Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC

The Colonnades

31 March 2022 10:30 - 31 March 2022 13:30

INDEX

NHS
Hertfordshire Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 31 March 2022
Da Vinci
Time: 10.30am – 13:30pm

A G E N D A					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
1.	**Welcome and Apologies for Absence**	Chair			10:30
2.	**Declarations of Interest**	Chair	**Note**	Attached	
3.	**Service User Story**				10:30
4.	**Minutes of Meeting held 27 January 2022**	Chair	**Approve**	Attached	11:00
5.	**Matters Arising Schedule**	Helen Edmondson	**Review & Update**	Attached	
6.	**CEO Brief**	Karen Taylor	**Receive**	Attached	11:05
7.	**Chair's Report**	Chair	**Receive**	Verbal	
	QUALITY				
8.	**COVID-19 Update**	Sandra Brookes	**Receive**	Attached	11.15
9.	**Report from Integrated Governance Committee: 17 March 2022** **a) Quarter 3: Integrated Safety Report** **b) Risk Management Strategy**	Diane Herbert Jacky Vincent Helen Edmondson	**Receive** **Receive** **Approve**	Attached Attached Attached	11:20
	OPERATIONAL AND PERFORMANCE				
10.	**Report from Finance and Investment Committee: 22 March 2022** **a) Quarter 3: Performance Report**	David Atkinson Hakan Akozek	**Receive** **Receive**	Attached Attached	11:35
11.	**Finance Report**	Maria Wheeler	**Receive**	Attached	11:45
12.	**Gender Pay Gap**	Janet Lynch	**Receive**	Attached	11:50
13.	**Community Survey Update**	Sandra Brookes	**Receive**	Attached	12noon
14.	**Annual Staff Survey**	Janet Lynch	**Receive**	Attached	12:10
	STRATEGY				
15.	**Draft Annual Plan 2022/23**	Paul Ronald	**Approve**	Attached	12:20

16.	**Draft Capital Plan 2022/23**	Maria Wheelter	**Approve**	Attached	12:30
17.	**Mental Health and Learning Disability and Autism Collaborative**	Ed Knowles	**Receive**	Attached	12:40
	GOVERNANCE AND REGULATORY				
18.	**Audit Committee Report**	Catherine Dugmore	**Receive**	Attached	12:50
19.	**Audit Committee Terms of Reference**	Catherine Dugmore	**Approve**	Attached	13:00
20.	**Trust Risk Register**	Jacky Vincent	**Receive**	Attached	13:10
21.	**Board Assurance Framework**	Helen Edmondson	**Approve**	Attached	
22.	**Report from Nominations and Remuneration Committee**	Chair	**Receive**	Attached	13:20
23.	**Any Other Business**	Chair			13:25
24.	**QUESTIONS FROM THE PUBLIC**	Chair			
Date and Time of Next Public Meeting: Thursday 28 April 2022					

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

March 2022

Members	Title	Declaration of Interest
Hakan Akozek	Director, Innovation and Digital Transformation	Shareholder in Go2Healthcare Limited Wife is an Executive Partner in South Street Surgery, Bishop's Stortford
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 Independent member of Audit & Risk Committee Latymer Foundation of Hammersmith (2 x schools) Independent member of Queen Mary University of London Finance & Investment Committee
Sarah Betteley	Chair	Director DEVA Medical Electronics Ltd

Sandra Brookes	Director, Service Delivery & Service User Experience	Nil Return
Tim Bryson	Non-Executive Director	Director of Tim Bryson Consultancy Services Ltd Chair of Family Psychology Mutual CIC
Catherine Dugmore	Non-Executive Director	WWFUK Trustee RGB Kew Trustee Natural England Board Member Aldwickbury School Trust Limited Housing 21 Board Member Cambridge Community Services NHS Trust
Helen Edmondson	Head of Corporate Affairs & Company Secretary	Nil Return
Diane Herbert	Non-Executive Director	Nil Return
Kush Kanodia	Associate Non-Executive Director	Intersectional Advisory Board – Inclusion London Advisory Board – Global Disability Hub Ambassador – Disability Rights UK Trustee & Director – Centre for Access Football in Europe Trustee & Director - AbilityNet
Janet Lynch	Interim Director People & OD	Harpenden MacMillan Fundraising Committee Member
Paul Ronald	Director of Performance Improvement	Chair – MIND in Mid-Herts
Karen Taylor	Chief Executive Officer	Nil Return
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 Member of Green Angel Syndicate
Maria Wheeler	Director, Finance, Performance & Improvement	Nil Return
Paul Wood	Interim Director Strategy and Partnerships	Nil Return
Asif Zia	Director, Quality & Medical Leadership	Nil Return

Minutes of the PUBLIC Board of Directors Meeting
Thursday 27 January 2022
VIRTUAL and Face to Face

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Sarah Betteley | SBe	Chair
Catherine Dugmore | CD	Non-Executive Director
Jon Walmsley | JW	Non-Executive Director
Tim Bryson | TBr	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
David Atkinson | DA	Non-Executive Director
Patrick Vernon | PV	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
Kush Kanodia | KK	Associate Non-Executive Director
DIRECTORS	
Karen Taylor | KT	Chief Executive Officer
Paul Ronald | PR	Director of Performance Improvement
Jacky Vincent | JV	Director, Quality and Safety & Chief Nurse
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Prof Asif Zia | AZ	Director, Quality & Medical Leadership
Janet Lynch | JL	Interim Director People and OD
Paul Wood | PW	Interim Director Strategy and Partnerships
IN ATTENDANCE	
Kathryn Wickham | KW	PA to Chair & Company Secretary (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Hakan Akozek | HA	Chief Information Officer (virtual)
Rob Croot | RC	Deputy Director Finance
Barry Canterford | BC	Lead Governor & Engagement Champion – virtual attendance
Mark Graver | MG	Deputy Director Communications
Katie Dyton | KD	Interim Experience Lead (Agenda Item 3 only)
APOLOGIES	
Maria Wheeler | MW	Director Finance and Estates

Item	Subject	Action
001/22	**Welcome and Apologies for Absence** SBe welcomed all to the meeting. Apologies for absence were received from Maria Wheeler.	
002/22	**Declarations of Interest** The Declarations of Interest Register was noted. **NOTED**	
Shared Experience Pamela Gaines shared her story about her previous role as an Associate Practitioner with the Occupational Therapy Team. Pamela is currently a Health Care Assistant.		
003/22	**Minutes of the Meeting held: 25 November 2021** The minutes were reviewed with two amendments. Subject to these	

	amendments the minutes were approved as an accurate record of the meeting. **APPROVE** **The Board APPROVED the minutes**	
004/22	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
005/22	**CEO Brief** KT presented the CEO Brief to the Board which was taken as read. Headline messages of note to the Board were: On 13 December 2021 NHSE/I had declared a Level 4 National Incident with the Trust stepping up its incident management accordingly. On the 19January 2022 the Prime Minister announced England would be reverting to 'Plan A' restrictions. Staff had seven days left to receive their 1st dose of the vaccine in line with the implementation of the mandatory vaccination for all NHS staff. On the 24 December 2021 NHSE/I had published the 2022/23 priorities and planning guidance with KT noting that it had included what the Trust expected to be the requirements. Recently the Adult Social Care White Paper had been published and this would be discussed later on the agenda. System wide the ICS continued to develop. The timeline for it being a statutory body had been delayed until July 2022 in comparison to the initial 1 April 2022 date. She reported that its establishment would be a staged process and continued with an update on the ICS with KT advising that Christine Allen, Chief Executive of West Herts had announced her retirement in June 2022 with KT noting this was a further change in system leadership. She updated the Board on the appointment process underway to the leadership posts at the ICS. The Hertfordshire Mental Health and Learning Disability (MHLD) Collaborative continues to develop with Ed Knowles being appointed as the new Development Director. As a Trust, in response to the NHS being on Level 4 Alert the Trust had stepped up its Incident Management to seven days a week 8am-8pm with KT acknowledging the work of our staff who had gone above and beyond and recorded a formal thank you on behalf of the Board. Services continued to get busier with the impact of demand from the pandemic being seen across all age groups. In December the CQC published a final report for Warren Court following the recent inspection. All actions had now been undertaken and the Trust had been stepped down from regular monitoring. A full report on the action plan would be considered later on the agenda. Forest House remained under considerable pressure, due the service user acuity and availability of staff. The Trust had reduced the unit to ten beds. We were awaiting feedback following the CQC inspection and it was noted that the	

	CQC had issued a Warning Notice which the Trust would be making formal Representation to the CQC. KT outlined that our staff continue to be a key focus for the Trust. Recruitment continues to be strong, with over 500 posts in the recruitment pipeline, 178 of which had been offered and accepted by external candidates. Vacancy rates remained high. In our 2021 Annual Staff Survey we had achieved a final response rate of 50%. The report was currently in draft form and embargoed. As of 31 December 2021, the Trust was on track to deliver a break-even position. Following recent recruitment Hakan Akozek would take up the post of Director for Innovation and Digital Transformation on the 1 February 2022 and David Evans as Director for Strategy and Partnership at the beginning of May 2022. No questions were put forward. **RECEIVED** **The Board RECEIVED the CEO Update**	
006/22	**Chairs Report** SBe provided Board members with a verbal update on the work undertaken since the last Board meeting. SBe advised she had attended the East & North Chairs meeting and the South & West Herts Chairs meeting which had held good and robust discussions. SBe had attended the Transition Oversight Board where the South & West Herts Strategic Plan development had been discussed. SBe had been a panel member for the Princess Alexandra Hospital NED interviews on the 18 January 2022 and would be a panel member for the Herts & West Essex ICS NED interviews in early March. SBe had attended the quarterly Staff Network Chairs meeting noting the meeting had discussed an issue with recruitment to the carer network along with the mandatory vaccination of staff. SBe attended the weekly MH Chairs meeting of which Tom had been the guest speaker. SBe attended a weekly Good Governance Institute (GGI) events where they had recently discussed the Health & Care bill and Board leadership. **RECEIVE** **The Board RECEIVED the verbal update**	
	QUALITY & PATIENT SAFETY	
007/22	**COVID 19 Incident Management Update** SBr presented the paper which provided the Board with an update on the work overseen through Incident Command regarding the COVID-19 pandemic and described the actions being taken to address surge in community transmission	

	of COVID. She outlined the current situation with regard to Trust activity and acuity of Service Users. Points highlighted for the Board were: The NHS remained at Level 4 Incident Management and as a result, the Trust Incident Management response continued to operate seven days a week 8am-8pm. The focus for incident command had been on: • Managing several outbreaks across Trust services • Maintenance of flow and the availability of beds. • Continuing to ensure staffing is maintained at safe levels across the Trust Staffing absence had been high across services, but was starting to reduce. Staffing levels in inpatient and crisis services had been maintained above minimal levels with SBr noting we had not had to implement business continuity plans or extremis actions. There have been a number of COVID-19 outbreaks across the in-patient wards. Next steps included a review of the ongoing structure of incident management whilst recognising the NHS remained at a Level 4 incident, and the development of a recovery plan. SBr noted that whilst COVID pressures may be reducing we were mindful of winter pressures with the implementation of the winter plan continuing to be a priority. SBr concluded reporting that the East & North Herts temporary structure hospital was due to open next week however this was waiting to be confirmed. As a Trust we had been asked to look at re-deployment of staff to support the hospital. SBr invited questions. CD paid recognition to all staff on behalf of the Board and noted a well done to the team. SBe asked about the uptake for the Wellbeing events laid on for staff with JL confirming that they had been well received. **RECEIVE** **The Board RECEIVED the update**	
008/22	**CQC Final Inspection Report – Warren Court** JV introduced the report which provided the Board with details with regard to the draft action plan for submission following receipt of the Care Quality Commission's (CQC) Inspection Report regarding Warren Court. The report was taken as read. Key points of note for the Boards attention were:	

	The Action Plan addresses all the issues identified by the inspection, its delivery was being monitored by the SBU and would be monitored by the CQC. It was noted that all of the actions were due to be completed by early February 2022 with the exception of one which related to specialist training for staff, which would be completed by the end of September 2022. The report was required to be returned by the 2 February, informing the CQC of the actions taken and how the Trust considered it was meeting the standards. The CQC would then monitor against the plan. The action plan (included in the pack) had been reviewed and considered by the Executive team. The Board approved the draft action plan noting that there would be final review of it by the Executive team members and any necessary amendments prior to submission on 2 February 2022. **RECEIVE** **The Board APPROVED the report**	
009/22	**Report of the Integrated Governance Committee held: 20 January 2022** DH presented the report which provided an overview of the work undertaken at the Integrated Governance Committee (IGC) at its meeting held on 20 January 2022. The report was taken as read. Key highlights of note to the Board were. The results of the Committee's self-assessment had achieved a result of 90% against 89% the previous year. The Committee had reviewed its Terms of Reference with four changes made and these were set out for Board approval later on the agenda. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
a)	**People and OD Report** JL presented the report which updated members of the Board on the position for October and November pending the end of Quarter 3 report, which would be received in February 2022. The report was taken as read. Points of note highlighted to the Board were: Recruitment, retention and staff wellbeing remain a particular focus. Recruitment remained strong with targeted campaigns and incentives being offered. The report outlined the work to implement the requirements of the new legislation on mandatory COVID vaccination for staff.	

	It was noted that the Trust was refreshing its approach to apprenticeships to increase its use and ensure high conversion rate of staff to substantive posts at the Trust. **RECEIVE** **The Board RECEIVED the report**	
b)	**Guardian of Safe Working** AZ presented the Quarterly Guardian Report which covered the period October- December 2021. During this quarter there were four exception report raised by our Junior Doctors. The main themes from these exception reports were staff shortages on wards and natural breaks. It was of note that the Trust had one of the lowest number of exception reports in the region. Overall, there had been a slight increase in bank locum spend since the previous report with this being a direct result of doctors having to self-isolate and both ad hoc and long-term sickness absence. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
c)	**Safer Staffing** JV presented the report which provided an update on the work of safe staffing activity for quarter three along with key activities, challenges and work in place to progress to ensure safe staffing levels at HPFT. The report was taken as read. Over the quarter there had been an increase to staffing levels with bank and agency. This was due to the acuity and complexity of service users and the prescribed safe and supportive observations as well as the challenges with COVID and sickness. A question was raised with regard to use of HCAs to support registered staff, JV outlined that the decision would be based on needs and safety of services and would also consider factors such as the need for continuity of care. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
	PERFORMANCE	
010/22	**Finance Report** RC introduced the report which set out the Trust's financial position to 31 December 2021. The report was taken as read with the points below highlighted to the Board. The Trust was on track to deliver against the revised financial plan of a breakeven position.	

