of 4%). The August data is now available and has reduced to 4.91%. Our analysis of the absence data up to the end of July shows that the top 5 reasons for absence are as follows:

	Count of Absence	Sum of FTE Days Lost	Sum of Absence Estimated Cost
Other/Unknown	155	1293.08	£118,632.15
MSK	106	958.59	£75,217.30
Cold & Flu	93	508.75	£50,904.52
Mental Health	81	1409.13	£133,182.70
Gastrointestinal problems	71	249.04	£26,666.11

The following chart shows the trends since the end of Q4 of 20/21, with only gastrointestinal absence remaining constant. Increases in respiratory illness are being experienced, as anticipated, in the local community as pandemic restrictions are lifted. Of significant concern are the increases in musculoskeletal problems and mental ill health.



Points to note include:

- Absence can no longer be recorded as "unknown" on eRoster or Spike to improve our intelligence in relation to absence reasons.
- Instances of coronavirus in the community were rising and this has been mirrored by an increase in staff absence due to Covid-19.
- Significant work continues across the Trust regarding health and wellbeing to promote self-care and support staff to keep mental ill health levels as low as possible, details of which are set out in the following sections.
- We have a fast track physio service available to all staff. However, in order to increase uptake, we are developing a system to provide immediate advice and support to managers on managing musculoskeletal absence as soon as they record any such absence on eRoster/Spike.
- DSE training and risk assessment was relaunched in July 2021 to ensure that all staff's training on self support was up to date and that they have the correct equipment and support in place to avoid musculoskeletal issues.
- The reduction in sickness absence in August was experienced across all reasons for absence, save for gastrointestinal related absence, which increased.

3.4 Appraisals

The appraisal rate has been improving since compliance was significantly impacted in 20/21 as a result of the pandemic. Compliance is currently at 88% (down slightly from 89% in both June and July), compared to 72% in August 2020.

Our refreshed strengths based appraisal conversation template has assisted with the increase and we continue to discuss compliance regularly with SBUs and provide exception reporting and automated reminders to ensure the focus on appraisals continues.

3.5 Mandatory Training

Our essential training compliance at the end of Quarter 1 was 83%, whilst our mandatory training compliance was at 91%. As at the end of August, our essential training compliance increased to 84% and mandatory training remained at 91%, both against a target of 92%.

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 - February. 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 resumed during Quarter 4 of 2020/21.

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). 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. A comprehensive recovery plan for Respect training has been put in place which has seen us train 488 staff since the beginning of June 2021. We are projected to achieve compliance during Q3, albeit with additional measures in place, including increasing the number of weekend courses and training more trainers.

3.6 Temporary Staffing

During July, 10,855 bank and agency shifts for registered nursing and HCA posts were requested across the Trust, with an overall fill rate of 87%. This compares to 9,658 shift requests in June and a 91.5% fill rate. Bank staff spend remained similar to last month at £1.8 million in July. Agency spend remained at £714k in July. The August data will be available shortly and reported in our full Quarter 2 report.

The Agency Locum Agency usage has remained at 6 for some time, but has risen to 7 as at the start of September. The majority of the cover is required as a result of long-term sickness absence. This is predicted to reduce to 5 in Q2, due to positive recruitment to the two Consultant and Specialty Doctor vacancies.

3.7 Employee Relations Cases

The number of cases has increased slightly since the end of Quarter 1 from 6 to 8. The 2 longest standing cases concluded in July reducing the average time to investigate to 8 weeks . However, 4 new cases commenced in July. Currently there are 7 suspensions, 2 of which involve the police for non-work issues. The remaining 5 cases are at the investigation stage.

4. Other People and OD Activity

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

4.1 Medical Staffing & Education

52 new junior doctors successfully started with us in August, with a streamlined onboarding process, ensuring that the 52 new doctors have all the relevant IT access, ID Badges, scrubs and laptops on their first day. Each trainee has a peer mentor assigned to them. Our medical education team facilitated the induction for our new junior doctors, which was described as follows:

> "The induction was very well organised and extremely informative. All of the speakers were knowledgeable and enthusiastic."
>
> "……induction was very well done and ran to time which is always appreciated!"
>
> "…..the topics were very good and I would keep the same programme next time."

We are currently conducting an annual Quality Audit with the trainees about their experience and placement and have worked with Trainee reps and the Communications Team to produce the second edition of our trainee doctor newsletter.

Our medical education schedule continues to be provided online, including Clinical and Educational Supervisor training, MRCPsych programme, SAS development days, academic teaching and monthly CPD events for all medical staff.

In August 2021, we hosted a Mock CASC exam via Zoom. The event ran smoothly and was a positive experience for not only candidates, but also examiners, actors and the administrative support.

4.2 Workforce Planning

A workforce plan for the Trust was developed during Q1 following a workforce planning audit that took place in December 2020.

In July, the newly established Workforce Planning and Development Group held its inaugural meeting and commenced the process of developing SBU level workforce plans. During July and August, HRBPs worked with SBUs, heads of professions and finance colleagues to develop the SBU workforce plans. Every SBU now has a draft plan and these are currently in the sign off process.

4.3 Health and Wellbeing

A significant amount of wellbeing support has been achieved over the summer period and has been well received by staff and all involved. In October we will bring an annual report on progress against the Wellbeing Strategy to the People and OD Group. Some of the key activities achieved since Quarter 1 are as follows:

4.3.1 Wellbeing Festival

HPFT launched it's first Health and Wellbeing festival on the 16th August consisting of two strands:

- An onsite presence over numerous days at Kingsley Green, Lexden and Little Plumstead Hospital including food vans, massages, wellbeing and union stalls.
- A mobile offering for all remaining community sites delivering a pop-up presence with goody bags for those visiting the Wellbeing Wagon.

Feedback has been overwhelmingly positive, the onsite festival at Kingsley Green saw in excess of 250 staff accessing the food offer per day. Staff asked if a more regular presence could be considered but overall reflected that they felt valued and cared for. Staff raised a number of ideas for improving wellbeing in the future.

All feedback will be collated at end of festival period (10 September).

4.3.2 Wellbeing Team

In October the current Health and Wellbeing Lead will be leaving HPFT and as such we are in the process of recruiting a replacement.

The wellbeing team has seconded a member of staff for an 8-week period to help with running the summer wellbeing festival, providing additional support to the OD Team and to provide a development opportunity.

Funds have been agreed for a Fixed Term 12 Month Full Time Band 5 Health and Wellbeing Project Officer due to a need for increased capacity and we plan to run a recruitment campaign in September to fill the vacancy.

4.3.3 Health and Wellbeing Champions

To date we have recruited 20 Health and Wellbeing Champions across the Trust, we will continue to work to recruit a member in each team particularly focussing on inpatient units.

In September we will run two training sessions for our current champion group, teaching them the skills and required knowledge to successfully champion health and wellbeing across HPFT. This will be complemented by an ongoing CPD programme of opportunities.

In the Autumn we will design a campaign aimed to recruit a more diverse group of champions, with a particular focus on recruiting male staff members into the group.

4.3.4 Mental Health First Aiders

Since March 2021, Mental Health First Aid courses have been delivered across the ICS by in house trained facilitators. As part of our roll out of Mental Health First Aiders within HPFT we are in the process of setting up a network to support our MHFAs and provide ongoing CPD to them. This group will also include supervision, monitoring of conversation numbers and signposting to support.

We are working with the ICS to establish a CPD offering for all MHFAs and Instructors across the area to ensure that high quality supervision is available.

4.3.5 Programme of Activities Q3

A programme of activities for Quarter 3 has been agreed by the People and OD Group and will be delivered both virtually and in person. The programme includes regular offerings and special events such as World Mental Health Day in October.

As part of the advertising for the programme of activities we are in the process of delivering Wellbeing Noticeboards to all sites, focussing initially on inpatient units. These will be maintained by Health and Wellbeing Champions and Mental Health First Aiders and provide detail of support and events for all staff.

4.4 Here for You Service

Across the ICS, the issue of staff burnout is of particular concern. The Here for You service are therefore running a series of support sessions focussing on burnout for staff members to discuss the concept of burnout, how to recognise the symptoms, space for reflection, coping strategies and ways in which to identify when more help is needed and where to access this support.

In response to the situation in Afghanistan, additional support for staff affected by these events has also been made available.

4.5 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.

We continue to run a range of sessions with different teams, including Away Days, reflective sessions and team development sessions.

We continue to support leadership development, with regular training and forums moving to an online format. Participants for Cohort 11 of HPFT Leadership Academy have been confirmed and the programme is commencing in September. The local Mary Seacole Programme is now taking place, with Cohort 10 having started in July, Cohort 11 starting in September and Cohort 12 in October 2021.

A programme of senior leaders development is in place, coaching as a management style, management fundamentals, coaching, HLM 360 feedback and access to ICS and regional programmes such as compassionate conversations..

We are working with A Kind Life (previously April Strategy who supported the development of our values) to build on our already well embedded Trust values to roll out the Respectful Resolutions pathway. This is a set of tools to support quicker, more positive resolutions when poor behaviour does occur, reducing bullying and

harassment. Internal stakeholder engagement sessions to develop the pathway have been undertaken and the work has been shared with the Senior Leadership forum.