	The monthly expenditure run rate in December had remained in line with November and to enable a breakeven position at the year-end would need the release additional, planned, balance sheet flexibilities. RC noted the high number of Out of Area Placements was a significant fact with regard the current run rate. KT outlined that the Trust was working with NHSE/I to review the pathway for acute care but it was unlikely to reduce to zero the number of Out of Area Placements. **RECEIVE** **The Board RECEIVED the report**	
011/22	**Report of the Finance & Investment Committee held: 18 January 2022** DA presented the report which provided a summary of the items discussed at the Finance & Investment Committee meeting held 18 January 2022. Highlighted to the Board were the below points. The Committee had received a Deep Dive outlining an expected break even end of year financial position for the Trust and preparation of the financial statements for 2021/22. The presentation had provided a run rate analysis for the year and set out plans for how to establish a sustainable run rate going forward. The Committee noted the planned approach to the year with regard to IFRS15 and preparing for IFRS16 which would be in place from 1 April 2022. The Committee received and considered a report which set out the summary of performance during quarter three with the Committee reflecting on the stressed environment whilst also acknowledging the incredible work across the Trust from our staff. The Committee considered a report that provided an update on the progress to date in relation to the Provider Collaborative with DA noting the pleasing signs with bed flow for CAMHS. The Committee considered the proposal to dispose of The Stewarts and recommended this for approval by the Board. The outcome of the Committee's self-assessment was noted. The Committee reviewed its Terms of Reference with a proposal for two changes. The Committee agreed the amendments and recommended the updated Terms of Reference to the Trust Board for approval. The Committee received Planning and Financial Planning updates for 2022/23 along with an update on the current Annual Plan. The Committee reviewed the Trust Green Plan which once approved would be incorporated into the HWE ICS Green Plan. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	

a)	**Quarter Three Annual Plan Report** PR presented the report with the below headlines pulled out for the Board's attention. The report was taken as read. Quarter three had been a challenging period. Of the 93 actions set, 70% were complete or well progressed. Continuing progress has been made across all seven Strategic Objectives. Actions were being taken during Quarter four to improve the position. It was noted that the Finance and Investment Committee had considered the Trust performance at its last meeting. **RECEIVE** **The Board RECEIVED the report**	
	STRATEGY	
012/22	**Planning 2022/23** **Annual Plan 2022/23** PW presented the report which provided the Board with an update on the annual planning process and focus areas for the 2022/23 Annual plan. The report was taken as read with the below headlines noted. We had commenced the development of the annual plan using the Trusts existing strategic objectives as a framework and by reviewing progress against the 20/21 annual plan. The publication of the 22/23 national planning guidance in December meant the Trust was undertaking a period of stocktake and re-set to understand its impact and how this worked with the increase in demand the Trust was experiencing. PW outlined that there had been engagement with the Senior Leaders team session. It was noted that a further update would be presented to the Board in March 2022. A short discussion was held with TB who welcomed the Annual Plan and acknowledging the huge amount of work undertaken. It was agreed to set up a NED Briefing and a workshop for the Board. It was noted that some the Trust's priorities required a system wide approach e.g., suicide prevention **Financial Plan** RC presented the report which set out an initial high level draft financial plan for 2022-23. The report was taken as read. Key points of note for the Board were: The report set out a high-level draft of the financial plan for 2022/23 which reflected the Trust's forecast outturn position for 2021-22 of breakeven position for the year. Planning Guidance for 2022-23 was received on the 24 December 2021 and did not contain any unexpected information . Although the planning guidance had been published the full details of financial planning requirement was as yet unknown. As such, the draft financial plan remained subject to revision	**HE**

	following the publication of national technical guidance. RC noted the plan was based upon key assumptions as set out in the body of the report. With regard to the Delivery Value programme to date identified schemes had a projected value of £5.5m with a workshop planned this month to identify additional schemes to meet the planning requirement of £10.3m. The primary focus of the Delivering Value program would be the reduction of Out of Area placements and reducing spend on temporary staffing. The Board received the reports with no questions put forward. **RECEIVE** **The Board RECEIVED the reports**	
013/22	**System Update** PW presented the paper which was taken as read. Key headlines for the Board to note were: Key activities relating to the System, Partnerships and Collaboratives with detail laid out in the body of the report. The paper also provided a detailed briefing on the White Paper on social care reform. The ICS ask & Finish groups were established with HPFT contributing to help shape the outputs. South & West Herts HCP colleagues were working to develop an operational model, but there were still work to do on this. It was noted that Trust clinicians were working closely to co-produce the virtual hospital pathways. East & North Herts HCP were focused on Public Health and looking at the wider health needs of the population. Progress was being made with regard to Most Capable Provider in Norfolk and community forensic services. We would continue to work with a range of partners in the system to support development of the new ICS architecture and to ensure the needs of service users with Mental Health and Learning Disability were met. KT added that the Trust were contributing to the discussions regarding the membership of the Integrated Care Board and Integrated Care Partnership. PW invited questions. **RECEIVE** **The Board RECEIVED the report**	
014/22	**Green Plan** RC presented the HPFT Green Plan to the Board which followed a detailed discussion by the Finance and Investment Committee who had made a recommendation to the Trust board for approval.	

	Points drawn out for the Boards attention were: The ambition was to have net-zero carbon by 2040. The Finance & Investment Committee had reviewed and recommended the Plan to the Board approval. The Plan would be incorporated into the HWE ICS Green Plan and signed off by 31 March 2022. The Plan would be aligned to Trust's Capital Plan for 2022/23 and would be reviewed annually. Governance of the Plan would be led by a sustainability steering group. Next steps would be to have increase involvement of staff, Service User Representatives and colleagues from NHS England and the HWE ICS System. In response to SBe question it was confirmed that the new build at East and North Herts had been designed with key sustainability requirements in place. Following a short discussion, the Board provided their approval, noting it was a great opportunity to build support from staff and consider the Trust approach to biodiversity. **APPROVE** **The Board APPROVED the Trust Green Plan**	
GOVERNANCE AND REGULATORY		
015/22	**Report of the Audit Committee held 2 December 2021** CD presented the report which provided Board members with an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 2 December 2021. The report was taken as read. CD highlighted the below two matters of escalation for the Board: To note the recommendation to the Council of Governors to extend the external audit contract with KPMG for one year. (The Council of Governors when it met in December approved the extension of the contract with KPMG). To note that the Committee approved the awarding of contract for internal audit and counter fraud services to RSM. No questions were put forward. **RECEIVE** **The Board RECEVIED the updates**	
016/22	**Finance & Investment Committee Terms of Reference** DA presented advising the purpose of the report was to present the Terms of Reference following review by the Finance and Investment Committee at their meeting held 18 January 2022. The Terms of Reference were previously reviewed in March 2021.	

	Two changes had been made to the Terms of Reference following a review by the Committee namely: addition of the Director of Innovation and Digital Transformation as a member and clarification of the Committee's role with regard to the Treasury Investment Strategy and Policy. The Board considered and approved the Terms of Reference. **APPROVED** **The Board APPROVED the Terms of Reference**	
017/22	**IGC Terms of Reference** DH presented the report advising that each year the Integrated Governance Committee was required to review its Terms of Reference and suggest any updates it wished to make. The recent Committee self-assessment had demonstrated the Committee was working effectively and in line with its Terms of Reference. Four changes had been made to the Terms of Reference following a review by the Committee: • amendment to quoracy • addition of details of the Committee's responsibility with regard to People • inclusion of information on Committee's role with regard to compliance with CQC requirements. • clarity of Committee's role with regard to Experience The Board approved the revised Terms of Reference. **APPROVED** **The Board APPROVED the Terms of Reference**	
018/22	**Appointment of Mental Health Act Manager Chair - Chair's Action** SBe noted the paper informed the Board and was seeking agreement for a Chairs action to be carried out for to enable Maria Watkins to become an MHA Manager. SBe confirmed that Maria had successfully completed her three training hearings with positive feedback. The Board provided their approval for the appointment of Maria Watkins as an MHA Manager. **APPROVED** **The Board APPROVED the Chairs Action**	
019/22	**AOB** SBe gave her thanks to the Executive Team for their work during this current phase of the pandemic and increased demand on services. No further items of business were put forward.	
020/22	**Questions from the Public** No members of the Public were present.	
021/22	**Date of Next Meeting** The next public meeting is scheduled for 31 March 2022.	

Close of Meeting

Committee Meeting: PUBLIC Board of Directors
MATTERS ARISING SCHEDULE

Matters Arising from meeting held on: 27 January 2022					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
00	**Staff Story**	RC	Clarify process to access Sir Captain Tom funds	February 2022	**A**
9a	**Q3 People & OD report**	JL	Data on apprenticeships conversion rate to be provided	February 2022	**A**
12a	**Annual Plan**	PW	Draft Annual Plan to come to March board	March 2022	**G**
12b	**Financial Plan**	MW	Draft financial plan to come to March board	March 2022	**G**
Matters Arising from meeting held on: 25 November 2021					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
13	**System Update**	PW	Future Board to receive System Adult MH Strategy	TBC	**A**
Matters Arising from meeting held on: 30 September 2021					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
10	**Emergency Preparedness, Resilience & Response – Core Standards**	SBr	Further update to be presented to the Board later this year	March 2022 Moved to March so can be considered at a public meeting	**A**
Matters Arising from meeting held on: 29 July 2021					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
10a	**Q1 Performance Update**	PR	Consultation on MH Access Targets – future performance report to set out how this stands against proposed standards	November 2021 Awaiting publication of definitions and specific targets. Have followed up	**A**

				NHSE/I and will update when available	

Board of Directors PUBLIC

Meeting Date:	31 March 2022	Agenda Item: 6
Subject:	CEO Briefing	
Presented by:	Karen Taylor, Chief Executive Officer	

National update

The national activity is summarised below:

COVID -19

Nationally the NHS remains on alert level 4. The national COVID-19 restrictions ceased in England at the end of February. Nationally we are seeing an increase in the number of reported cases of the virus, with particular spikes in the younger population. New guidance has been published on visiting in NHS facilities and we are awaiting guidance with regard to access for health workers to Lateral Flow Devices.

The public consultation by the Department of Health and Social Care regarding the intention to revoke the regulations that relating to the vaccination of workers against coronavirus COVID-19 closed on 16 February 2022. On 1 March the government published its response and subsequently passed new legislation which came into effect on 15 March that, in effect, means there will no longer be a legal requirement to be vaccinated as a condition of employment in the NHS. The full outcome of the consultation are available Revoking vaccination as a condition of deployment across all health and social care: consultation response - GOV.UK (www.gov.uk)

On 16 March 2022 the draft Terms of Reference for the Covid Inquiry were open for public consultation that closes on 7 April 2022. The final terms of reference will be published once Baroness Hallett has consulted with the public, including with bereaved families and other affected groups.

NHS Providers briefing on CQC Monitoring the Mental Health Act in 2020/21 report- HE

The Care Quality Commission (CQC) has published Monitoring the Mental Health Act in 2020/21 Monitoring the Mental Health Act | Care Quality Commission (cqc.org.uk), the regulator's annual report on the use of the 1983 Mental Health Act (MHA). The report sets out CQC's activity and findings from engagement with people subject to the MHA and its review of services for people detained using the MHA during 2020/21.

It set out that services have continued to experience unprecedented pressure during the pandemic. Despite this, the CQC has seen many examples of good practice and the dedication of staff. CQC recognised that, with social distancing and other restrictions in place, services have had to balance a duty of care towards patients at the same time as upholding the principle of least restriction. Overall, the regulator found that services rose to the challenges this presented.

CQC found that staff are exhausted, with high levels of anxiety, stress and burnout, and there is a high level of vacancies. The regulator concludes that the negative impact of working under this sustained pressure poses a challenge to the safe, effective and caring management of inpatient services and to the delivery of care in a way that maintains people's human rights.

CQC highlights concerns that reduced access to community mental health services during the pandemic may in part have contributed to an increase in the number of people detained under the MHA. The report also raises concerns about children and young people being placed in unsuitable environments while they wait for an inpatient child and adolescent mental health bed.

The report states many parts of the mental health hospital estate need upgrading, and many of the improvements required will be dependent on adequate capital funding being available.

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 (ICS)
The go live date for the Integrated Care Board (ICB) is still expected to be 1 July 2022, and work is continuing to ensure Hertfordshire and West Essex meet the requirements of the NHSE Gateway process. Hertfordshire County Council are leading the work to develop the Integrated Care Partnership and to establish how it will work with existing structures and with the emerging Health and Care Partnerships (including the Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative).

The appointment of Executive Directors to the ICB is well underway and we should expect the formal announcement of the outcome of the Director level appointments soon. The process to recruit non-Executive Directors has concluded, with an excellent response to the advert. Announcement of the successful post holders is expected soon. All of these are important milestones to the establishment of the new system infrastructure. The next stage will be to start the appointment process for members of the ICB which will include system partners.

The three CCGs are also preparing to close and move functions over to the ICB. This involves the mapping of CCG functions and staff to ensure a smooth transition to new systems and processes.

Dr Rakesh Magon, Consultant Psychiatrist has been appointed as the Hertfordshire & West Essex ICS Mental Health and Learning Disability Clinical Lead (1 day a week). He will be supporting the MHLD programme team to ensure that we share best practice across our ICS and we anticipate he will be starting this role at the beginning of April, working a day a week in the role.

Hertfordshire Mental Health, Learning Disability and Autism (MHLDA) Collaborative
The Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative has continued to drive forward at both a strategic and operational level during March. This has included system-wide discussions on the scale of demand faced by the Collaborative and the resource required to meet it as well as practical design activity across Collaborative partners to better support children and young people with Attention Deficit Hyperactivity Disorder (ADHD). Also, of note has been the agreement to develop the Collaborative physical health strategy and the update received on the approach to developing housing for people with learning disabilities across Hertfordshire.

The Collaborative has successfully recruited to the role of Primary and Community Mental Health Transformation Manager. Further recruitment is planned over the course of March/April to bring in the project and programme management expertise required to push forward the Collaborative's priorities.

Hertfordshire Health Care Partnerships
South & West Herts Health and Care Partnership are in the process of Business Planning for 2022/23 and are engaging with partners organisations around priorities.

East & North Herts Health and Care Partnership have confirmed their 10 key priority areas and are now reviewing their delivery and clinical advisory structures to ensure that they are in a position to help progress these areas.

East of England (EOE) Provider Collaborative
The number of young people waiting for a CAMHS bed across the East of England is expected to see an improvement over the next quarter. The number of closed beds has reduced since the last report but there remains a challenge in finding suitable beds for some young people with complex

needs. Providers across the region are working on the transformation of services; however, workforce remains an ongoing risk.

Good progress is being made in both secure and adult eating disorder services in the mobilisation of their transformation initiatives. Both services are expected to go live in March-April 2022. The Patient Flow Hub has now expanded to all other providers in the region and the Hub has taken an active role in supporting referrals and flow and is able to produce accurate daily capacity and waiting list positions.

Whilst the financial position of the collaborative remains under pressure but has improved and is forecasting a break even position.

Trust-wide update

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

COVID-19

We continue to stay at Level 4 incident management and it is anticipated cases will continue to rise across the region until the end of the month and with a predicted peak mid-April. The Trust continues to operate according to current IPC guidance, and this will be replaced from April by the national IPC manual.

Operational update

Services have continued to respond to high levels of demand, which for some service areas is now at the higher end of national demand projections for mental health services. Levels of staff absence have stabilised in the last month, however, the organisation is starting to see increases in reported Covid 19 sickness and outbreaks across in-patient areas, which was anticipated with the reduction in restrictions outside of the NHS. The organisation continues to have an incident management structure in place, with a focus on planning ahead of the Easter break and with consideration of the projections of increasing Covid-19 infection in the community impacting on staffing.

Demand for acute adult beds has remained high with ongoing use of out of area placements (OOAPs), although we have seen some reduction in the number of OOAPs. The transformation of the acute pathway remains a priority. Despite a positive decrease in s136 detentions during the latter part of 2021, as a result of the work with have been doing in partnership with police colleagues, the rates of detention have risen slightly and there are occasions when people are detained beyond 24 hours, which is linked to bed availability. Work in underway with the police to address this. Referrals for community adult mental health services continue to be high. This is resulting in longer waiting times for routine assessment and the trust has seen a decline in performance against the 28 day target.

The CAMHS crisis team have seen a high number of presentations into Emergency Departments, due in the main to self-harm, however many young people have been discharged with ongoing support. Over the past year a number of young with complex needs, often related to easting disorders, have been supported on paediatric wards within the acute hospitals and we are working with the East of England Collaborative to address this. We are also progressing the development of a paediatric liaison and support model into the acute Trusts.

Demand on older people's beds both functional and dementia, has continued to increase, with a number of out of area beds being used. This has in part been due to difficulties in facilitating discharge. Work is progressing well with social care colleagues to agree solutions and the winter pressures scheme to temporarily "top up" some placement costs has helped create flow across the bed provision.

Hertfordshire learning disability services have experienced unprecedented demand on assessment and treatment beds over recent weeks and beds in Essex have had to be used to facilitate

admissions. The teams are doing some analysis regarding the reasons for this in order to agree actions going forwards, with partners.

Commissioners have almost finished their safe and wellbeing reviews for inpatients with a learning disability. This was a national programme following the Cawston Park closure. Commissioners in Hertfordshire for SRS have identified some areas to be addressed, including the extent of meaningful activities provided. HPFT is working with commissioners on an improvement plan to ensure all resident's needs are met whilst the wider service transformation takes place.

Forest House Assessment Unit

The Trust continues to robustly monitor progress against the Service Improvement Action Plan, which incorporates improvements to be made against the CQC Key Lines of Enquiry (safe, effective, Caring, Responsive, well-led). It also incorporates the actions necessary to address the issues raised within the Section 29A Warning Notice. On 11 February 2022 the Trust received the draft inspection report and the Trust responded as part of the Factual Accuracy process. As reported previously, the Trust will be re-rated for the CAMHS inpatient services as result of the focussed inspection. The Trust is expecting to receive the final report imminently and this will include a summary of the aforementioned Warning Notice.

Our People

Our vacancy rate in February was 14.37% and has remained stable since December. This equates to 568.04 WTE vacancies. Recruitment capacity and activity has expanded significantly, with numerous campaigns for nurses, Healthcare Support Workers (HCSWs) and AHPs taking place across the Trust and campaigns for particularly hard to recruit to areas also taking place. At the end of February, we had maintained our high levels of recruitment with 174.4 WTE candidates in the external post-interview vacancy pipeline and a further 350 WTE posts were in the pre-interview stage of recruitment. In addition, we are continuing our expanded international nurse recruitment campaign to recruit 50 registered nurses from overseas and have made 17 offers to international nurses. We are also working to secure the employment of over 100 nursing students from University of Hertfordshire who will be graduating this summer. We implemented and are advertising a relocation payment for all nurses, AHPs, medical staff and psychologists together with a Welcome Payment for those in specific staff groups who apply before 31 March to join particular hard to recruit to areas.

Our unplanned turnover remained the same for the third month in a row at 12.82% in February, which means that we maintained our net positive recruitment position, as we had 53 new starters and 49 leavers.

As part of our retention work, we continue to provide a robust health and wellbeing offer to our staff. We have seen sickness absence reduce significantly from 6.19% in January to 5.25% in February. This was mainly as a result of both absence due to COVID-19 and absence due to mental ill health reducing significantly in February. A significant amount of wellbeing support continues to be provided, including pilates, mindfulness, hypnorelaxation, DBT sessions, yoga, wellbeing talks, fitness sessions, art and craft sessions and virtual pampering sessions. During February, we collated the feedback from our Winter Wellbeing Festival which took place during January. The event was very positively received across the 37 sites visited and the 1700 staff who attended. Food trucks and coffee vans delivered free treats and goodies and the wellbeing team had individual conversations will staff about their wellbeing and how they would like us to shape the future wellbeing offer. Staff who attended described the event as a very welcome "morale boost", a "welcome break", an opportunity to "reconnect" and that they felt "listened to" and "included".

We have recruited and trained 21 Inclusion Ambassadors, who will be deployed onto all interview panels for recruitment to Band 8a and above roles from Quarter one. The Inclusion Ambassadors are members of the BAME staff network and will enhance the equality and inclusion focus during the recruitment process. The scheme was co-produced with the network and aims to improve confidence in equity and inclusion in the recruitment/promotion practices and improve representation of BAME staff in the Band 8a and above staff group. A more detailed report will be considered later on the agenda

Staff Survey

We achieved a final response rate of 50% (1788 respondents) in our 2021 annual staff survey. The final results are under embargo until 9:30 am on 30 March 2022. We also ran our Quarterly Staff Pulse Survey in January and achieved an 18.5% response rate, with overwhelming positive results: 74% of our people recommended us as a place to work; 75% said they would be happy with the standard of care we provide if a loved one needed it; 90% said that service users are our top priority; and 88% said that the Trust supports their health and wellbeing.

Once the national staff survey embargo is lifted, we will engage with all our staff to celebrate what they have achieved together and co-produce action plans to address areas for further development identified in both the annual and the quarterly surveys.

Finance 2021/22

The Trust is on plan to deliver a breakeven financial position at 31 March 2022, in line with the revised Financial Plan. Further detail will be provided in the Finance paper on today's agenda. Given the national regime and funding arrangements in 2022/23, the financial environment will become more challenging, this is reflected in the Financial Plan paper also on today's agenda.

Planning 2022-23

The Trust has been considering its priorities for 2022/23. The development of the Trust Annual Plan has been informed by the national and local priorities in the different health and care systems that the Trust operates in. These include the NHS England Delivery Plan for mental health for 2022/23, the national NHS learning disability priorities, work in our local system such as the current consultations on developing new Mental Health and Dementia strategies for Hertfordshire and the refresh of the Hertfordshire Learning Disability 'Big Plan'. Development of the draft Plan has been informed by engagement with users and carers through the Service User Council and the Carers Council, and workshops with Experts by Experience. In the coming year we are looking to

Alongside the development of this Trust internal plan, we are contributing to the development of overarching system plans for 2022/23 and in particular working with the Hertfordshire Mental Health, Learning Disability and Autism Collaborative to align our strategic direction of travel in Hertfordshire with that of the Collaborative. Contract discussions with our commissioners are also taking place at the same time.

Negotiations with commissioners are ongoing and are expected to conclude in April 2022. The discussions have focused on the increased demand an acuity the Trust is experiencing the addition income needed to ensure the Trust continues to provide high quality care.

Executive Team

Paul Woods, Interim Executive Director of Strategy and Partnerships is leaving the Trust at the end of March 2022. David Evans will be starting in post as the substantive Executive Director, Strategy and Partnerships on 1 May 2022.

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:** 8
Subject:	Covid-19 and Incident Command	**For Publication:** Yes
Author:	Sam Garrett, Financial Controller	**Approved by:** Fiona McMillan-Shields, Managing Director E&N SBU
Presented by:	Sandra Brookes, Executive Director for Service Delivery and Experience	

Purpose of the report:

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

Action required:

The Trust Board is asked to receive and note this report.

Summary and recommendations to the Board:

Introduction

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-19 infections and suspected or confirmed cases are managed effectively 7 days a week. It also provides an update on the approach the Trust has been taking to manage surges in activity and demand, and high levels of staff absence.

Incident Command continues to be managed across 7 days a week from 08:00 – 20:00, with daily SitReps completed and attendance at the daily system calls by Strategic Commanders. Tactical meetings have reduced to 2 days per week, Monday and Thursday, as approved by Strategic Command, but Operational, Tactical and Strategic Commanders remain in place daily, along with the team supporting Incident Command, to ensure that issues remain well-managed.

The focus for incident command has continued to be:

- Managing a number of outbreaks across Trust services
- Monitoring of winter pressures when necessary
- Maintenance of flow and the lack of available beds across the estate
- Continuing to ensure staffing is maintained at safe levels across the Trust.

Summary

There have been a number of COVID-19 outbreaks across Trust services and, as at 17th March 2022, there are 9 being actively managed at Logandene, Astley Court, Albany Lodge, Lambourn Grove, Beech Ward, Lexden, Broadlands, Kao Park, and Victoria Court.

Positive inpatient service has reduced to 19 as at 17th March and have reduced further in the week since to 11.

On 17th March 86 staff were confirmed positive with COVID-19, including 25 within inpatient services. All absence including annual leave is just under 21% with high levels of annual leave in addition to Covid absence and high levels of other sickness absence; excluding annual leave absence is 6.5%.

These pressures within HPFT do mirror those within the wider system, with cases across the East of England increasing reportedly by as much as 70%, and with a peak expected in 2-3 weeks' time, and high levels of reinfections. Local system Acute Trusts report high levels of Covid-19 admissions, many with this as their primary reason for being in hospital, and despite cohorting a number of beds having to be temporarily closed; ITU usage remains relatively low however with people unwell enough to need hospital treatment but not intensive care.

Nationally a similar pattern is reported and the Incident remains at Level 4 and therefore HPFT's Incident Command structure will stay at current level for now.

For HPFT there was a peak around December and January with reductions from end of January and through February and early March. Positive cases for both staff and service users started to increase in the 2nd week of March and whilst they have declined since, are still at February levels now. This combined with additional annual leave being taken due to the end of the leave year, and upcoming April school holidays, are putting additional pressure on staffing levels. Plans are being put in place to manage this including an escalation process for agreeing additional staff if needed.

Recommendation
The Trust Board is recommended to note the update provided within this report.

Relationship with the Annual Plan & Assurance Framework:

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 Implications for Finance, Staffing, IT and Legal

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

Individual risk assessments of BAME staff

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

None

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

Executive Team 23 March 2022

Incident Command Update

17th March 2022

1. Introduction

1.1 This report will focus on the management of Incident Command and the actions the Trust has taken to address and manage staff shortages, Covid-19 outbreaks, the issues that have arisen a result of the most recent surge of Covid-19, and the impact on the Trust.

2. Current Status of Incident

2.1 The NHS response to Covid-19 continues to be managed as a Level 4 incident, however SRG and HETCG have stepped back activity to bi-weekly. Within the Hertfordshire Integrated Care System there remains significant challenges across all sectors and providers given current issues with bed flow and unavailability of sufficient beds.

2.2 For the country in general the government announcement has stepped back restrictions including the ending of general mandatory isolation and widespread free testing due to end. This does not result in immediate changes for the NHS and as such this was clarified via various communications to all staff. A document published in February: "Living with Covid-19 White Paper – Update" details the remaining requirements for staff who test positive, that regular testing and reporting continues for staff, and that IPC requirements remain (including mask-wearing in healthcare settings). Further information is still awaited regarding staff access to testing from April.

2.3 A further paper was published in March: "*Visiting healthcare inpatient settings while COVID-19 is in general circulation: principles".* The majority of the text is unchanged but aspects which have been amended include an emphasis on the importance of visitors for service users' wellbeing, visiting being accommodated for at least one hour per day, two visitors per bedside, and the application of the guidance to outpatient settings. Implications for HPFT are being worked through by the IPC team, are going to CPAC, and HPFT guidance will then be amended if necessary once fed back next week.

2.4 HETCG has continued to meet fortnightly; the national update this week highlights increasing numbers of cases across the country and specifically in the East of England. The national case rate as measured by Test and Trace has increased by 60% in the last week with East of England growing by 70%. Hospital admissions are also expected to increase though the position for critical care remains manageable currently.

3. Trust Incident Response Structures

3.1 The Incident Command approach continues to focus on prioritising maintaining safe, effective, and timely care; the oversight of outbreaks of Covid-19 across in-patient areas and safer staffing being the key issues to address.