4.6 Engagement

Following the refresh of our engagement strategy in July, the People and OD Group received at its September meeting a detailed action plan to support the strategy, which was approved and is now being finalised. The overarching strategy is as follows:

In September, the People and OD Group received the key findings from the Q1 pulse survey, which was conducted in June, and the new Q2 national quarterly staff survey (QSS), which was nationally mandated to be conducted in July. While aspects of this continued to be positive, there were some areas of concern, notably a decrease in staff reporting concerns, an increase in bullying and harassment, and workload pressures. The findings will be shared further through SBU's to enable further discussion and action.

The Pulse Survey and QSS was open to 4,508 staff, which includes our Bank staff and all received an email invitation to complete the survey. We received 651 (14.5%) responses in Q1 and 628 (14%) in Q2. This response rate, whilst lower than the 22% achieved in the previous quarter, is consistent with previous quarters. The Trust has continued to have good engagement in both surveys and has maintained a positive position. The key highlights from these surveys are as follows:

- 82% recommend HPFT to friends and family if they need care or treatment (84% in Q4).
- 75% recommend HPFT to friends and family as a place to work (77% in Q4)
- 60% said it was easy to make improvements at work (60% in Q4).
- 84% use feedback from service users, carers or customers to learn and make improvements (82% in Q4).
- 88% state that HPFT takes positive action to support their health and wellbeing (89% in Q4).
- 71% have opportunities to develop new skills (68% in Q4).
- 7% negative decrease in reporting of errors in Q1 to 88% after remaining consistent at around 95% across the Trust for the past 2 years.

- 11% of staff reported experiencing Bullying and Harassment in the last 3 months, which is a 3% negative increase on the previous quarter.
- 41% of staff give feedback to colleagues not demonstrating our values (46% in Q4).
- 15% of staff reported their workload is never or rarely manageable (15% in Q4).
- 56% report working additional unpaid hours (60% in Q4).

The following engagement questions were asked for the first time since the 2020 annual staff survey as part of the new NHS QSS:

- 56% stated that they often/always look forward to going to work (63.8% in the 2020 annual staff survey)
- 70% stated that they are often/always enthusiastic about my job (76.3% in the 2020 survey)
- 76% stated that time often/always passes quickly when they are working (80.7% in the 2020 survey)
- 68% stated that there are frequent opportunities to show initiative in their role (75.9% in the 2020 survey)
- 70% stated that they are able to make suggestions to improve the work of their team/department (77.9% in the 2020 survey)
- 86% agreed that care of service users is HPFTs top priority (87.7% in the 2020 annual staff survey)

We are now preparing for the launch of the annual National Staff Survey, ensuring that there is a robust communication and engagement plan, with senior leaders taking a central role in promoting the survey and ensuring a high response rate.

5 Conclusions

Whilst a number of our people and OD activities are on plan, of particular concern is recruitment, retention and wellbeing. These will remain our areas of focus for the remainder of Quarter 2 and into Quarter 3.

6 Recommendation

The Board is asked to note the current 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.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 15
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 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 operational, financial and contractual 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 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: -

1. Note the progress made by the Provider Collaborative;
2. Seek any additional information required;
3. Agree the recommendations outlined below in relation to contracting as Lead Provider for CAMHS and the sub-contract with Essex Partnership University NHS Foundation Trust for Adult Secure services.

<u>Contracting arrangement recommendations</u>

1. The Board agree the sub-contracts with those organizations listed in table 1 related to the provision of CAMHS tier four services across the East of England on the basis of the contract values in Table 2
    a. That there is no material change in these contract values ahead of contract signature
    b. That comparison of the contract terms and conditions shows no material changes

2. The Board agree that the Trust move forward to agree the sub- contract with Essex Partnership University NHS Foundation Trust for secure services on the following basis:
    a. The contract value of £8,347,500
    b. That the final terms and conditions continue to show no material changes from earlier contracts with NHS England

as One

Our Values
Welcoming Kind Positive Respectful Professional

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 six trusts act in accordance with the Mental Health Provider Partnership Agreement.

The initial focus is on transformation of:

- Secure/Forensic Services (both mental health & learning disabilities)
- Child & Adolescent Tier 4 Services
- Adult Eating Disorders

On 24 June 2021 the Trust Board approved the Trust taken the steps necessary to entering the Provider Collaborative as set out in the governing Agreement. These steps included signing the contract between the Trust, acting as lead provider for specialist CAMHS services in the East of England, and NHS England.

Following the June Board approval to implement the Provider Collaborative, it formally went live on 1 July 2021.

The areas of responsibility 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.

This paper provides a brief update on the progress to date in the following areas:

- Lead provider for Child & Adolescent Tier 4 Services
- General provider update
- Whole Provider Collaborative Finance Position
- Key Risks & Mitigations

<u>Lead provider for Child & Adolescent Tier 4 Services</u>

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

Pump priming investment has been made available to the other regional providers to support these accelerated transformation schemes.

There continues to be regional pressure on CAMHS services in terms of flow, closed beds and workforce. There are a number of initiatives underway to help relieve these pressures. This includes a focus on reducing 100+ day length of stays for young people, (these currently account for 45% of the beds currently in use), and an agreement to work across the collaborative in terms of recruitment training and support for staff.

Working in partnership with the TACT team, the Trust is now in a position to agree sub-contracts in its role as Lead Provider for CAMHS.

<u>General provider update</u>

Non-recurrent funding of £700k has been secured via the accelerated transformation fund to support the role out of LD community forensic services in Norfolk. Project is underway to implement the service in Q4.

HPFT has also been successful in securing £200-250k as part of the accelerated business case funding for Adults with Eating Disorders. This will be used to develop an intensive community service as part of the wider Community Eating Disorder team with the aim of reducing admissions.

The Patient Flow Hub, which HPFT will host, is expected to begin in Q3 following successful recruitment.

Whole Provider Collaborative Finance Position

The finance controls and reporting within the Provider Collaborative are still in their infancy. There remain some challenges around the data quality to enable accurate reporting on the financial position to take place. TACT have reported a month 4 position of £116k deficit. If this were to continue, HPFT can expect its share of the deficit under the risk sharing arrangements to be £167k at the end of the year.

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

Relation to the Trust Risk Register:

978-**Quality and safety:** The Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff.

Relation to the BAF:

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

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

Report received by Finance and Investment Committee on 22nd September 2021.

1.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.

2.Lead provider for Child & Adolescent Tier 4 Services

2.1 Clinical Design

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.

The accelerated business case has been agreed and arrangements are being put in place with TACT for each local area to access the funding being made available.

CAMHS continues to be under significant and unprecedented pressure across the region and nationally. This pressure is as a result of increases in demand, challenges with delayed transfers of care and at the time of writing, 54 beds being closed across the region.

There are a number of initiatives underway to help relieve this pressure, including a focus on reducing 100+ day lengths of stay. At present 45% of CAMHS beds in region have young people with a length of stay over 100 days. In Hertfordshire, this is just 12.5% suggesting there is significant room for improvement once the initiatives outlined above are introduced.

In addition, all providers are reporting challenges in terms of workforce. Providers are working collaboratively to consider actions regarding recruitment, training and support for staff.

2.2 Finance

As the Lead Provider for the CAMHS Tier 4 service line of the Provider Collaborative, the full amount of this income is managed through HPFT. This increases our income by circa £42m per year (£32m in 21/22) and increases our commissioning costs with existing and new providers by a similar amount.

The TACT team are forecasting that the CAMHS ‘arm’ of this arrangement will perform well and produce a surplus position that could look to support other areas of expenditure such as the bed management team, the ongoing cost of TACT and overspends within the Adult Secure and Adult Eating disorder ‘arms’.

HPFT are looking to gain assurance on this TACT assessment through the NHSE data portal. There have been some delays with the publishing of data at present and emphasis has been placed on the TACT assessment, with no concerns.

The TACT team are currently reporting that during 21/22, there is c £4.9m of non-recurrent funding available to support the cost of the TACT team and bed management team, but there is a risk that efficiencies cannot be sufficiently driven in services, to cover those expected future costs in subsequent years.

HPFT are currently reporting a break even position as a Lead Provider to account for expected overspends within other service areas.

2.3 Contracting arrangements

On the 24 June 2021 the Trust Board approved the entering of the Collaborative Agreement and therefore the requirement as a lead provider to enter into Lead Provider Contract for Specialist CAMHS services in the East of England, and NHS England. For the period July21 – March 22 the value of the contract is £32,159,576.

This lead provider contract with NHS England requires us to enter into a range of sub-contracts with other providers and provider collaboratives who provide care to

service users from the East of England. Under the terms of the above contract with NHS England these contracts are required to be signed by 1 Oct 2021.
These sub-contracts are being managed by the East of England Provider Collaborative's (EOEPC) contract and finance teams, part of the EOEPCs Transformation and Commissioning Team.

2.4 Sub Contracts Relating to CAMHS

The required sub contracts and the proposed values of these are summarized in the table below:

Table 1:

Block Contracts with providers from EOE PC	
Cambridgeshire & Peterborough NHS Foundation Trust	3,920,584
Essex Partnership University NHS Foundation Trust	5,863,665
Norfolk & Suffolk NHS Foundation Trust	1,898,386
	11,682,635
Cost & Volume Contracts with other NHS Lead Provider Organisations	
East London NHS Foundation Trust	1,139,105
Northamptonshire Healthcare NHS Foundation Trust	1,313,244
Oxford Health NHS Foundation Trust	1,408,542
South London and Maudsley NHS Foundation Trust	202,810
	4,063,701
Cost & Volume Contracts with independent sector providers	
Elysium Healthcare	5,955,790
Priory Healthcare Ltd.	4,134,160
Newbridge Care Systems Ltd	184,574
Cygnet Health Care Ltd	1,374,564
The Huntercombe Group	192,926

The block subcontracts with other members of the EOEPC reflect current payments made under the existing funding arrangements.

The cost and volume contract values are based on activity levels for 2020-21 adjusted for the nine months the EOEPC will have operated during 2021-22. Additionally, the prices applied are subject to final agreement with these organizations.

There is therefore some risk associated with the values attached to these cost and volume contracts from either price increases prior to final contract close or increases in activity levels over the next nine months.

However, any price adjustments prior to contract close are unlikely to have a material impact on the values shown in table 1. Additionally, there is currently limited excess capacity in the system that is capable of meeting any additional demand.

Excluded from these contracts, totaling £27,588,350 for the period July 21 to March 22, is the cost of the Trust's own direct provision of these services through Forest House and the associated community-based services and some further smaller contracts that have yet to be confirmed.

We are satisfied that the value of the lead provider contract with NHS England provides sufficient headroom to meet the anticipated cost of the contracts in table 1 and these further commitments.

At the time of writing, we have not received a draft copy of the contract. However, we expect the terms and conditions of the subcontracts to fully reflect the terms of the head contract. We will undertake a comparison before moving to signature.

2.5 Recommendation 1:

The Board agree the sub contracts with those organizations listed in table 1 related to the provision of CAMHS tier four services across the East of England on the basis of:

a. The contract values in table 1
b. That there is no material change in these contract values ahead of contract signature
c. That comparison of the contract terms and conditions shows no material changes

3.General provider update

3.1 Secure services

EPUT is the Lead Provider for Adult Secure services. However, HPFT has led the development of the clinical model for learning disability services.

HPFT has been successful in securing £700k as part of the accelerated business case funding. This will be used to develop a community forensic learning disability team in Norfolk in 2021/22 with enough funding to deliver the service for 12 months.

In future years, the team will be funded through a combination of efficiencies by reducing occupied bed days and through local CCG investment. The plan is that this service will then be expanded across the East of England region in future years.

A programme manager has been appointed to lead on the development of the service, which is expected to start in Q4 21/22.

3.2 Contracting arrangements

The sub-contract with EPUT needs to be signed by 1 October 2021. The proposed value for the nine months of 2021-22 is £8,347,500. As the Provider Collaborative contract with NHS England only covers service users from the East of England, we will expect ongoing funding from NHS England to cover service users from elsewhere in the country.

The expected income from these two sources is compared with an expected value for the sum of our secure provision in table 2.

Table 2:

	£
Expected value based on last contract with NHSE	10,386,750
Proposed subcontract value	8,347,500
Receiving from NHS England	1,887,750
	10,235,250

The “expected” value is based on the last contract (adjusted for subsequent funding uplifts) we negotiated directly with NHS England, which was a cost and volume contract. While this is the indicative value of the contract it did not guarantee that level of funding.

We will confirm through separate contract discussions with NHS England the ongoing funding for those service users from outside the East of England.

While we do not have sight of the contract entered into between EPUT and NHS England but we have been able to compare the terms and conditions with our previous contracts with NHS England and see no material changes.

3.3 Recommendation 2:

The Board agree that the Trust move forward to agree the sub-contract with Essex Partnership University NHS Foundation Trust for secure services on the following basis:

a. The contract value of £8,347,500
b. That the final terms and conditions continue to show no material changes from earlier contracts with NHS England

3.4 Adult Eating Disorder Services

CPFT is the Lead Provider for Adult Eating Disorder services but has been working collaboratively with the other partners, including HPFT within the Clinical Design Group.

The collaborative has begun by defining what should be in a core eating disorder service in order that clinical design initiatives can be equal across Trusts and geographies and can be focussed.

HPFT has been successful in securing £200-250k as part of the accelerated business case funding. This will be used to develop an intensive community service as part of the wider CEDS team with the aim of reducing admissions. The Trust is currently awaiting the transfer of funds from CPFT but recruitment is underway. There is a Single Point of Access in place to streamline access to inpatient beds. There are no specialist adult eating disorder beds within the county and challenges remain in accessing those in region. Work to develop a supportive day service aimed to reduce hospital admission is proving to be successful.

In future years, the intensive community service will be expanded to the three trusts not currently allocated funding, and further inpatient savings will be used to fund support for a pathway for people with severe and enduring eating disorders and a complex cases panel.

4.Provider Flow Hub

In addition to the three key areas of focus for transformation, the Trust is also the host for the Patient Flow Hub.

The Provider Collaborative became responsible for managing referrals and flow on 1 July. An outline model and specification has been developed for the Provider Flow Hub to deliver an end to end service that will manage referrals, allocate patients regionally based on needs, have oversight of capacity and support discharge and flow.

This is a new function and the Trust is recruiting to the new service and roles. The team manager and other posts are expected to be in place in October 2021 with the service taking on more functionality over the remainder of Q3.

There are currently interim arrangements in place with the support of TACT. These arrangements are seeking to set up the key data flows and bed reporting but are not making clinical decisions or allocations. Whilst significant progress has been made, challenges remain in receiving timely and accurate returns from all providers.

5.Whole Provider Collaborative Finance Position

This risk is highlighted within the TACT month 4 reporting, whereby the position was reported to the Provider Collaborative Board as a £116k deficit, broken down as below:

Table 3

Provider Collaborative Commissioning Budget M4 Estimates based on NCMS Records

	Adult Secure		CAMHS		AED		TOTAL	
	Budget	Actual (Estimate)	Budget	Actual (Estimate)	Budget	Actual (Estimate)	Budget	Actual (Estimate)
	£000	£000	£000	£000	£000	£000	£000	£000
Lead Provider Contract with NHSEI	6,111	6,111	3,573	3,573	885	885	10,569	10,569
Income from Out of Area Provider Collabs	222	154	67	0	0	0	289	154
TOTAL INCOME	6,333	6,265	3,640	3,573	885	885	10,858	10,723
CPFT Block	258	258	436	436	182	182	876	876
HPFT Block	928	928	241	241	0	0	1,169	1,169
EPUT Block	2,042	2,042	652	652	0	0	2,694	2,694
NSFT Block	1,165	1,165	211	211	0	0	1,376	1,376
NCMS Pilot Recurrent	0	0	86	86	0	0	86	86
Out out of Area Provider Collabs	17	54	130	174	42	50	189	278
Independent Sector Providers	1,893	2,062	1,866	1,379	657	919	4,416	4,360
Contingency	30		18		4		52	0
TOTAL EXPENDITURE	6,333	6,509	3,640	3,179	885	1,151	10,858	10,839
Net Surplus / (Deficit)	**0**	(244)	**0**	**394**	**0**	(266)	**0**	(116)

The data that has produced these variances has been acknowledged to be limited in its accuracy and therefore the deficit of £116k was provided on a prudent basis. This is highlighted by the TACT team forecasting a position of breakeven at the end of August. The fluctuations between months is expected to continue until further data cleansing and validation can be completed by the TACT team.

A continuation of the above risk would represent a full year deficit of circa £1m. Under the Provider Collaborative agreement, this would be split 6 ways and therefore represent an additional cost to HPFT of circa £167k. However, this risk is currently present within poor data. The TACT team are currently expecting this risk to drop as

the data validation continues and will continue to be highlighted and assessed in futures reports

6.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. As lead provider for CAMHS we are focusing on how we influence other providers to mobilise transformational change at pace.
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.

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 16
Subject:	H2 FY22 Financial Planning update	**For Publication:** Yes
Author:	Maria Wheeler - Executive Director of Finance	**Approved by:** Maria Wheeler Executive - Director of Finance
Presented by:	Maria Wheeler - Executive Director of Finance	

Purpose of the report:

To provide an update to the FY 2022 financial plan approved by the Trust Board in March 2021. The paper sets out the latest Half 2 planning update from NHS England, and the impact on the 2021/22 Financial position.

The matter has been discussed in detail at the Finance and Investment Committee on 22nd September.

Action required:

To review and note the contents

Summary:

In March 2021 the Trust Board approved the financial plan for FY2022. This was ahead of planning guidance, which was subsequently published by NHS England for the first half of the year (H1). The planning guidance for the second half of the year (H2) is due w/c 27th September 2021, although NHS England have provided some early indications of the requirements for H2 ahead of any formal publication. This paper sets out the impact on the financial position.

The Headlines for the H2 planning guidance are as follows

- £5.4bn additional funding nationally
- £500m additional Capital Allocation (covers shortfall in NHS E Plan)
- Rollover financial envelopes
- 3% pay award - Funding Confirmed
- Efficiency an additional 0.82% in H2 on top of 0.28% in H1
- Covid Income reduced by 5%. IE paid at 95%.
- Mental Health Investment Standard (MHIS), Service Development Fund (SDF) and Spending Review (SR) funding no change set for year.
- PPE continues to be centrally provided.
- Vaccinations funded outside financial envelope
- Expectation all organisations will breakeven

It should be noted that overall the financial regime has remained the same. The ICS have been granted a financial envelope, which its expected to managed within. The system has also been given the same top up support to ensure continuity of service and recognising the recovery process and the financial effects of the pandemic remain into 2021/22. Contracting remains

suspended and will remain so for the duration of the financial year.