3.2 The Trust's Covid-19 incident response continues to be managed from 08:00 – 20:00 as per NHS level 4 requirements (confirmed this week as continuing for the time being), and this is planned to continue for as long as the current surge continues. Formal Tactical Command meetings are twice weekly Monday/Thursday, with a full response team remaining in place including duty Tactical Commander 7 days a week 08:00 – 20:00.

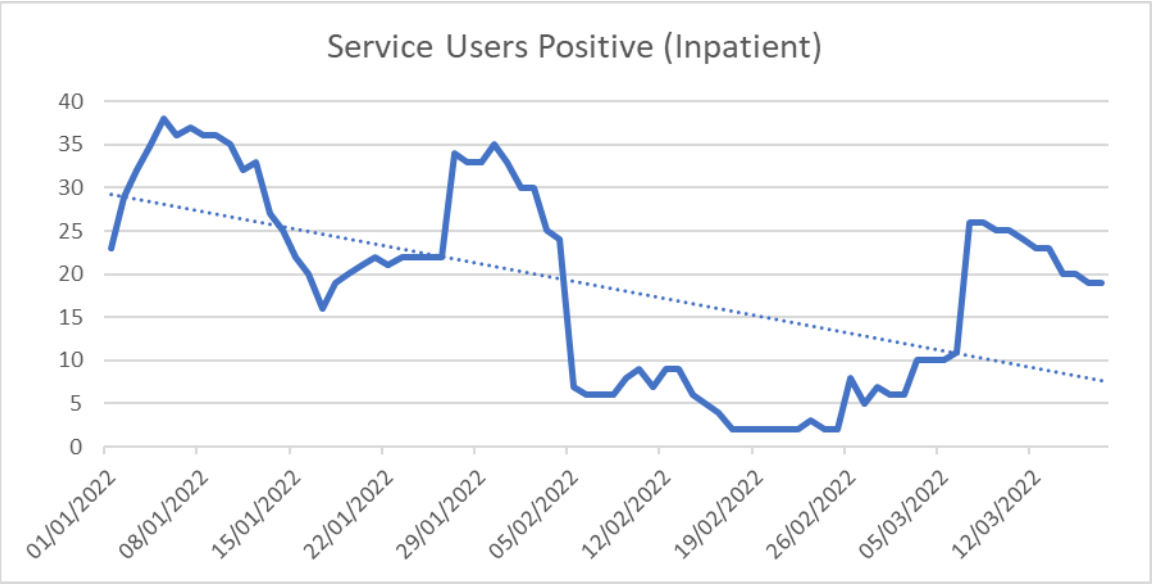
3.3 The Trust Incident Command framework and agenda has continued to focus on:

- Oversight & daily review of bed capacity, predicted discharges, those awaiting admission in the Lister, Watford, or Princess Alexandra Hospital Emergency Departments or the community, use of Section 136, and Out of Area beds.
- Monitoring of staffing levels and implementation of contingency plans to ensure safe levels of staffing.
- System pressures, forecasting of Covid-19 infection rates and any requests for Mutual Aid.
- Agenda is focused on Incident management and not on business as usual activities, though clearly at times there is an overlap.

4. Covid-19

4.1 On 17th March there are 19 Covid-19 positive service users within inpatient settings, a decrease on last week's 25 individuals, showing that outbreaks have been managed. This will be monitored closely over the coming week.

Figure 1 Positive service user inpatient cases



4.2 On 17th March there are 9 “active” Covid-19 outbreaks at Albany Lodge, Lambourn Grove, The Marlowes, Beech Ward, Lexden, Kao Park, Broadlands, The Colonnades, and Logandene, which is an increasing number this week. Outbreaks continue to be managed with senior nursing oversight and (where still necessary) daily Outbreak Control Team (OCT) meetings attended by system partners, and daily SitRep returns made nationally.

4.3 The approach to admissions and transfers to wards with an outbreak remains in place to support bed flow where needed; this requires Senior Nurse oversight and sign-off by Tactical and Strategic Commanders.

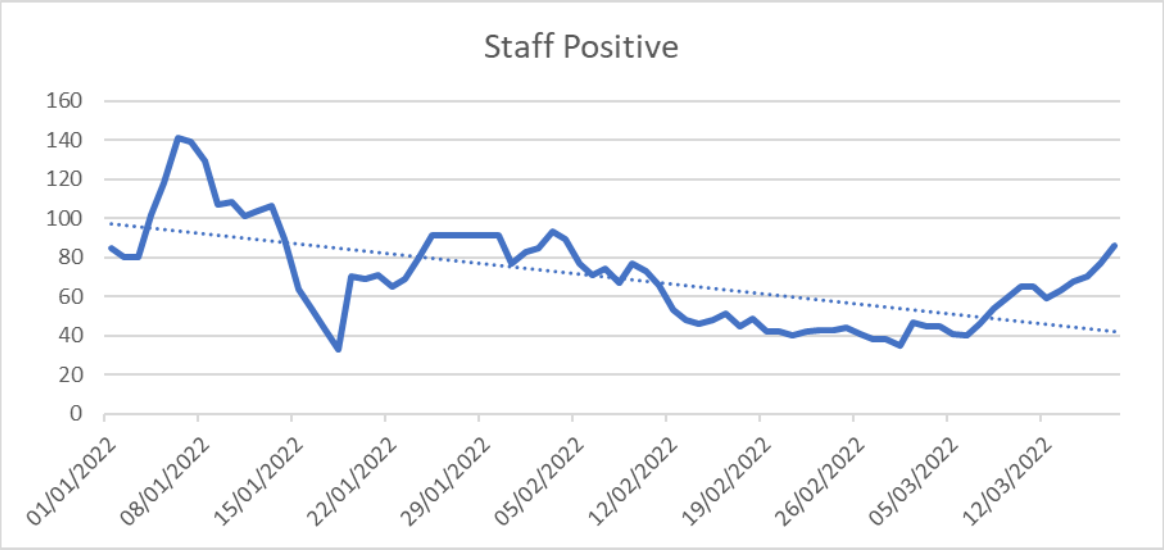
4.4 As noted above there has been an increase in cases with a 70% increase in the East of England, thought due to be increased transmissibility and rate of reinfections.

4.5 Covid-19 related service user deaths have sadly increased to 223 this week. 3 individuals have passed away, 1 in the community with Covid as cause of death, 1 having tested positive in a care home within 28 days of his death, and 1 with Covid pneumonitis as cause of death.

5. Safe and Effective and Timely Care Delivery

5.1 Staff positive cases have also increased significantly this week with 86 on 17th March (65 last week).

Figure 2 staff positive cases

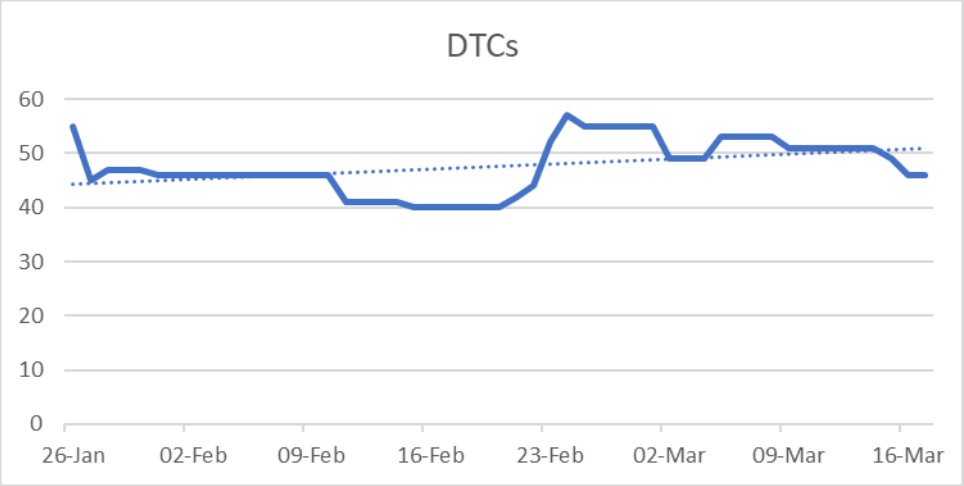


5.2 Staffing levels have remained challenging and daily operational intervention continues to be required to ensure safe staffing and each clinical area has a clear plan for deployment of staff, including contact details, registration, and training details, should this be necessary.

5.3 During this week whilst staffing has remains challenged particularly for inpatient, this has appeared to be within current "normal" parameters. There does remain an underlying position of staff vacancies with key current covid absence tipping them into a more vulnerable position. All have detailed response/action plans to support improvements and address underlying issues.

5.4 All absence including annual leave all sickness & non-working isolation is 21%, an increase on last week and the highest since the February half term holiday which had high levels of annual leave; in addition to Covid reasons increasing, non-Covid sickness has increased. Covid only absence is at 6.5% again an increase on last week which was just under 6%.

5.5 Delayed Transfers of care are being tracked daily to ensure timely escalations are actioned, these have reduced from 51 last week to 46 as at 17th March.



6 Vaccination programme and Vaccination as a Condition of Employment (VCOD)

6.1 The mandatory vaccination is going through parliamentary process and consultation and there will be a debate in parliament to consider the legislation. Every trust has been instructed to take no further action at this time and not to start dismissing or issuing notice to unvaccinated staff. Request for vaccination remains in place for new staff being recruited to HPFT.

7. Winter planning

7.1 Operational Command and Managing Directors are continuing to undertake regular review of the need to confirm any activation of Business Continuity Plans

with no services requiring escalating over the past week, and no further bad weather expected at this point.

8. People

8.1 LFD Testing continues to fluctuate with latest frontline staff averaging at 30%; no significant improvement from last week despite having focused on this during this week's meetings. It is likely that the uncertainty around having to pay for testing (even though this is not expected to apply to NHS staff) has impacted this.

Figure 3 staff tested twice SBU percentage

SBU	% Compliance
367 Corporate Support Services	**28.74%**
367 SBU Essex and IAPTS	**50.00%**
367 SBU Learning Disability and Forensic	**36.09%**
367 SBU MH East and North Herts	**30.92%**
367 SBU MH West Herts	**21.32%**
Trust Total – 30.44%	

9. Infrastructure and Enablers

9.1 Work is progressing to agree the conditions to support safe return of the workforce to enable and prioritise clinical face to face activity, improve morale, and staff support. Risk assessments for buildings are largely now complete with a final deadline next week at which point any issues will be reported back.

9.2 There was no further communication regarding a potential cyber attack however assurance had been given that SBU plans and back-ups were in place including working satellite phones.

9.3 The Trust has confirmed that it has no contracts with either Russia or Belarus nor any exposure to products from those countries, with the small potential exception of use of NHS Supply Chain which states it has only 1 out of many thousands of projects originating from Russia.

10. System and Partnership

10.1 The pressures noted above within HPFT do mirror those within the wider system, with cases across the East of England increasing reportedly by as much as 70%; a peak expected in 2-3 weeks' time; and high levels of reinfections. At HETCG local system Acute Trusts reported high levels of Covid-19 admissions, many with this as their primary reason for being in hospital, and despite cohorting a number of beds having to be temporarily closed; ITU usage remains relatively low however with people unwell

enough to need hospital treatment but not intensive caring HETCG is due to meet next week.

11. Communications

11.1 There has been a general reminder to all staff this week that Covid vaccination is still available and is recommended for all staff. Appropriate communications will be issued once visiting guidance has been updated and issued.

12. Reflection on Key Risks

12.1 Key risks currently relate to the assessment of risk and actions and protocols needed to mitigate the return of staff to routinely working from Trust sites, with a plan to collate updated risk assessments relating to this next week. Incident Command will continue to monitor risks and escalate to Strategic any significant increasing concerns in these areas.

12.2 Numbers of positive staff and service users, and numbers of outbreaks, have increased this week; progress will be monitored closely next week and planning will start for the Easter holidays to ensure sufficient staff remain available.

12.3 Although nothing was forthcoming last week the risk of a cyber attack is ever present and clearly a potentially more significant issue at the present time in the view of the conflict in the Ukraine. However, the Trust is well-prepared. There was also no risk for HPFT in terms of contractual arrangements with Russia.

13. Recommendation

13.1 The Trust Board is recommended to note the update provided within this report.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:** 9
Subject:	Integrated Governance Committee Report: 20 January 2022	**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 17 March 2022.

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 17 March 2022 is outlined in the body of the report.

Recommendation:

To receive and note the report.

To note that the Trust Risk Register and Board Assurance Framework are recommended for approval by the Board following consideration at the Committee.

To note that the Committee approved the updated Risk Management Strategy.

Relationship with the Business Plan & Assurance Framework:

Strategic Priorities 1, 2, 3, 4 and 5. and associated Board Assurance Framework principal 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 17 March 2022. In accordance with its terms of reference and was quorate.

2. Deep Dive – Staff Survey

The Committee received a detailed presentation on how the results of the national staff survey undertaken in 2021. It was noted that the results were embargoed until 31 March 2022. It was noted that overall staff survey results were positive.

The Committee discussed these areas in detail, including the action already completed or planned to improve the experience for our staff. The Committee noted the actions identified by the Senior Leadership team and commitment to co-production with staff to focus on the areas that need improvement.

In response to Jon Walmsley's question, Louise Thomas confirmed that the Trust response rate was in line with 2020 and other similar trusts. It was noted that the May Committee would receive an update on the action plan.

3. Quality and Safety

3.1 CQC Update- Forest House

The Committee was updated on the CQC focused inspection of Forest House Assessment Unit (FHAU). The report set out that the inspection process focused particularly on the safety and the Well-led KLOEs and that the service line (Child and Adolescent Mental Health Wards - CAMHS) would be rated following the inspection.

The report set out that the CQC had completed two unannounced visits to FHAU met with young people and their families/carers currently receiving care and treatment at FHAU and staff members. The Trust has also submitted information as requested by the CQC as part of the process, including data regarding complaints, incidents, recruitment and retention, supervision and appraisals, sickness absence, staff meetings, and meetings with young people.

The Trust also provided the CQC with the unit's Service Improvement Action Plan, detailing key actions taken to date and currently being implemented. The Committee noted the actions that had already been taken by the Trust and recent correspondence from the CQC. The Committee noted the Board would have an in-depth discussion at its meeting in March 2022, including an update on the Service Improvement Plan and the communication from CQC.

The Committee was updated that the Trust received the draft Inspection Report, and a Factual Accuracy process has been followed and submitted to the CQC by the Trust.

In response to Tim Bryson's question, it was reported that the Quality and Risk management Committee was providing assurance on the Service Improvement plan. It was agreed that the next Committee would receive an update on the progress against the headlines of the Plan.

3.2 COVID-19 Update

The Committee considered a report that provided a summary of the management of the incident, noting that the Incident Command structures were still in place. It was noted that the NHS remained at level 4 alert status.

They have also updated Trust's response to the pandemic noting the impact on staff availability, the number of outbreaks and the issues that have arisen due to the latest surge of the virus. The Committee noted the current position concerning outbreaks and the levels of positive cases amongst community Service Users and staff.

It was noted that the mandatory vaccination requirement had ceased at the end of February 2022.

In response to Kush Kanodia's question, Sarah Damms set out that each service user had an individual risk assessment to weigh up the person's physical and mental health needs. That the Trust would make reasonable adjustments as required. It was confirmed that when the fourth booster was available, the Trust would support a vaccination programme for staff and service users.

3.3 Quarter Three Integrated Safety Report

The Committee considered a full quarter three report that provided detailed information on safety, including trends, themes and actions taken in response to identified learning for quarter three.

The report set out the number of incidents reported in the quarter and how it compared to quarter two and the same quarter in 2020/21. It also set out that the highest number of incidents were categorised as Violence and Aggression, and there had been a decrease in the number of incidents of self-harm.

The Committee considered the information provided concerning Serious Incidents, deaths and never events. It was noted that there had been an increase in the number of incidents reported in the quarter compared to the previous quarter but a reduction in incidents resulting in moderate or severe harm. It was noted that there had been no Never Events and no Prevention of Future Death reports issued by HM Coroners to the Trust.

The report detailed that there had been a reduction in reported ligature incidents. Thematic analysis of AWOLS showed the majority related to a failure to return from Section 17 leave, resulting in no harm and service users running away from staff whilst on escorted leave.

In response to Jon Walmsley's question, Asif Zia set out the staff received regular updates on Mental Health Act requirements to ensure they followed best practice.

3.4 Update on Quality Priorities and Strategy

The Committee received a presentation on the Quality Strategy aligned with the quality priority areas. The Committee noted that the strategy was focused on the three domains of safety, experience, and effectiveness. Each of them had three objectives that specifically detailed the Trust's key priorities.

The Committee was updated on the work underway to support the delivery of the priorities, such as Simulation Hub, Serious Incident reviews, and Research strategy.

It was noted that the Quality Strategy was halfway through its original lifetime, but the Committee commented that all of the priority areas remained appropriate. It was also noted that many work areas of the Trust contributed to the delivery of the Strategy priorities.

The Committee noted the importance of considering the wider determinants of health and the need for a holistic approach to service user needs.

3.5 Update on actions following deep dive into suspected suicides
The Committee received a detailed presentation of the deep dive into a number of unexpected deaths in Northwest Herts Adult Crisis and Community Services. The Committee noted the themes identified. The Committee was updated on the comprehensive range of actions being taken, such as urgent clinical review of cases, risk management training, recruitment to the teams, and senior leadership oversight.

The Committee was assured by the close monitoring in place and senior leadership being provided by the Executive Team. The Committee emphasised the importance of the involvement of carers and families and noted the work underway to re-establish local support groups.

4. Quality – Effectiveness

4.1 Bi-annual Physical Health Report
The Committee received a report that provided an update on the physical health work of the Trust, particularly to support those with a Learning Disability. It was noted that the Trust is committed to optimising the physical health of service users and that the Trust has invested in physical health, funding new roles and utilising technology to enhance physical health care.

The Committee noted that a number of staff had recently been recruited to the team. It was reported that the Trust was also looking at new roles to support the physical health offer.

4.2 Quality Impact Assessment (QIA) Update
The Committee received an on the QIAs undertaken in the year to date. It was noted that the Delivering Value policy is being updated, including the QIA element. The Committee was informed that the revised policy would require project Leads to identify if a QIA is required when completing a project initiation document (PID). The levels of sign off were also set out in the report.

The monitoring on the impact the scheme will have on quality will be developed and entered onto the Trusts Quality Dashboard (on SPIKE), which will enable the Delivering Value Group to monitor trends and ensure that the schemes are delivering on its desired expectations. This will be a new process that will provide more transparency across the organisation.

5. People

5.1 People and OD Report

The Committee considered a report on the Trust's performance against the key people and organisational development metrics and activity as set out in the Annual Plan, noting that the report sets out the position at month 10. The committee also received an update on the position for month 11.

The Committee considered the information on the detailed workforce metrics, including vacancy rates, recognising the professions which are areas of particular concern. The Committee also discussed the unplanned turnover rates, noting the top reasons for leaving and the stabilisation of the figures over the last three months. The Committee was updated on the actions in place to improve the position were discussed, including the Retention Pathfinder project, which commenced in December, recruitment incentives in place

The Committee noted the feedback from the Winter wellbeing festival to support staff wellbeing. The Committee noted the improvement in the sickness rate for February. In response to a question, it was noted that the Trust had a strong offer to staff to support wellbeing and the staff survey results evidenced this.

It was agreed that the next Committee meeting would receive an update on workforce planning.

5.2 Freedom to Speak up Guardian Report

The Committee considered the data on the number of concerns received to date for the quarter, noting a significantly smaller number pro-rata than the previous quarter.

The Committee was updated that following a competitive recruitment process, Yusuf Aumeerally has been appointed to the substantive, full-time post of Lead Freedom to Speak Up Guardian (FtSUG).

The Committee considered the report that set out the concerns received in the quarter to date, but it was difficult to identify themes due to the small number. It was noted that those raised in quarter four none had been anonymous.

The Committee was updated on the recruitment of FtSU Champions and the number of staff who have indicated they are interested in the role, noting they were from a range of services. They have all been offered training and development sessions, over half of them have attended.

6. Governance

6.1 Trust Risk Register

The Committee received a presentation on the updated Trust Risk Register (TRR). The Committee considered each of the updated seven risks, noting two new additions relating to Cybersecurity and Insufficient inpatient beds. The Committee reviewed the current and target risk scoring.

It was noted that the TRR identifies the high-level risks facing the organisation and that it is a dynamic document that is kept under regular review.

It was reported to support the review of the TRR, each Director has reviewed the risks that they are Senior Responsible Officer for. It was noted that the next steps were to finalise the mitigations and for the TTR to be considered at the next Board meeting.

The Committee supported the risks as described, confirming that they were an accurate reflection of the highest-scoring risks for the Trust. The Committee confirmed that they agreed with the scoring as described. The Committee agreed the risks recommending them for approval by the Board.

The current geopolitical situation was discussed, and the need to keep this under review in terms of the risk it may pose to the Trust being able to deliver services.

6.2 Board Assurance Framework

The Committee received an update on the Risk Management and Board Assurance Framework internal audit report for 2021/22. It was noted that the audit had provided substantial assurance, the highest level possible.

The Committee received an update on the revised Board Assurance Framework (BAF)that was in line with the Annual Plan for 21/22. The report provided an update on the latest iteration of the BAF. The updated version includes updated controls and lines of assurance together with the most recent dates for the assurance evidence. The new actions and additional sources of assurances relating to the internal audit reports for 2021/22 had also been included. It was noted that the actions plans for Warren Court and Forest House were new actions in the BAF.

The Board Assurance Framework was approved for recommendation to the Board to approve. It was noted that a significant amount of work is underway to support the risk management framework.

6.3 Policy Compliance Report

The Committee considered a report that set out the management, oversight and governance of procedural documents. The Committee noted the percentage of procedural reviewed and were in date noting the slight decrease in compliance since the end of quarter three.

The Committee was updated on the actions that have taken place to improve the compliance level, which include all authors and their direct line managers whose procedural documents have expired have been contacted directly to expedite the review and ratification and asking that they ensure there is mitigation in place to manage any risks.

It was noted that the QRMC at its meetings in May and July 2022 will require an update on compliance and will monitor the trajectory and drill down into the barriers to the reviews being completed. An update will also be provided to the IGC at the next meeting.

6.4 Quality Accounts Indicators

The Committee was updated on the Trust's current guidance concerning the production of a Quality Report. The Quality reports include information on the

Quality of services delivered to our SU's and the Quality indicators chosen as important clinical measures.

The Committee was informed that there had been a review of the measures noting the need for the Trust to restore and reset how it was delivering against some of them but also to reshape services to ensure we are meeting service users' needs

It was noted that NHS improvement had not informed NHS providers of any forthcoming mandatory indicators for 2022/2023. So in the absence of this, the Trust had identified its own areas of focus and was undertaking consultation before finalising the indicators. It was noted that the Council of Governors had been updated on the possible areas and had been asked to vote on their preferred indicators.

Tim Bryson reflected that the proposed list covered a number of services but that the Trust might want to consider including one for older people services.

6.5 Risk Management Strategy

The Committee considered the updated Risk Management Strategy. It was noted that it had been reviewed and updated to ensure it clearly set out the Trust's framework for leading, directing and controlling the risks to its key functions. To enable this, it purposefully seeks to separate risk management strategy from risk management policy.

The Committee noted that Risk Management is an integral part of HPFT's management activity and is fundamental to delivering and embedding high quality, safe and sustainable services for the people we serve, to supporting good governance, is central to delivery of the Trust's Good to Great strategy and strategic and operational management.

It was noted that following approval of the strategy, the Risk Management Policy will be reviewed and amended to ensure it is in line with the strategic approach.

The Committee approved the revised Risk Management Strategy.

7. Items to Note

The Committee received the following reports to note. All papers were distributed in the pack, and questions were invited from Committee members.

7.1 Quality, Risk Management Committee (QRMC)

The Committee received a report from the QRMC, which had met on 4 March 2022. The report detailed the areas considered. In response to Jon Walmsley's question, it was confirmed that the demand for SPA services was being discussed with commissioners.

There were no matters for escalation to the IGC.

7.2 People and OD Group

The meeting noted the report from the People and OD Group meetings held on 10 February 20220 and 2 March 2022.

There were no matters for escalation to the IGC.

7.3 Information Management and Governance Subcommittee (IMGS)
The Committee noted a report from the Information Management and Governance Sub-committee, which held its last meeting on 3 March 2022.

There were no matters for escalation to the IGC.

7.4 Committee Planner
The Committee noted the updated planner.

8. Items for Escalation

It was noted that there were no formal items for escalation to the Board.

Board asked to:

- note that the Trust Risk Register and Board Assurance Framework are recommended for approval by the Board following consideration at the Committee.
- note that the Committee approved the updated Risk Management Strategy.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	31 March 2022	**Agenda Item:** 9a
Subject:	Quarter 3 2021/22 Integrated Safety Report	**For Publication:**
Authors:	John Fanning Head of Safety Nikki Wilmott, Head of Safer Care and Standards Simon White, Practice Development and Patient Safety Team Ingrid Richardson, Head of Social Work and Safeguarding	**Approved by:** Bina Jumnoodoo Deputy Director of Nursing and Quality
Presented by:	Jacky Vincent Executive Director of 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. To consider ceasing collection of data via the Safety Thermometer.

Summary and recommendations:

There has been an increase in the number of incidents reported this quarter 3 compared to the previous quarter but a reduction in incidents resulting in moderate or severe harm.
There have been no Never Events and no Prevention of Future Death reports issued by HM Coroners to the Trust

The Trust reported 35 Serious Incidents externally this quarter. This was a decrease of 3, when compared to the previous quarter. There was also a decrease (7) in self-harm incidents, and a decrease (1) in unexpected deaths and an increase (2) in violence and aggression incidents reported as Serious Incidents and subject to investigations this quarter.

There was a 61% reduction of reported ligature incidents this quarter compared to the previous quarter, however an increase of 1 for incidents involving anchor points from 3 in quarter 2 to 4 in quarter 3.

There was an increase in the number of AWOLs and Missing Person incidents this quarter from 25 in quarter 2 to 35 in quarter 3 but still significantly lower than a peak 85 reported in quarter 3 2018/19. Thematic analysis shows the majority of the AWOLs relate to a failure to return from Section 17 leave, resulting in no harm and service users running away from staff whilst on escorted leave. Albany Lodge continues to be the highest reporter of AWOLs and the proximity of Albany Lodge to local pubs is a factor in service users becoming intoxicated whilst on leave and failing to return.

There were 389 Service User to staff assault incidents reported this quarter, 13 of these were categorised as moderate harm.

The use of restraint was comparable to the previous quarter. 37% of physical interventions were attributed to one individual at Lexden ATU who has now been discharged to a bespoke placement.

The first four safety suites in the Trust have opened this quarter and work has commenced on building three more suites across the Trust.

The Trust is participating in a Reducing Restrictive Practice CQI project with the Eastern Academic Health Science Network.

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.
There has been a focus in improving sexual safety within our inpatient units this quarter with regular meetings and development of a sexual safety work plan.

The Board is asked to receive and discuss the report and its implications.

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 3 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 4 March 2022 IGC 17 March 2022

Quarterly Integrated Safety Report Quarter 3 2021/22

Executive Summary

The Quarter 3 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 3 increased by 2.6% when compared to the previous quarter, however the number of incidents resulting in moderate or severe harm was 2.61% of the total reported, a significant reduction from 4.41% in the same quarter in 2020/21. There have been no Never Events and no Prevention of Future Death reports issued by HM Coroners to the Trust.

The Trust reported 35 Serious Incidents externally this quarter . This was a decrease of 3, when compared to the previous quarter. There was also a decrease (7) in self-harm incidents, and a decrease (1) in unexpected deaths and an increase (2) in violence and aggression incidents reported as Serious Incidents and subject to investigations this quarter.

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 completed 52% of action plans by the action plan due date. This quarter has seen challenges in updates being provided/actions being progressed due to acuity and pressures within services including Covid pressures. Measures have been put in place to address this. In this quarter, the East and North (E&N) Strategic Business Unit (SBU) and the Safer Care Team have implemented a weekly catch-up call with SBU leads to make 'live' updates on actions taken, in response to learning. This is in addition to a weekly call with West SBU and these are the two SBUs where the highest number of SIs are reported.