A high level summary of the financial impact of the Planning guidance against the Trust financial plan is set out below.

Impact of planning guidance on the financial position

The table below sets out the impact of the planning guidance against the original Trust planning assumptions

Description	£m	£m
Financial Plan position	**(1.0)**	
H1 impact		
Efficiency Benefit H1 0.28% planned 1.0%		0.90
Rollover of blocks 75% Covid v's 100%		1.20
Total H1 Impact	**2.10**	
H2 impact		
Efficiency Benefit 0.82% v planned 1.25%		0.75
Rollover of blocks 25% Covid v's 95%		3.78
Total H2 Impact	**4.53**	
Total Impact for year	**6.63**	
Revised unadjusted position	**5.63**	

The table above shows an improved planning position of £5.6m. The key elements are as follows; The required efficiency, reduced from 1% to 0.28% in H1, and from 2.5% to 0.82% in H2, a benefit of £1.6m. Covid Income was assumed at 75% in H1 but received 100%, and 25% in H2 and received 95%, a benefit of £5m.

The Trust is also expected to breakeven which is a worsening of the position by £1m

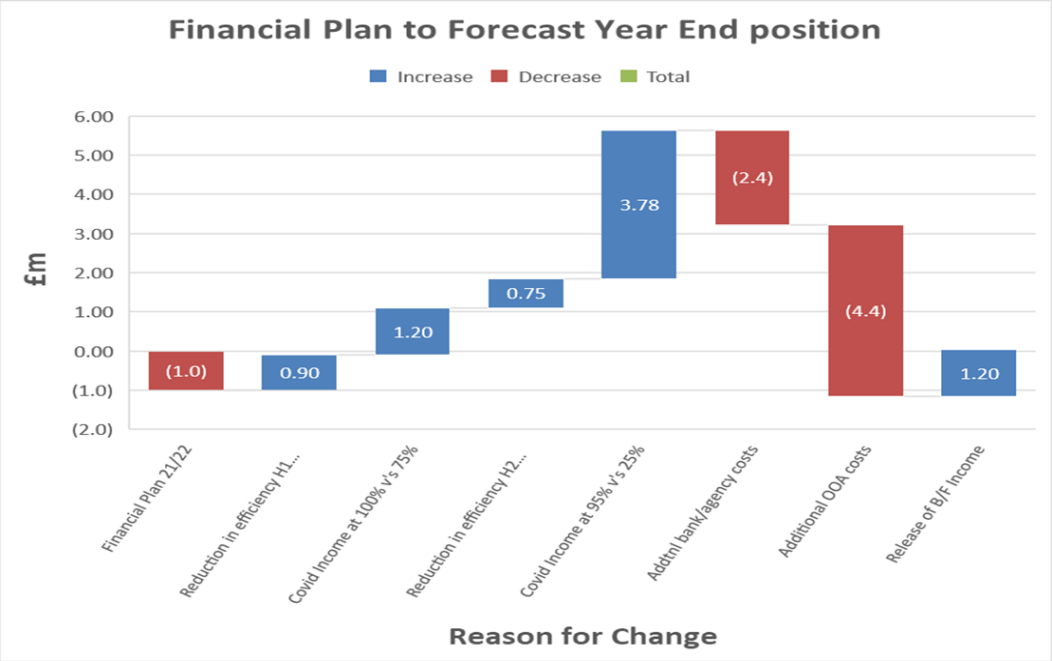
Overall favourable impact of £5.6m.

A further update will be provided when the NHS England Planning guidance is formally published.

The Forecast Financial Position for 2021/22

The increased level of income reflected the expectation that it would be needed to support increasing demand for services, which has been the case for HPFT. As reported previously, there has been a sharp increase in demand for services, in terms of volume and acuity. The additional income has been used to resource frontline services to continue to provide high quality services to our service users, and support our staff in highly challenging operational environment.

The table below provides a high level view of the extra funding and how it has been deployed.



The table above shows the key areas of support have been in the need to secure high numbers of inpatient beds and the need for increased levels of staff to cope with the sharp increase in acuity of the service users being managed by the Trust.

The Trust remains confident it will deliver a balanced financial position in 2021/22.

Transformation Funding

The Trust has continued with its transformation programme in 2021/22. It has fully utilised £3.2m of Service Development funding brought forward from 2020/21. In 2021/22 the Trust will receive a further £4.4m of Service development funding and £3.5m of spending review allocation, to continue the programme for 2021/22 and beyond.

Look forward – 2022/23

Planning guidance has not been provided so far for 2022/23, however early indications are that the financial position will be more challenging than in 2021/22. The expected efficiency requirements are likely to be higher, and also a reduction in Covid income could also be applied.

The Trust has started work on its delivering value programme for 2022/23 in anticipation of a higher efficiency ask. A number of schemes due to begin in year which should provide a full year impact into 2022/23, along with a number of schemes in the development stage which will deliver in 2022/23. The objective will be to ensure schemes are embedded for the start of the financial year, to extract maximum benefit.

It is expected that the NHS will return to formal contracts in 2022/23, and the contracting process is likely to begin formally following the publication of the 2022/23 planning guidance. In practice discussions with commissioning colleagues are ongoing.

Conclusion

The Trust has received more income in year to what was expected, but this has been fully utilised in supporting frontline services, coping much higher levels of demand for services, and much higher acuity of service users, resulting from the pandemic.

The Trust continues to develop its services despite operating in a very challenging environment with the continued rollout of its transformation plans.

The formal contracting process will recommence for 2022/23

The Trust expect to breakeven, a requirement of the planning guidance. The financial environment is likely to be more challenging in 2022/23, where a robust delivering value programme to put in place appropriate financial controls, which will be vital if the Trust are to achieve its financial objectives.

Relationship with the Business Plan & Assurance Framework:

Reflects the financial consequences of the NHS England H2 planning guidance

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

Finance and Investment Committee 22nd September 2021
Executive Team 15th September2021

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 17
Subject:	Hertfordshire Mental Health & Learning Disability Collaborative - Update	**For Publication:** Yes
Author:	Karen Taylor, Deputy Chief Executive/ Executive Director, Strategy & Integration	
Presented by:	Karen Taylor, Deputy Chief Executive/ Executive Director, Strategy & Integration	
Approved by:	Karen Taylor, Deputy Chief Executive/Executive Director, Strategy & Integration	

Purpose of the report:

To provide an update to the Trust Board on the work of the Hertfordshire Mental Health and Learning Disability Collaborative over the last three months and key priorities/upcoming milestones.

Action required:

To receive the report, noting the progress made and ongoing collaboration with statutory and third sector partners to both deliver key transformation priorities and further develop the Collaborative.

Summary and recommendations to the Board:

This report summarises the significant activity that has taken place across the Hertfordshire MHLD Collaborative since the last update to the Trust Board. During the summer period the Collaborative has continued to deliver on existing commitments and responded to significant system pressures, whilst maintaining focus on the further development and formalisation of the Partnership (in the context of national guidance and broader Integrated Care System development). Two reports are attached with this paper giving detail on the work being progressed.

The Programme Directors report (Appendix 1)

This report, presented to the last Collaborative Partnership Board held in September, provides a helpful summary of the key areas of focus which are grouped into the following key areas:

- *Collaborative response to immediate demand pressures*
  - CAMHS Acute (Tier Four) Pathway – demand and managing bed capacity
  - Community CAMHS Eating Disorder demand and backlog
  - Demand for learning disability social care services
  - Pressures in specialist learning disability discharge pathways

- *Strategic Response to Covid (Niche)* – a proposed action plan and investment plan is being developed to be brought back to the Integrated Care System Partnership Board in November

- *Hertfordshire Adult Mental Health Strategy 2021-2026* – this has been co-produced with Partners and Stakeholders from across the system and includes the voices of communities and particularly "hard to reach" groups. A Public Consultation on the Strategy will commence in September for 12 weeks, with the final Strategy being presented to the Hertfordshire MHLD Collaborative Board in January for approval

- *SMI & LD Covid vaccinations* – noting the continued successful vaccination rates, above the national average (LD 92% first dose 19+, SMI 78% first dose), preparing to mobilise for the winter and Autumn round of vaccinations (flu and Covid booster)

- *Transformation Priorities* - The Collaborative continues to focus on delivery of the Long-Term Plan ambitions, and other locally agreed priorities. Of note is the mobilisation of the new Mental Health roles in Primary Care, the review of the Mental Health Older Persons pathway, the update of the Learning Disability Big Plan, new Funding for an LD Coordinator pilot aimed at improving uptake of Annual Health Checks in two PCNs and the new Adult Autism service is to be launched in the Autumn.

- *New Funding* - Within this period there have also been a number of funding awards from NHSE, including - Suicide Prevention £303K per year across HWE for next 3 years, Suicide Prevention funding of £64K per annum across HWE, for two year commencing 2022/23, CYP Mental Health Support Teams (Wave 5) – 3 additional MHSTs within the ICS footprint during 2021/22. Funding proposals have also been submitted for 2021/2022 Learning Disability and Autism allocations for both Adult and CYP, totalling approximately £1.4m.