The Mortality Governance Team continues to screen all deaths in the Trust and disseminate 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.

Within quarter 3 2021/22 there were 64 reported ligature incidents within inpatient services which is a 61% decrease on the previous quarter. There was a slight increase of ligature incidents involving anchor points from 3 in quarter 2 to 4 in quarter 3. Three of these involved the same service user on Robin Ward. Learning from a neighbouring Trust following a HSE

prosecution related to deaths involving ligature anchor points is being embedded and a local ligature forum has been established in the region with other Trusts.

There was an increase in the number of AWOLs and Missing Person incidents this quarter from 25 in quarter 2 to 35 in quarter 3 but still significantly lower than a peak 85 reported in quarter 3 2018/19. Thematic analysis shows the majority of the AWOLs relate to a failure to return from Section 17 leave, resulting in no harm and service users running away from staff whilst on escorted leave. Albany Lodge continues to be the highest reporter of AWOLs and the proximity of Albany Lodge to local pubs is a factor in service users becoming intoxicated whilst on leave and failing to return. Leave is an important part of discharge planning and recovery principles.

There were 389 reported assaults by service users on staff during this quarter - a 12% increase on the previous quarter. Overall, 376 (97%) service user to staff assault incidents resulted in no / low harm and 13 (3%) in moderate harm 13 of these assaults were categorised as moderate harm. The increase in assaults can be linked to a limited number of individuals involved in multiple incidents within inpatient services. 80 of the assaults were carried out by ne individual in Lexden ATU who was a delayed transfer of care awaiting a bespoke placement in the community. This service user has since been successfully discharged.

The use of physical restraint in this quarter is comparable to the previous quarter at 679. One service user within Lexden ATU accounted for 252 (37%) of the total incidents and has since been reintegrated back into the community. There were no incidents involving prone restraint this quarter.

There has been an increase of 42% in incidents requiring seclusion this quarter. 76% of seclusions occurred within the LD&F SBU with the three Learning Disability Assessment and Treatment Units being the highest reporters – 41% of total seclusions. There has been an increase in seclusion within Forest House, largely due to managing complex young people on a GAU who are awaiting low secure or PICU beds.

Increased scrutiny and the review of Long-Term Segregation (LTS) continued to be a focus during the quarter and 5 individuals were in LTS at the end of quarter 3. The first four safety suites were opened during this quarter in Dove Ward, Warren Court, 4 Bowlers Green and Astley Court. These robust safety suites will provide a much larger space for those who require seclusion and enable those who require care under the LTS framework to access outdoor space. Work has also commenced this quarter to build safety suites at Broadlands, Oak Ward and Beech Ward.

There was 1 reported pressure ulcer incident this quarter, a reduction from 7 in quarter 2. This was a category 2 pressure ulcer. There were no category 3 or 4 pressure ulcers.

The number of falls reported was 160 compared to 123 in the last quarter. Of these, there were 4 falls resulting in moderate harm and 1 resulting in severe harm.

A physical health nurse has been employed to assist in the delivery of the Trust's physical health agenda.

The Trust are participating in a Reducing Restrictive Practice Continuous Quality Improvement (CQI) project with the Eastern Academic Health Science Network and other Trusts in the region.

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 2021/22 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, the Trust Risk Register was last presented to the Integrated Governance Committee (IGC) in November 2021, there have been no changes to the risk scores.

3.2 The top 5 risks on the Trust Risk Register have an impact on safety:

Risk	Rating (Current) LxC	Owner
1. Demand: Increased number of referrals Ensuring we have sufficient capacity to respond to the increased demand on our services (including CAMHS, Eating Disorders, Adult inpatients).	16	Sandra Brookes

2. Safety: Increased acuity and complexity of presentation; increased risk of violence and aggression Ensuring safe and quality care is provided and staff are supported to manage the increase in acuity and complexity. Ensuring the management of increased emphasis on risk assessment and training, safety huddles and SWARMS Ensuring the provision of increased training and support for staff	16	Jacky Vincent
3. Winter: Increased pressure on services; demand and workforce. Managing the delivery of core and operational services through the coming winter period, including the impact of COVID and flu. Delivering a COVID booster and flu vaccination programme to staff and service users. Ensuring a robust winter plan to manage the increased demand	16	Sandra Brookes & Asif Zia
4. Workforce: Sufficient numbers and skills; staff resilience and wellbeing Recruitment and Retention - Ensuring we have the right staff, with the right skills to deliver safe care and services Providing support for staff – wellbeing support, supervision, rest and recuperation, training, and development	16	Janet Lynch
5. Mental Health Act: Increased number of Section 136 detentions Managing and reducing the number of Section 136 referrals/Length of time to admit Increasing AMPH and workforce capacity to ensure no delays	15	Sandra Brookes

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 expected to 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 is 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 and aggression will be investigated.

5 Safety Alerts

5.1 There was a total of 26 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:

- CEM/CMO/2021/020 Neutralising monoclonal antibodies (nMABs) or antivirals for non hospitalised patients with COVID-19
- CEM/CMO/2021/021 Neutralising monoclonal antibodies (nMABs) or antivirals for non hospitalised patients with COVID-19
- CEM/CMO/2021/022 Neutralising monoclonal antibodies in the treatment of COVID-19 in hospitalized patients
- NatPSA/2021/010/UKHSA The safe use of ultrasound gel to reduce infection risk.

5.3 There were 4 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/2021/021 – Inpatient Toilet Roll Dispenser Ligature Risk
- HPFT/2021/022 – Falls from Office Chairs
- HPFT/2021/023 – Alcohol Based Hand Sanitisers
- HPFT/2021/024 – Bracelets for Breaking Glass.

5.4 There is one overdue alert:

- NatPSA/2021/007/PHE Potent synthetic opioids implicated in increase in drug overdoses:
    - Action plan has been created
    - Alert was cascaded and inpatient services are compliant as Naloxone ampoules are stocked and in date in all inpatient service areas
    - Regarding community services, unable to provide the Naloxone (prefilled) syringes to the hubs or individual community areas without the appropriate training
    - CGL have offered to provide both the prefilled syringes and also online training and we are currently working with our Learning and Development team to progress with this training and, once established, Naloxone can be provided to our community services.
    - Naloxone is now in stock
    - The e learning package is now available
    - The SOP is drafted and going for ratification at DTC on 14/03/2022.
    - Alert is being requested / added to Paris.

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 18th October 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 detailing 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.
- Overdue alerts are flagged to the Executive Director, Quality and Safety (Chief Nurse).

6.3 CQC Unannounced Focused Inspection – Warren Court

- The CQC carried out an unannounced focused inspection at Warren Court following a number of whistleblows raised regarding concerns about the safety and quality of the services. The inspection was focused and the CQC did therefore not look at all Key Lines of Enquiry.
- The service was not rated at this inspection.
- The CQC findings included 7 'must dos' and 1 'should do' actions.
- Key headlines:
    - Seclusion records in accordance with the Mental Health Act (MHA) Code of Practice (CoP) – gaps were found in several sections in one record relating to care and health needs. Some detail was also lacking in records of medical reviews for episodes of seclusion
    - Feeling safe – service users with whom the CQC spoke to told them that they do not always feel safe in the service due to the level of physical assaults between service users. Due to high levels of acuity, and to support safeguarding plans, service users were often moved between houses, which they found unsettling. Also, that staff did not ensure service users had access to regular service user forum meetings
    - Duty rotas – not accurately reflecting movement of staff across the service
    - Safe and supportive observation records - records not always fully completed
    - Specialist training – not able to demonstrate that staff were in receipt of specialised training to support them in their roles
    - Team meetings – not regularly taking place
    - Staff morale – variable; staff described low morale due specifically to increased acuity, incidents of assaults on staff and difficulties with maintaining staffing levels. Some staff did not feel that senior managers were visible, or that they could raise concerns without fear of reprisal.
- The report of actions must be returned to the CQC by 2nd February 2022. The Trust is also required to inform the CQC in writing when it has taken the actions in the report and how the Trust considers that it is now meeting the standards. The CQC will then check to make sure that the Trust has taken the action to meet the standards and will report on its judgements. The Trust Board on 27 January will be briefed on the planned February submission.

6.4 CQC Unannounced Inspection – Forest House Adolescent Unit (FHAU)

- The CQC have carried out a focused inspection process at FHAU, following a number of whistleblows which raised concerns regarding the safety and quality of the services provided. The inspection process focused particularly on the Safety and the Well-led Key Lines of Enquiry (KLOE). The CQC completed two unannounced visits to FHAU, have met with young people and their families/carers currently receiving care and treatment at FHAU and also with staff members. The Trust submitted information data requested by the CQC as part of the process, which included data regarding complaints, incidents, recruitment and retention, supervision and appraisals, sickness absence, staff meetings and meetings with young people. The Trust also provided the CQC with the unit's Service Improvement Action Plan, detailing key actions taken to date and currently being implemented.

7 Conclusion

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

Part B- Incidents, including Serious Incidents

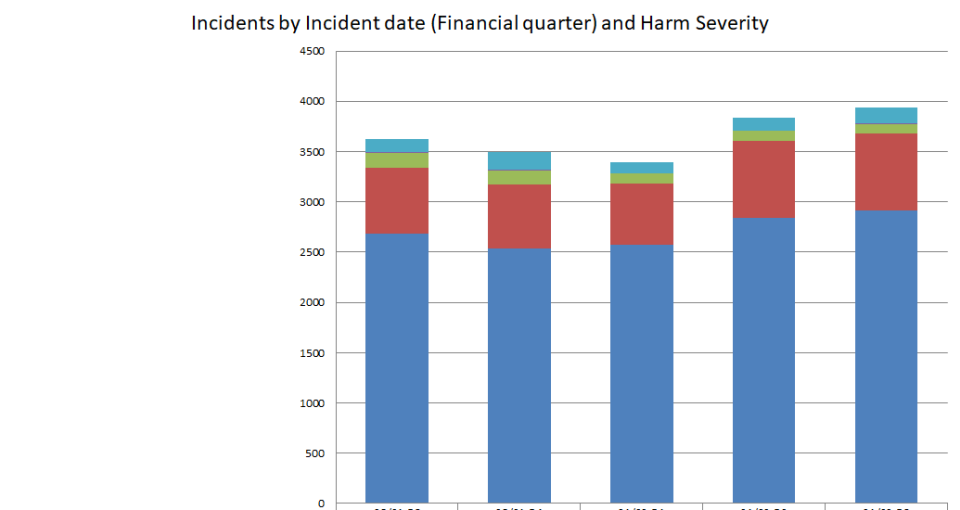
1. Introduction

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 number of incidents reported on Datix was 3,937 which is an increase of 2.6% from 3,836 reported in quarter 2. When compared to the same quarter in 2020/21, this is an increase of 8%. Fluctuation over time can be expected for example if there is high acuity on a ward or one service user accounts for several incidents reported. The number of incidents graded as *moderate* or *severe harm* was 2.61% of the total reported compared to 4.41% in quarter 3 of 2020/21 (figure 1).

2.2. In support of embedding a positive reporting culture, and the impact on safety and quality, the Trust continues to encourage timely and good quality incident reports, with actions taken such as refresher training delivered where there is a need identified. Practice Governance Leads also support reporting practice and oversight within the Strategic Business Units (SBU).



	20/21 Q3	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3
Death	127	172	111	124	154
Severe Harm (permanent/long term harm)	7	10	3	5	7
Moderate Harm (short term harm/further treatment given)	153	138	97	105	96
Low Harm (minimal harm/minor treatment given)	651	642	609	760	764
No Harm (no injury sustained/apparent)	2685	2532	2573	2842	2916

Figure 1

Never Events

2.3. The Trust had no incidents that would meet Never Events criteria in this reporting period.

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. This suspension ceased for November 2021 with the collection of October 2021 data onwards.

2.5. The following is a description of a mixed sex accommodation breach which refers to all service users in sleeping accommodation who have been admitted:

- A breach occurs at the point a service user is admitted to mixed sex accommodation outside the guidance
- Service users should not normally have to share sleeping accommodation with members of the opposite sex
- Service users should not have to share toilet or bathroom facilities with members of the opposite sex
- Service users should not have to walk through an area occupied by service users of the opposite sex to reach toilets or bathrooms; this excludes corridors
- Women only day rooms should be provided in mental health inpatient units.

2.6. There were no reported breaches in the quarter.

2.7. There was 1 near miss in December 2021 on Dove Ward when a male service user was admitted to the female wing but with ensuite rooms there was no breach. Also in December 2021, Victoria Court commenced the cohorting of service users following a COVID19 outbreak, resulting in the wings being categorised as COVID positive and COVID negative rather than male and female. As each bedroom has a toilet / sink it was determined that this did not constitute as a breach. In these cases the individuals service users care plans and risk assessments were updated as per policy.

Medicines Safety

2.8. The reporting rate for medication incidents (both internal and external to the Trust) showed a 11.6% increase to 173, when compared to the previous quarter of 155. Of the reported 148 medication incidents internal to the Trust, 141 (95%) resulted in *no harm, 3* (2%) resulted in *low harm*. 4 incidents (3%) were classified as moderate harm.

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

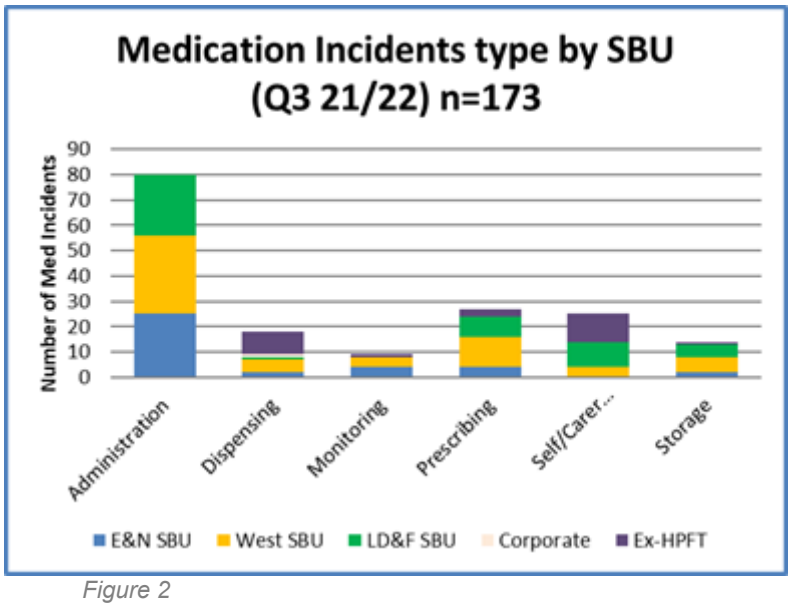


Figure 2

Serious Incidents

2.10. The Trust reported 35 SIs externally (figure 3). This was a decrease of 3, when compared to the previous quarter. There was also a decrease (7) in self-harm incidents,

and a decrease (1) in unexpected deaths and an increase (2) in violence and aggression incidents reported as Serious Incidents and subject to investigations.

StEIS Category	Q2 2021/22	Q3 2021/22
Unexpected/avoidable deaths	19	18
Apparent/actual/suspected self-inflicted harm	13	6
Disruptive/aggressive/ violent behaviour	3	5
Slip/trip/fall	0	3
Personal accident	0	1
Safeguarding Adults	0	1
Practice & Clinical Care	1	0
Sexual assault	1	0
Alleged Homicide	1	1
TOTAL	**38**	**35**

Figure 3

2.11 34 SI 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 on an exception basis.

2.12 The Trust and SBUs completed 52% of actions by the action plan due date. This quarter has seen challenges in updates being provided/actions being progressed, due to acuity and pressures within services. In this quarter, East and North SBU and the Safer Care Team have implemented a weekly catch-up call with SBU leads to make 'live' updates on actions taken in response to learning. This is in addition to a weekly call with West SBU and West SBU actions being added to Datix to give the SBU live dashboards of action updates. These are the 2 SBUs where the highest number of SIs are reported.

Duty of Candour

2.13 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 Serious Incident report continues to be shared in full with the service user, families, and HM Coroners.

2.14 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 a Serious Incident will be called. Support is provided to those completing duty of candour by the Safer Care Team as required.

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). There was a higher than average number of deaths in November (50) and December (59). 46 (78%) of deaths in the quarter (Dec) have not been screened at the time of this report

3.2 SPIKE2 includes deaths reported on the national spine. This has improved the timeliness of screening of deaths and updating of Trust systems to show a person as deceased and not open to services. This has saved time for staff by avoiding sending letters/appointments to service users who are not known to be deceased and reducing DNAs. We now have the lowest number of deceased on SPIKE. Currently the report is being extended to improving reporting of deaths for IAPT services

3.3 154 deaths were reported for Q3 (figure 4), an increase of 26 when compared to the previous quarter (128). Although fluctuations in numbers can be expected between quarters, the increased numbers of deaths cannot be attributed to suspected or confirmed COVID19 deaths. The total number of Covid 19 confirmed or suspected deaths for this period was 8. Cause of death for all deaths were not available at the time of reporting to provide a breakdown. However, the majority of the deaths screened were in the Expected Natural (EN1) category.

	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3	Total
East and North Hertfordshire SBU	78	81	111	73	87	100	530
Essex & IAPT SBU	15	12	23	12	14	14	90
Learning Disabilities & Forensic SBU	12	14	17	8	7	17	75
West Hertfordshire SBU	19	24	22	19	20	23	127
Total	**124**	**131**	**173**	**112**	**128**	**154**	**822**

Figure 4

3.4 The higher numbers of deaths were in the East and North SBU, which includes older aged adult services.

Structured Judgement Reviews

3.5 There were 21 SJRs completed in the quarter, which included deaths that occurred outside of quarter 3. The SJRs comments on care is in the context that some of the deaths occurred during a peak in the Covid-19 pandemic, and that staff would have been likely to have been working in very challenging circumstances. There were many good practice themes.

3.6 The Mortality Governance Team adopted a RAG rating methodology using a risk matrix to identify prioritise learning themes from SJRs. Three themes out of 30 were prioritised having been RAG rated red. These included:

- Life threatening poor nutrition: inadequately evaluated; not urgently escalated within the team
- Lack of involvement of service user with prescribing decisions and verifying mental capacity to participate in treatment
- Psychiatrist oversight for Clozapine monitoring: no evidence of oversight or involvement.

3.7 Details of learning themes are disseminated in governance structures within the SBUs. Medical CPD events have taken place and other training opportunities for all staff will be explored in the next quarter. Any concerns that don't meet SJR criteria are also flagged with relevant staff requiring a response back to the Mortality Governance Team

Learning Disability Mortality Review (LeDeR)

3.8 There were 23 deaths of service users known to the Trust's learning disability services reported to the national LeDeR programme which is an increase of 28% when compared to the cases reported in the previous quarter, of 18.

3.9 LeDeR has undergone a policy review and the local Integrated Care Systems (ICSs) will be responsible for ensuring reviews are undertaken and actions are implemented. The Trust will continue to notify deaths through a new web-based platform. The reviews will be undertaken by a central pool of reviewers. No learning from reviews have been received from LeDeR during this period of change.

3.10 The primary representative for the LeDeR steering group is the Deputy Director of Nursing and Partnerships, who leads on physical health for the trust. The recommendations from reviews will be taken forward through the physical health outcomes group in the learning disability and forensic strategic business unit and the physical health committee

Suicide

3.11 The number of deaths that were thought to be as a result of suicide, was 17 (figure 5). For the same reporting period last year, there were 11. These figures are before the coroner has determined whether they were suicides. 6 of the 11 deaths reported as suspected suicides in quarter 3 of 2020/21 received a suicide conclusion, and 5 deaths have not yet been to inquest.

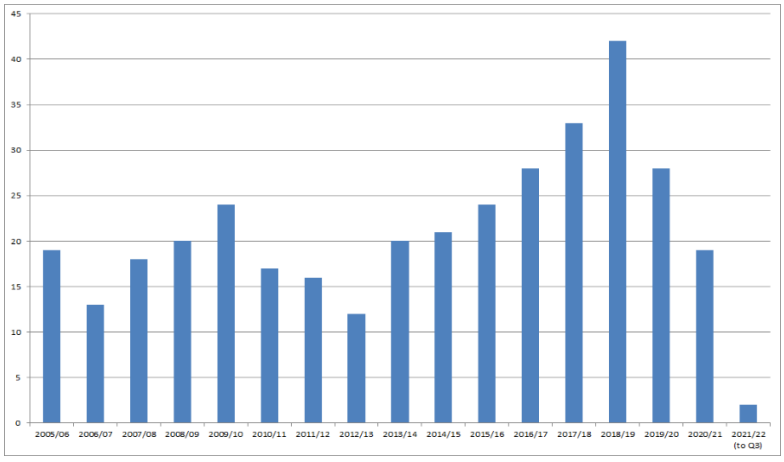


Figure 5

3.12 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 6). 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.

3.13 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, only data from 2019/20 onwards will be reported.

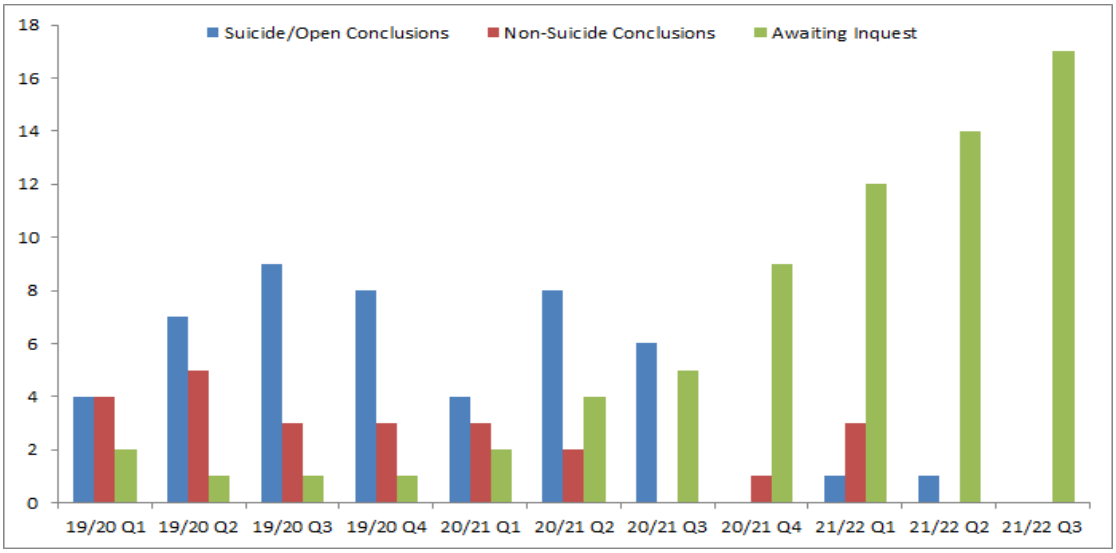


Figure 6

Prevention of Future Deaths (PFD)

3.14 The Trust reviews and shares learning from PFD reports issued by HM Coroners to other organisations. 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 to strengthen our own services and processes.

3.15 From the national publications of PFD reports in the quarter, 9 were relevant for the purposes of learning; key areas of learning included:

- The quality of the SUI investigation report
- Delays in assessment and receiving treatment
- Lack of communication with primary care and other Trusts involved in care
- Unsatisfactory risk assessments and care plans
- No appropriate formal mental capacity assessments
- Staff interpretation of intention and lack of professional curiosity
- Lack of inclusion of support workers in regular meetings about service users.

3.16 Learning from PFD reports continue to be discussed at the Safety Committee and SBU Quality Risk Meetings, for onward dissemination. PFD reports also inform the Trust and wider system partners in our suicide prevention work streams as also informs our simulation and safeguarding training.

Least restrictive care

4.1 The Trust continues aiming to provide the least restrictive practice. Restrictive practice includes restraint, seclusion, long term segregation and rapid tranquillisation. It also includes blanket restrictions.

Restraint

4.2 Figure 7 shows there has been an increase of 3 incidents in the use of physical interventions from quarter 2 2021/22 to quarter 3 2021/22. 387 of the 679 (57%) of the incidents were attributed to the three Learning Disability Assessment and Treatment Units. One service user within Lexden accounted for 252 (37%) of the total incidents, the service user has since been reintegrated back into the community in late November 2021 reducing the total incidents of restraint for December to just 2 within Lexden.

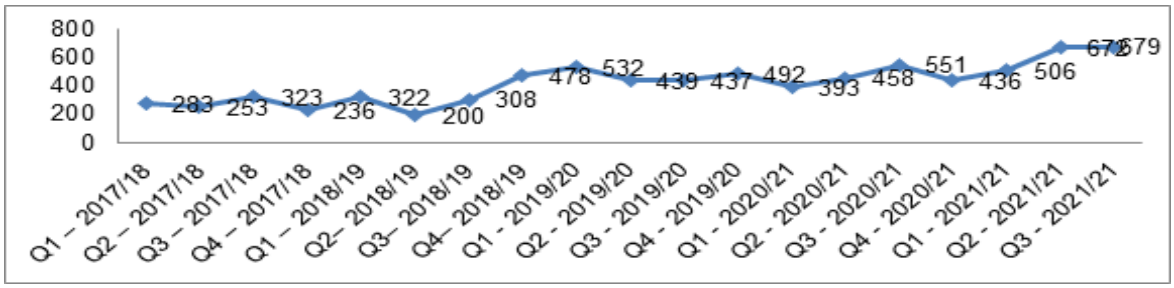


Figure 7

4.3 The pattern of higher number of restrictive practices including restraints was anticipated due to the closure of a private hospital by the CQC whereby three service users with complex challenging behaviours have been transferred into the Trust's Learning Disability Assessment and Treatment services as an emergency: two in Astley Court and one in Lexden.

4.4 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 SBU's whereby during some incidents service users have attempted/removed staff PPE.

4.5 The Trust has developed a recovery RESPECT training plan which continues to be implemented however the trajectory has been impacted on due to not all training vacancies being filled and the recent Covid-19 wave. A further 'train the trainer' course was undertaken for late November with a further 5 inhouse trainers successfully completing the course.

4.6 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.

4.7 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.

4.8 There has been a downward trend of prone restraint to quarter 4 2020/21, within quarter 3 2021/22 there were 0 incidents. (figure 8).

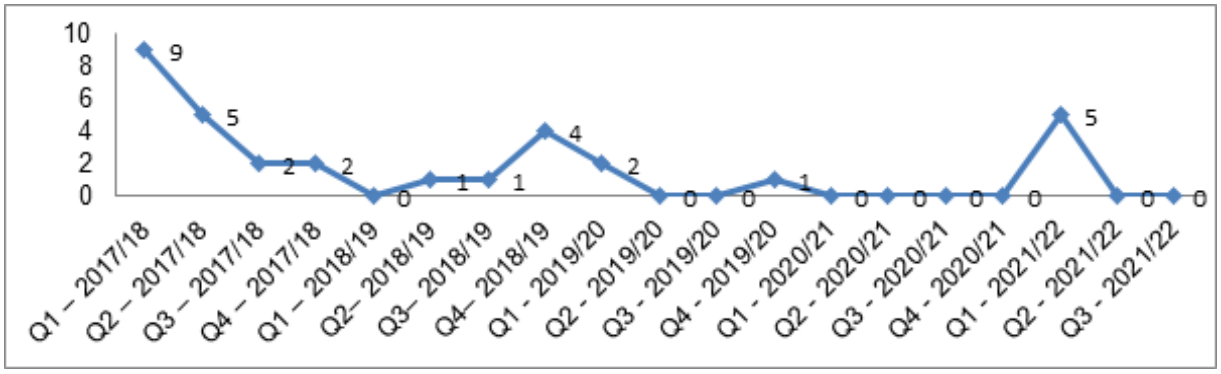


Figure 8

Seclusion

4.9 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 monthly, 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 MHA Code of Practice 2015 by the Practice Development and Patient Safety Team, with findings disseminated in the Trust.

4.10 An increase in seclusion has been reported from the previous quarter, quarter 2 2021/22 to quarter 3 2021/22 (78 to 135) which equates to a 42% increase (figure 9). 103 of the incidents (76%) where attributed to Learning Disability and Forensic services.