- *Next Steps Transformation* – noted as Primary Care, specialist community pathways, CAMHS ED day service, backlog autism assessment

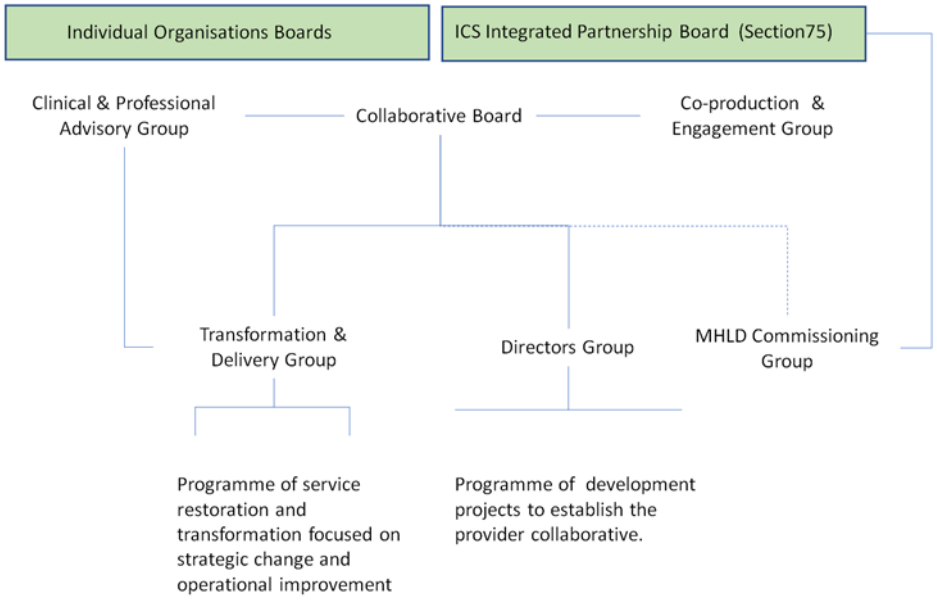
- *Development of the Collaborative* – the report also summarises activity that took place over the summer with regards to the development of the Collaborative itself. This saw the launch of the Clinical and Professional Advisory Group and proposals for the next steps of the Collaborative being developed. (see below)

Our next steps Together (Appendix 2)

The attached paper was presented at the last Collaborative Partnership Board held in September and the subsequent Board approval of all of the recommendations gives a sense of the building momentum of the Collaborative. This is important in terms of formalising arrangements that have been emerging and developing over the last 12 months in terms of:

- Having comprehensive oversight of transformation and delivery of plans
- Increasing engagement and involvement activities with wider public and stakeholders, including placing co-production with service users and carers centre stage
- Aligning commissioning activities alongside the Collaborative, moving towards a future Collaborative Commissioning function.
- Bringing continued pace, energy and focus on the development of the Collaborative during this next phase of ICS development
- Ensuring clinical and practice leadership is at heart of strategy development, service design and prioritisation

The following Governance Structure was approved:



The following full recommendations of the attached report were approved;

- Collaborative co-chair arrangements will transition from HPFT/ICS to HPFT/HCC, with full ongoing involvement and commitment from the HWE ICS Lead Director for MH&LD
- A dedicated Collaborative Development/Programme Director will be recruited to provide additional leadership and support for the next stage of Collaborative development
- The MOU will be developed for approval in October
- A 'Transformation and Delivery Group' will be established to strengthen oversight of all priorities agreed by the Collaborative
- The existing co-production groups remit will be expanded
- The Directors Group will be formalised, reporting into the Collaborative Board, and taking a strengthened programme management approach to the development of the Collaborative moving forwards
- The Herts MHLD Commissioning group will be aligned with the Collaborative
- CPAC is formalised as a Group within the Collaborative Governance Structure

Recommendations to the Trust Board

The Trust Board is asked to receive the report noting:

- The ongoing progress being made by the Collaborative
- The key next steps agreed by the Collaborative as outlined in Appendix 2.
- To note HPFT's ongoing role in working with partners to both deliver transformation priorities and the development of the Collaborative itself.

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

Aligns with Good to Great Strategy, and delivery Great Care, Great Outcomes, and the Annual Plan delivery. Strategic Objective 7 – Great Networks and Partnerships

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

N/A

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

N/A

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

N/A

Seen by the following committee(s) on date:

Executive Committee (update provided on 15 September 2021)

Mental Health & Learning Disability Collaborative
MH LD Collaborative Partnership Board

Mental Health & Learning Disability Collaborative Update Report - September 2021

1. Collaborative Development

1.1. As set out at our last Partnership Board in July, we have continued to work towards formalising our Collaborative, with significant work taken forward in the following areas:

- Collaborative interim governance arrangements,
- Transformation and delivery governance and oversight
- Memorandum of Understanding

1.2. In addition to this in August, we held our inaugural MHLD Collaborative Clinical and Practice Advisory Committee (CPAC). Membership was reviewed and draft Terms of Reference were agreed, which are on the agenda for approval.

1.3. We have set out our approach to formalising the interim Collaborative governance arrangements, which will further evolve in line with the ICS governance and operating arrangements. Key elements of our proposed approach include, formalising the remit of the Directors group and aligning commissioning activities towards a collaborative commissioning function. `

1.4. Options for transformation governance and oversight have been explored. The approached proposed by the Directors Group builds on existing arrangements, to strengthen the Collaborative's oversight of all ongoing and emergent transformation. This is on the agenda for approval.

1.5. Our Memorandum of Understanding, sets out how we will work together over the next 6 months and into shadow form. The MOU has been updated to reflect the recent national guidance and the MHLD Collaborative and both Hertfordshire Place Based Partnerships have worked together to ensure consistency in our agreements. The MOU has now been circulated to Partners and will be brought back to the October Partnership Board for approval.

2. ICS Prioritisation Framework.

2.1. The MHLD Collaborative have been asked to review and approve the pilot of the ICS Prioritisation Framework, in line with the principles (Appendix 1). It is intended that the pilot will commence in September following feedback from the Collaborative and all Place-based Partnerships.

2.2. The purpose of the framework is to ensure that a holistic review of all key areas is undertaken when considering business cases and service changes across the HWE ICS. It will ensure that the organisation / system considers the impact on quality of all proposed business and service changes.

2.3. The prioritisation framework will be supported by an Equality Impact Assessment, to ensure the organisation / system is compliant with the Public Sector Equality Duty (PSED), identifying the likely or actual effects of changes on individual, groups and

communities in respect of the nine protected characteristics, as well as the ICS's tenth protected characteristic, which is carers.

2.4. In its current pilot form the ICS Prioritisation Framework does not form a prioritisation tool, however it may contribute to a process to achieve this in the future.

2.5. The Framework was reviewed by the Directors group, who considered the contributions from practice and clinical leads. The following key observations have been made which will be fed back to the ICS:

- Impact criteria need to be inclusive of areas relevant for MHLD population
    - impact of individual's recovery
    - risk to self or others
    - impact on Carers
- Need to specify "impact on other services / agencies" under potential risks of implementing change section. Private social care providers are particularly relevant for dementia and LD populations as well as impact on statutory services and VCSE sector.
- Need to specify consideration of Legal implications - Human Rights Act and Mental Capacity Act etc.
- Criteria to include "evidence of Co-production"

2.6. It was also noted that the Framework does not set a criteria for what kind of business cases this should be used for and would therefore need to be clearer that this is not for all changes and would be only be applicable to changes anticipated to impact across the wider system.

2.7. There is also a service change template that needs to be considered by providers, prior to adoption.

2.8. It is recommended the Board approves the pilot ICS Prioritisation Framework, subject to the above feedback provided to the ICS.

3. Transformation and Delivery

3.1. Since the last Partnership Board the MH & LD Collaborative has been working together to respond to a number of challenges that are impacting on delivery of care across the system:

- Adult Mental Health Acute & Community Pathway pressures
- CAMHS Acute (Tier Four) Pathway – demand and managing bed capacity
- Community CAMHS Eating Disorder demand and backlog
- Adult Learning Disability - demand for social care services, including for carers
- Discharge pressures in specialist learning disability in-patient services

3.2. A number of mitigating actions have already been taken and key next steps agreed in the short and medium term, which will be presented at today's Board.

3.3. We have continued to focus on our Long-Term Plan (LTP) and Transforming Care (TC) commitments, with the key achievements in delivering increased access and new service models across CAMHS, primary and community adult mental health and Crisis Care.

3.4. Key achievements and developments within our priority transformation areas will be presented in more detail in the Transformation update.

4. Planning for our Population

Strategic Response to Covid-19 for Mental Health and Learning Disabilities

4.1. An overview of the work carried by across the local system by Niche to estimate the likely impact of Covid-19 on mental health and learning disabilities and consider how best to mitigate this was presented to the ICS Board on 20th July. There was agreement that this is a significant concern for the local health and care system and that mitigating action would need to encompass all levels from whole system prevention to acute inpatient services.

4.2. Further work is now taking place to ensure that all the work currently underway is mapped and the gaps both for the remainder of 2021/22 and the next three years identified. The immediate focus has been on the increased demand levels already presenting within the system and the actions required to address this. (as detailed earlier in this report). Alongside this the potential mitigating actions will be developed in more detail and bought back to Collaborative Board in October, prior to being presented to the ICS Partnership Board in the autumn for approval. It is anticipated this will support discussions for the planning round for 22/23.

5. ICS Mental Health Workforce Plan

5.1. Nationally, there is an expectation for each ICS to have a dedicated MH & LD workforce oversight group and this will be established in line with the ICS Boundary reporting to both the ICS MHLD Programme and the ICS People Board. The MHLD Collaborative will therefore be within the scope of this group

5.2. Mental Health (MH) workforce expansion continues to be a high priority in 2021/22, given the scale of expansion and transformation required to deliver the ambitions of Mental Health Long Term Plan and other priorities, including our response to Covid-19.

5.3. Key priorities in the context of the continuing pandemic, increased demand and acuity include:

- Retaining our current staff, ensuring a high focus on health, wellbeing and morale
- Recruiting to vacancies, in particular LD and MH nursing vacancies
- Planned increase in workforce across several services; Children and Young People, Perinatal Mental Health, Adult Community Crisis, Adult Community Mental Health and Acute Inpatient. The staff groups expected to see the most growth are nursing, therapists, psychology and psychiatry. Growth in this year is relatively modest but planning for greater growth in 22/23
- Maintaining the internal banks at HPFT and EPUT to ensure continued high shift fill rates
- Workforce planning and transformation - skill mix reviews, embedding new roles and new ways of working, including use of technology

5.4. The plan is for modest growth of workforce this year however whilst there is reasonable confidence in this being achieved, operational and staffing pressures are increasing which increases the risk to this workforce growth and delivery of workforce transformation. Mitigations include recruitment and retention initiatives, new roles, international recruitment, retire and return schemes, focussed workforce planning and health and wellbeing programmes at ICS and local level.

6. Conclusion

6.1. This report has summarised the significant activity that has taken place across the Hertfordshire MHLD Collaborative since the last Partnership Board in July.

6.2. During the summer period the Collaborative has continued to deliver on existing commitments and responding to significant system pressures, whilst maintaining focus on the further development and formalisation of our Partnership in the context of national guidance.

6.3. Recent work to understand the impact of Covid-19 on the mental health and learning disability population has shaped our priorities and will inform our strategic direction and future planning across 2021/22 and beyond.

6.4. Over the next period we will continue to focusing on developing and formalising our Collaborative, whilst continuing to deliver on existing commitments and respond to local need.

Hertfordshire Mental Health & Learning Disabilities Collaborative

Our next steps Together

September 2021

1. Purpose

This paper provides an overview of the key next steps for the development of our Hertfordshire Mental Health & LD Collaborative.

2. Introduction

Our Collaborative has been developing well over the course of the last two years, focussed on the work we can do together to improve care and outcomes, building on our existing partnership work. We can point together at several significant improvements made, our joint response to the covid pandemic, and increased funding secured into the county as a consequence of this work together.

We have, simultaneously, also been evolving our 'governance' approach, in line with the changing system architecture and emerging guidance (Health & Social Care Bill 2021, ICS Operating Framework 2021, and now more recently the Provider Collaborative Guidance 2021). Recognising the increasing momentum of our Collaborative and the need to move to 'shadow' form in conjunction with the wider ICS governance and operating framework it is timely to take stock and agree our key next development steps as a Collaborative.

3. Governance Arrangements

As we move into the Autumn it will be important and helpful to formalise a number of reporting and governance arrangements that have been developing over the last 12 months.

By doing this we will:

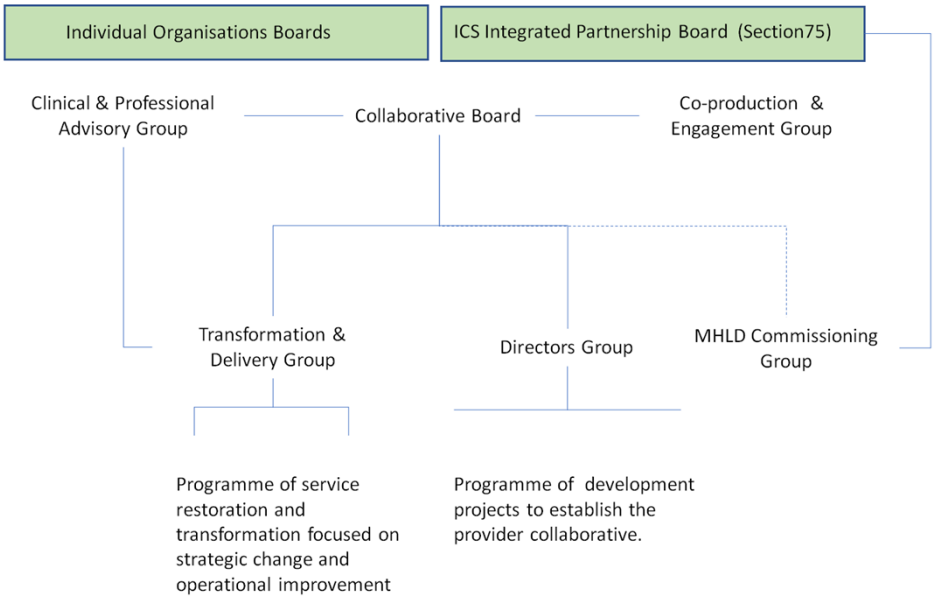
- Have comprehensive oversight of transformation and delivery of plans (through the proposed Transformation & Delivery Group)
- Increase engagement and involvement activities with wider public and stakeholder (through expanding the role of the existing coproduction group to also encompass wider engagement)
- Align commissioning activities alongside the collaborative, moving towards a Collaborative Commissioning function. (Aligning the existing commissioning group with the MHLD Collab)

- Bring continued pace, energy and focus on the development of the Collaborative during this next phase of ICS development (by continuing the Directors Group and being clear on the areas of focus for the next 6 – 12 months)
- Ensure clinical and practice leadership is at heart of strategy development, service design and prioritisation (through the Clinical and Professional Advisory Committee, and leadership within all transformation work)

Figure 1 below provides an overview of the proposed next stage of governance within the MHLD Collaborative, recognising this is the 'interim' governance that is likely to take us through to April 2022, but will continue to evolve in line with the wider ICS operating model and in line with ongoing discussions across partner organisations.

The key updates to our governance from the existing arrangements are:

- Creation of a Transformation & Delivery Group
- Expanding the remit of the existing co-production group
- Formalising the Directors Group – reporting into the Collaborative Board
- Aligning the existing Herts MHLD Commissioning group with the Collaborative (maintaining direct reporting into the ICS) with the intention of ensuring the Collaborative priorities align with commissioning decisions
- Formalising the CPAG



4. Collaborative Leadership

To date, Tom Cahill (HPFT CEO) and Beverley Flowers (ICS Mental Health & LD lead / Transformation Director) have chaired/led the Collaborative, with HPFT also providing the dedicated programme support for the programme of work. Project / transformation resource has been aligned with existing programmes of work, with all organisations

contributing to meetings and helping to shape priorities and deliver the programme of work together.

Given the next stage of development of the Collaborative, and in line with the recently released Collaborative Guidance it seems timely to consider these arrangements, with the proposal for the co-chair arrangements to move from the ICS to Hertfordshire County Council moving forwards. Beverley Flowers will remain a full member and will continue to support the development of the Collaborative as ICS lead for MH & LD.

Given the maturity of the Collaborative, the need to begin to formalise arrangements and also the scale of the programme of work, the ICS, County Council and HPFT have also agreed to put in place a full time Collaborative Development/Programme Director, working on behalf of all partners, reporting to the Chairs of the Collaborative.

As the Transformation and Delivery Group is established it is anticipated that leadership for different programmes of work will continue to be provided across the range of partners within the Collaborative, in the way we currently work together to achieve this. We will also want to identify, where appropriate, collaborative leads for new pieces of work. For example, such a role is being considered currently to support the primary mental health transformation across the Collaborative.

5. Collaborative Scope and Memorandum of Understanding (MOU)

Much discussion has taken place regarding the scope of the Hertfordshire MHLD Collaborative. Although there has now been significant agreement on this across partners, there remains further work to be undertaken, in line with the wider development of the ICS, the population segmentation work being undertaken and development of the Place Based Partnerships.

In the meantime, we will be seeking agreement across partners during September/October for the Collaborative Memorandum of Understanding, which will describe how we intend to work together for the next 6 months, and into the initial shadow period. It is worth noting that this is seeking to be consistent with the common threads that bind the MOUs across the place based partnerships and the MHLD Collaborative, and also reflective of the recently released national Collaborative guidance. The MOU covers an interim period and is a starting place for further evolution / development and it;

- Focuses on delivery of service improvements through collaborative action assuming at this stage there a no contractual change, no delegation of functions from the ICS and no funding shifts
- Evolves future approaches together within the Collaborative and between the Collaborative and place based care partnerships
- Describes the Collaborative vision, purpose and principles in this context
- Describes how we will make this work: governance, behaviour decision making

- Provides a commitment to each other on this basis but it is not legally binding

A draft MOU will be taken through the Directors Group in September and through to organisations, with a view to formal sign off at our next Collaborative Board meeting scheduled for 15 October 2021.

6. Recommendations & Conclusion

This paper has outlined a number of key next steps to support the development of the Hertfordshire Mental Health and Learning Disability Collaborative. The Collaborative Board are asked to discuss and agree the proposals contained in the paper, namely

- Formalising the Governance Structure as set out in Section 3
- Moving the Co-chair arrangement of the Collaborative from HPFT/ICS to HPFT/HCC as set out in Section 4
- Putting in place a dedicated Collaborative Development/Programme Director, as set out in Section 4.
- Developing the Collaborative MOU and proposed approach as set out in Section 5.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 18
Subject:	Report of the Audit Committee held 9 September 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 9 September 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:

Summary

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

In particular the Committee received a report on Clinical Excellence Awards and the payment made to consultants.

The Board is asked to note that the Committee agreed amendments to the Internal Audit Plan, noting that the Plan is still on schedule to be delivered in full.

The Committee received a report on irrecoverable debts and agreed to write off a small sum following advice from the debt recovery agency.

The Committee identified the need to urgently review one of the categories of data breaches reported.

Matters of Escalation

There was one matter for the Board to note, namely that the Committee approved the Trust Charitable accounts and Annual Report for 2020/21 for approval by the Trustees of the Charitable Funds.

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 9 September 2021

1. Introduction

The Audit Committee was held on the 9 September 2021 in accordance with its terms of reference and was quorate.

2. Minutes of meeting held on 19 July 2021

The meeting approved the notes and noted a report that provided a formal record of the matters discussed and the assurances provided.

3. Matters Arising

The Committee received a detailed update on the work underway to identify the contracts and shared service providers used by the trust and the proposed process to ensure they are compliant with all appropriate cyber security requirements. It was agreed that the Committee would receive an update on the planned proactive monitoring at a future meeting.

4. Notes from Other Committees

4.1 Notes of Finance and Investment Committee – 16 March 2021

Notes of the meeting were noted. It was highlighted that the meeting had focused on year end matters as well as the planning for 2021/22. The meeting also approved the business cases for the new inpatient unit in East and North Herts and capital investment for Albany Lodge, recommending them to the Board for approval.

4.2 Notes of Finance and Investment Committee – 10 May 2021

Notes of the meeting were noted. It was highlighted that the meeting had recieved a number of end of year reports linked with performance and the capital programme. The Committee also received an update on planning for 2021/22 and the East of England Collaborative. It was noted that going forward the Committee would increase its focus on digital transformation.

4.3 Notes of Integrated Governance Committee – 8 March 2021

Notes of the meeting were noted. The Integrated Governance sCommittee recieved a number of quarter three reports across people, safety, effectiveness and experience. The Committee also recieved and approved the Trust Risk Register and Board Assurance Framework.

4.4 Notes of Integrated Governance Committee – 13 May 2021

Notes of the meeting were noted. The Committee received a deep dive on People, covering feedback from internal audit reports, including workforce planning; current priorities and findings of the 2020 staff survey. The Committee recieved a number of quarter four and annual reports across people, safety, effectiveness and experience to support the year end process, including approving the Annual Governance Statement. The Committee discussed the trends with regard to violence and aggression and safety for SUs. The Committee also asked for an update on the demography of the Service Users detained.

5. Deep Dive Presentation – Board Assurance Framework (BAF)

The Committee recieved a comprehensive deep dive into the Trust's Board Assurance Framework. In particular they were updated on how the principal risks link with each strategic objective, the controls in place and the assurance used to provide an assessment of the controls. The Committee welcomed the informative presentation.

The Committee fedback that the principal risks aligned well with the strategic objectives. It was agreed that the Committee should consider how it uses the BAF to drive the areas of discussion and focus, in particualr consideirng its' role with regard to assurance of the internal systems of control.

It was noted that at times there are some challenges with regard to the use of data to support the controls in the BAF. It was noted that the groups feeding into the sub committees provide assurance on the risks identified in the BAF.

In response to questions Helen Edmondson reported that in line with the Well Led Review recommendations the BAF would be reviewed and reformatted, ready for 2022/23.

6. Internal Audit

6.1 Progress Report

The Committee received the Internal Audit Progress report and noted that two final audits had been completed since the last report to the Committee. The final reports had both provided substantial assurance. One further audit was being finalised and would be reported to the next Committee meeting.

In response to Catherine Dugmore's question it was confirmed that all possible infection control cases are reviewed by the team and the noted management action related to them needed to considered at the monthly IPC meetings.

The Committee approved amendments to the internal audit plan relating to the timing of the digitial tooklit internal audit. It was noted that the internal audit plan was on track and would be delivered in its entirity.

6.2 Internal Audit Action Tracker Exception Report

The Committee received the Audit Action Tracker Exception Report which detailed the progress made. It was noted that a number of actions had been closed, and actions were in place to close the overdue actions and that progress was continuing to be made. It was agreed the actions relating to the SU property audit would be updated in partnership with RSM to ensure they are an accurate reflection of the feedback from the task and finish group who presented to the Committee meeting in July 2021.

The Committee thanked the team for the significant progress that had been made in reducing the number of outstanding actions, noting this would continue to be an area of focus.

7 External Audit Progress Report

The Committee received an update on the external audit programme since year end. In particular the Committee were updated on the new audit software due to be used in 2021/22, noting the main impact would be the bringing forward of some of the work.

8. Value for Money Review – Update 2021/22

The Committee received an update on the work underway to respond to the recommendations following external audit's Value for Money Risk Assessment carried out as part of the year end process.

It was noted that the Trust is exploring the implementation of a register of regulatory information and requirements, to be based on existing governance processes with clearly identified lead officers, aiming for it to be proportionate to the risk. The aim is to have this in place from April 2022 at which time an update would be provided to the Committee.

The second recommendation related to performance reporting. It was reported that the system of reporting across operational performance, people and finance was being reviewed with the aim of integrated reporting perhaps with a Balanced Scorecard for each SBU, supported by a "Flash" early report including key indicators of each of the areas. It was noted that a number of stakeholders would be involved in the development of this and this would include FIC.

9. Clinical Excellence Awards (CEAs)

The Committee received a report following identification of an error with the payments for the CEAs for 2020/21. The Committee noted that a national agreement was made in April 2020 for local consultant clinical excellence awards (CEA's) to be equally distributed among eligible consultants as a one-off non-consolidated payment. Payments were made in March 2021 however; errors were made in determining eligibility and, as a result, there were errors with the payments. The Committee noted the sums involved but also the need to ensure staff affected had received clear communication regarding the error. In response to Catherine Dugmore's question it was confirmed that the consultant body had received clear open communication and errors were in the process of being corrected.

The Committee supported the proposal that internal audit be commissioned to undertake an advisory piece of work to review the new system and consider other systems in place to make ad hoc payments to staff.

10. Assurance Reports

10.1 Waivers- Quarter One

The Committee received a report that advised that five waivers had been received during Quarter 1 of 2021/22, compared to twenty in Quarter 1 of the previous financial year. The Committee considered the analysis of the reasons for the five waivers being used and did not raise any issues for further consideration.

10.2 Provision of Irrecoverable Debts- Quarter One

The Committee received a report seeking their support to write-off debts to the value of £940, across four items relating to unrecoverable debts for the period 1st April to 30th June 2021. The Committee approved the write off noting that the recommendation from the debt agency stated that all means of recovery had been exhausted.

The Committee received an update on provisions, noting the opening balance and that there had been no movement during 2021/22 Quarter 1. It was noted that this positon was regularly kept under review and an update would be provided at the next Committee.

10.3 Corporate Seal

The Committee received a report on the use of the Corporate Seal during the period 1st April to 31st August 2021. It was noted that during the reporting period there were four (4) transactions sealed and these are recorded in the Recording of Seals' Book kept securely with the Trust's Seal by the Company Secretary.

10.4 Standards of Business Conduct Compliance

The Committee considered a report that set out that in line with the Trust's Standards of Business Conduct Policy the Trust had started its annual process of updating the Register of Interests relating to all 'key decision makers' within the Trust.

The report set out that as of 1st September the Trust has a 92% compliance of 'decision makers', which saw 25 members of staff outstanding. The Committee was updated on the work underway to reach 100% compliance by the end of September 2021. It would complete the declaration by the end of September 2021.

10.5 Data Breaches – Quarter One

The Committee received the Quarter 1 report on data breaches. It was reported that in Quarter 1 there had been 90 data incidents reported by Trust staff, 44 of which were assessed as breaches but none of these required reporting to the Information Commissioner.

The Committee welcomed the report asking that the next iteration of the report provided information relating to analysis of those disclosed in error and those graded 3 or 4. An immediate action was identified in relation to the review of cases relating to SPA referrals.

11. Charitable Accounts 2021/22

The Committee considered and approved the Charitable Accounts and Annual Report for 2020/21. It was noted that the Charitable Funds accounts had been through an independent examination review process.

It was noted that the most significant income related to the Captain Tom fund grant, which was received through NHS Charities Together. The Committee noted that plans have been put together to appropriately spend the grant from the Captain Tom funds across the Trust in 2021/22. In response to David Atkinson's question it was noted that the centre wanted to receive an update on how the funds were used.

The Committee reviewed the expenditure relating to charitable activities and management fees, the latter being the charge required to be made by the NHS for administration of the charitable funds.

The Accounts and Annual Report were recommended for approval by the Charitable Funds Trustees.

12. Evaluation of External Audit

The Committee considered and approved the process for evaluating external audit services in line with good practice. It was noted that the results of the evaluation would be reported to the December Committee meeting.

13. Any Other Business

The Committee formally recorded thanks to Paul Ronald for his contributions to the Committee, offering particular thanks for his diligence and thoroughness.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 September 2021	**Agenda Item:** 19
Subject:	Well Led Review Action Plan	**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 update the Board with regard to progress with the Well Led Review Action Plan.

Action required:

To receive the action plan update.

Summary and recommendations to the Executive:

Summary

In April 2021 the Trust Board received the report that provided high-level findings from the external review. The report detailed that Deloitte concur with the outstanding rating given by CQC for the well-led domain. The areas of improvement identified were in the context of an already highly effective Board.

Attached is a table of the recommendations from the report, which has been updated with the progress to date.

The update on the sixteen actions on the plan sets out that:

- Nine of the actions have been completed
- Three of the actions are due for completed by end of 2021.
- Four of the actions have revised timescales for the following reasons:

Recommendation 7. BAF Agreed with Internal Audit and Audit Committee for the review to be completed by end of March 2022 as not advisable to change this component of the risk control system mid-year.

Recommendations 11 and 12: Committee Reports This is partly completed, with committees being regularly reviewed and training set up for October. In addition, the CQI element will be completed by end of March 2021.

Recommendation 13: Freedom Two Speak Up This action is partly completed and has been delayed by absence of a key member of staff. The Last element of the long-term resourcing plan is being finalised.

The plan is for all recommendations to be completed by end of March 2022 and the Board will receive a formal update in Spring 2022.

It is recognised that the Trust needs to ensure it continues to meet the requirements of the Well Led Framework and that a number of recommendations although completed are still valid as areas the Trust should keep under review. With this in mind the Executive Team will formally review all the recommendations on a six monthly basis.

Recommendation
To receive the progress against the recommendations in the action plan update noting there will be it will be a further update in Spring 2022.

Relationship with the Business Plan & Assurance Framework:

Reviews provide a tool to facilitate continuous improvement to develop and improve capacity and capability in the organisation. This in turn enables Boards to demonstrate that their organisations are providing high quality, sustainable care.

Summary of Financial, IT, Staffing and Legal Implications:

There will be a financial implication in relation to the cost of the independent review.

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

Governors have a key role in the Well Led Key Line of Enquiry No. 7: "Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?" The independent reviews usually include interviews and focus groups with Governors and other key stakeholders.

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

The independent review provides assurance for the CQC Well Led standard.

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

Well-Led Review: Summary of Recommendations – Action Plan – September 2021 Update

Theme	#	Recommendation	Further Actions	September 2021 update
One Board Effectiveness	1.	The Trust should formally define the rights (including voting rights) and liabilities of Associate NEDs and outline their role in relation to Board and Committee meetings.	Annual review of constitution and Scheme of Delegation: consider formal definition of the role. **July 2021** H of CA and Comp Sec	Implemented clear induction for new Associate NED to provide clarity of their role. Supported by regular ones to one and feedback. Review of Constitution did not identify need to formalise the role. ***Completed***
	2.	NED meetings with the Chair should be retained, and consideration should be given as to how these could be expanded to support and enhance the understanding of key matters in advance of significant items for debate at Board or Committee meetings.	Ensure briefing and workshop time is well planned. **May 2021** CEO and HoCA	Established monthly NED briefing/workshops to support and enhance understanding of matters in advance of Committee and Board discussions are in place. ***Completed***
	3.	The Board should revisit its forward plan for 2021 to ensure that there is protected time for strategic debate. We would advocate the use of away day time to refresh key strategic principles, with other ongoing strategic issues typically scheduled towards the start of Board and Committee meetings.	Ensure away day time is well planned. **May 2021** CEO and HoCA	Board Away days are scheduled for June and October 2021. The time will be used to consider strategic priority areas. ***Completed***
	4.	Recognising the limitations of the ongoing pandemic, there remains scope to improve the levels of engagement with the Board, and in particular the NEDs. This should include increased opportunities for NEDs to engage within the Trust, as well as for staff to attend and present on specific papers at Board and Committee level.	Continue to facilitate staff visits and NED engagement with services **June 2021** HoCA	Chair and NED visits have restarted in line within IPC guidance. ***Completed***
	5.	The impact of PODG should be kept under regular review, with a formal review undertaken in six months in order determine the impact this has made on the operation of IGC and the depth of coverage of workforce matters.	Review of PODG will be ongoing and a formal view considered by the Board during 2021. **Nov 2021** Director of People and OD Chair of IGC	Re framing of IGC agenda and change of Chair has enabled stronger focus on people items. Reporting of PODG into Executive and Board. ***November 2021***. .

	#	Recommendation	Further Actions	September 2021 update
	7.	Whilst a number of improvements to the BAF have been made, there remains scope to refine the content further and to more effectively use the BAF as a tool in order to shape meeting agendas and the focus of debate. The content of the BAF should also be updated to provide consistent and accurate detail on assurance levels, and expand the information within it on action to be taken and expected outcomes. Consideration should also be given to the extent to which the document enables the Board to identify progress made in relation to the management of principle risks.	Review BAF. Consider amendments that mean BAF provides structure to the work of Board and Committees. Consider clearer definition of Trust risk appetite to support discussions at Board and Committee. **September 2021** HoCA	Deep dive into BAF at Audit Committee. Working with Internal Audit to identify best practice. Agreed with Internal Audit and Audit Committee revised timescale to fit with annual assurance process ***Revised timescale of end of March 2022***
	8.	The Trust has adapted and evolved since the current management and governance SBU structures were put in place. There is therefore a need to ensure that they remain appropriate for the current levels of service provision, and that leadership roles within the structures are understood and consistently applied.	Continue to consider organisational structures and processes. **May 2021** Exec Team	SBU and organisational structures are regularly reviewed to ensure they support the Trust's strategic priorities. ***Completed***
	9.	Given the requirement outlined in the Well-led framework that "comprehensive assurance systems should exist at all levels of the organisation" there is a need to strengthen and standardise arrangements in place at SBU level. Therefore standardised agendas, minute templates and action logs should be used for SBU meetings. Core meetings should have a consistent administrator and report writing and minute writing training should be provided to all individuals with responsibilities in this area.	Provide standardised documents to support running of meetings for the whole organisation **September 2021** HoCA	Corporate Team reviewing best practice. Aim to develop a suite of documents for wide distribution. On schedule to finalise at end of September.

	#	Recommendation	Further Actions	September 2021 update
	11.	There is scope to further strengthen and streamline the quality and quantity of information provided within Board and Committee reports. This should focus on greater levels of analysis drawing the Boards attention to key matters for debate. In support of these changes a programme of training for those drafting key Board reports should be undertaken, for example some organisations have successfully implemented a Shadow Board training programme.	Consider best practice and training available to support improvement. Use CQI techniques to support identification of improvements. Implement support and training for teams. **July 2021** HoCA. Deputy CEO	Scoping of CQI project is underway to support effective use of sub committees. HoCA identifying training needs and options for provision of the training. Dates for training of senior managers set for October. ***Revised Timescale for CQI project end of March 2022***
	12.	In addition to the actions outlined in R11, steps should be taken to further reduce the number of individual papers provided to Board and Committee meetings, and to further integrate reporting in order to provide a more holistic oversight of performance across a range of metrics within individual service areas and locations.	See response to recommendation 11	Scoping of CQI project is underway to support effective use of sub committees. HoCA identifying training needs and options for provision of the training. Dates for training of senior managers set for October. ***Revised Timescale for CQI project end of March 2022***
Four Culture and Engage	13.	A range of activities should be undertaken to promote the role of the FTSUG once the new post holder is in place. In addition, consider appointing a number of F2SU champions at various grades and locations within the Trust in order to further increase awareness of and engagement with this role.	Ensure F2SU Champions in place to support the Guardian. Implement activities to promote Guardian role. **June 2021** Director of Quality and Safety	F2SU Guardian attended IGC. Business case including proposal for substantive full time F2SU Guardian and advocates being finalised. Comms programme in place for F2SU Month in October ***Revised timescale for delivery December 2021.***

	#	Recommendation	Further Actions	September 2021 update
	15.	In further support of the already comprehensive range of mechanisms in place to support and recognise staff achievements, there remains scope to increase the extent to which achievements, innovation, and learning is shared and recognised throughout the Trust.	Implement Recovery Strategy **April 2021** Deputy Director of People and OD	Wellbeing programme implemented. Summer Wellbeing festival. ***Completed***
Five Stakeholder Feedback	16.	As part of the planned refresh of the stakeholder map, ensure that the breadth of stakeholders and Trust leaders participating in these activities is further diversified. In addition, review any options for the Trust to further influence and inform the development of approaches within the system where relevant	Continue to populate the stakeholder map considering the most effective ways to influence. **May 2021** Director of Strategy	Stakeholder map has been refreshed. ***Completed***