4.11 There were 38 service users subject to seclusion in quarter 3 2021/22 across the Trust, however within the three Learning Disability units there were 12 service users secluded who accounted for 56 (41%) of the total incidents.

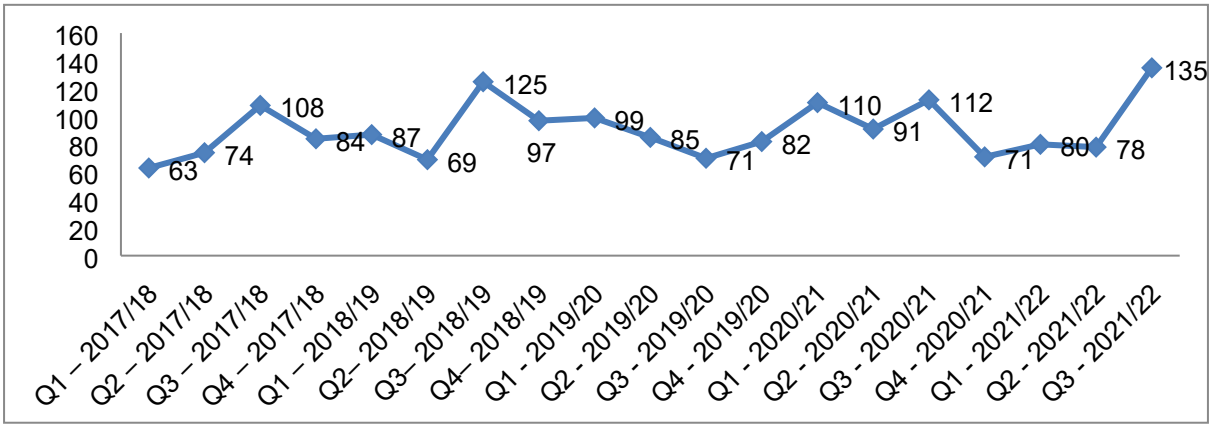


Figure 9

4.12 The mean average time spent in seclusion is 1219 minutes white is a decrease on the previous quarter, however this is excluding 1 service user who remains in seclusion at time of the report since 25/12/2021. 25 of the seclusions were in areas without a designated seclusion room these were within the Acute mental health services and FHAU, however for the purpose of reporting and ensuring safeguards are in place the Seclusion Policy was followed and where necessary following risk assessment by the MDT the service users are transferred to more suitable services.

Long term segregation

4.13 Long term segregation (LTS) refers to a situation where, in order to reduce a sustained risk of harm posed by the 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, weekly 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 user's has a regular external Independent Care and Treatment Review.

4.14 Currently there are 5 service users subject to LTS. In quarter 3 2021/22, there have been 2 new applications approved, 1 transfer from Oak Ward to Beech Ward (*) and 3 rescinded (figure 10). Additional use of the 'Barriers for Change Checklist' have been used, as part of the HOPE(S) model, with a focus on positive and proactive approaches. The HOPE(S) model is a human rights based approach to reducing Long Term Segregation. A Modern Matron from the LD&F SBU will be commencing a 3 year secondment in March as one of only 8 HOPE(S) Specialist Practitioners in England. This will be hosted by Mersey Care and he will be responsible for delivering the HOPE(S) model across HPFT and other Trusts in the region.

Unit	Section	Start Date	End Date
2 Forest Lane	3	18 02 2010	
Oak Ward*	3	12 02 2021	05 10 2021
Beech Ward*	3	05 10 2021	17 11 2021
Hathor Ward	3	21 05 2021	
Lambourne	3	09 11 2021	
A&T Lexden	3	18 06 2021	
5 Warren Court	37/41	30 09 2021	
Forest House	3	31 12 2021	11 01 2022

Rapid Tranquilisation

4.15 Rapid tranquilisation (RT) 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. There was a 41% increase in the use of RT from 49 incidents in quarter 2 2021 to 69 incidents within quarter 3 2021 (figure 11).

4.16 33/69 (48%) RT (figure 11) were within the acute mental health services, 20/69 (30%) within FHAU and 11/69 (16%) within Learning Disability and Forensic services with a singular event within Mental Health Services for Older People. The use of RT events 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).

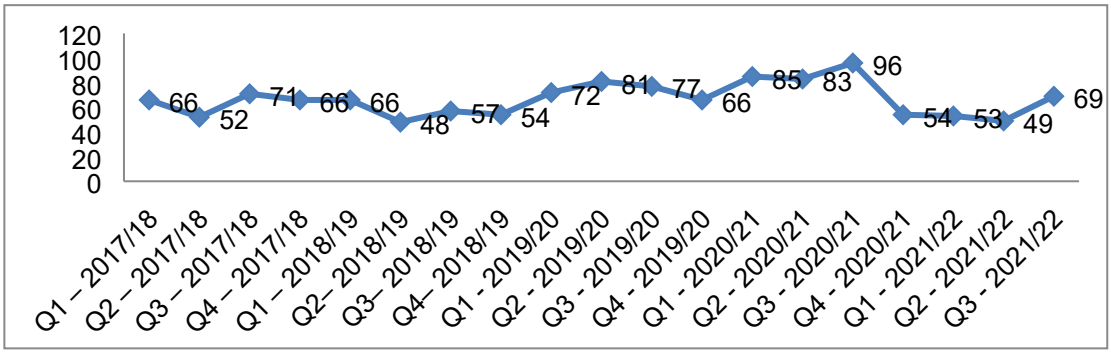


Figure 11

4.17 50% of all incidents reported within West SBU in quarter 3 were 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.

4.18 There is a difference in the use of RT 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 RT.

4.19 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.

5. Harm free mental health care

5.1 The Trust aims to provide care where service user, staff and carers do not come to harm. In order to understand this and respond ligature incidents, Absent Without Leave (AWOL) incidents and violence and aggression incidents are considered.

Ligature Incidents

5.2 Within quarter 3 2021/22 there were 64 reported ligature incidents within inpatient services which is a 61% decrease on the previous quarter of 116 (figure 12). There was an increase of 1 in the community on the previous quarter from 10 to 11 in quarter 3 2021/22. The breakdown across the SBU's; 39/64 (61%) SBU West, 5/64 (8%) SBU Learning Disability and Forensic, 5/64 (8%) Essex and 15/64 (23%) SBU East.

5.3 42/64 (66%) incidents within inpatient services involved items of clothing which is consistent with the national picture.

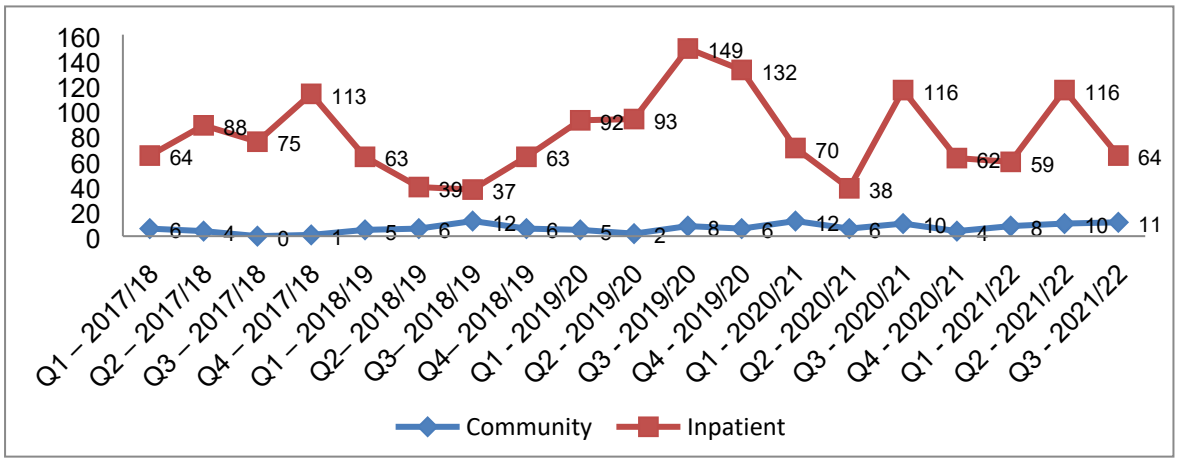


Figure 12

5.4 There were 4 reported ligature incidents involving anchor points over quarter 3 2021/22, which is an increase of 1 from the previous quarter. Three of these incidents involved the same service users using doors as an anchor point within Robin Ward and a single event involving a toilet roll holder within FHAU. 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.

AWOL and Missing Persons

5.5 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 13) however there has been an increase in quarter 3 2021/22 from 25 to 35 incidents (40% increase). Certain individual service users were involved in multiple AWOLs. Thematic analysis shows the majority of the AWOLs relate to a failure to return from Section 17 leave, resulting in no harm and service users running away from staff whilst on escorted leave. Albany Lodge continues to be the highest reporter of AWOLs and the proximity of Albany Lodge to local pubs is a factor in service users becoming intoxicated whilst on leave and failing to return. Leave is an important part of discharge planning and recovery principles. This can be expected over time due to ward acuity and some service users involved in more than one AWOL incident, during an admission.

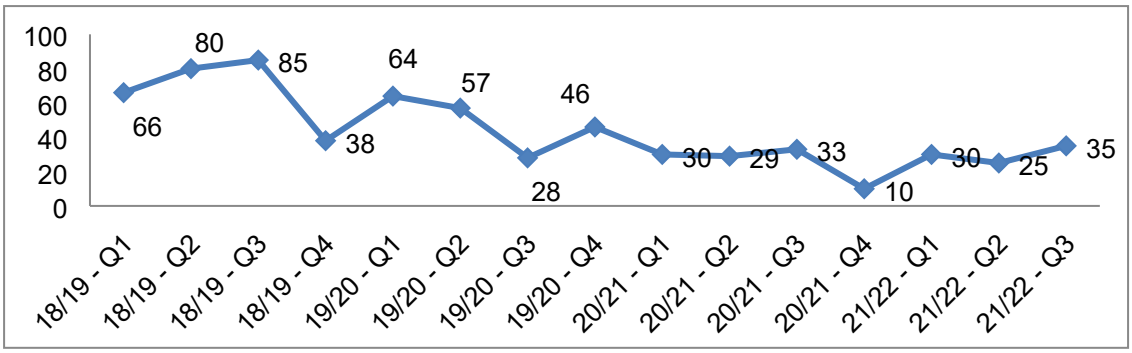


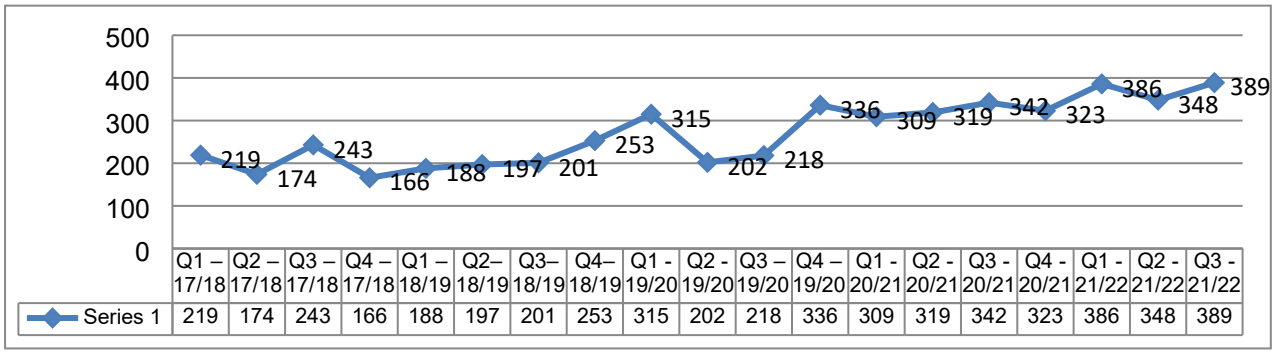
Figure 13

5.6 A significant piece of work took place in quarter 2 when the AWOL and Managed Entry and Exit practice and associated Policy (MEEP) were reviewed and updated alongside a quality impact assessment to incorporate learning and to support routine exit and entry from the ward.

Violence and aggression

Service User to Staff Assaults (Inpatients)

5.7 389 Service user to staff assault incidents have been reported within quarter 3 2021/22 which is an increase of 12% from the previous quarter (figure 14). Overall, 376 (97%) service user to staff assault incidents resulted in no / low harm and 13 (3%) in moderate harm (figure 15). 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.



	Q1 – 17/18	Q2 – 17/18	Q3 – 17/18	Q4 – 17/18	Q1 – 18/19	Q2– 18/19	Q3– 18/19	Q4– 18/19	Q1 - 19/20	Q2 - 19/20	Q3 – 19/20	Q4 – 19/20	Q1 - 20/21	Q2 - 20/21	Q3 - 20/21	Q4 - 20/21	Q1 - 21/22	Q2 - 21/22	Q3 - 21/22
Series 1	219	174	243	166	188	197	201	253	315	202	218	336	309	319	342	323	386	348	389

Figure 14

5.8 Lexden accounted for 82 (21%) of the total assaults on staff, although had no moderate or severe harm incidents. Of the incidents recorded within Lexden, one service users accounted for 98% (80/82), trust wide this figure was 21% (80/389) of the total incidents. The service users required specialised community single person accommodation and are 'delayed transfers of care', they were reintegrated into the community in late November 2021.

5.9 There were 13 moderate harm incidents involving assaults by service users on staff across SBUs: Learning Disability and Forensic, East and North and West. As part of

the reviewing process the Health and Safety Lead and the Subject matter Expert in Service in RESPECT meet monthly to explore further (Figure 15).

Quarter 3 2021/22 Service User to Staff Assaults by Harm					
SBU	**No Harm**	**Low Harm**	**Mod Harm**	**Sev Harm**	**Totals**
West	32	16	**3**	**0**	51
LD&F	58	94	**8**	**0**	160
East	49	45	**2**	**0**	96
Essex	38	44	**0**	**0**	82
Totals	177	199	**13**	**0**	389

Figure 15

5.10 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 above the mean average compared to the previous year.

Service User to Service User Assault (Inpatients)

5.11 The overall number of service user to service user assaults has decreased slightly from 105 quarter 2 2021/22 to 101 quarter 3 2021/22 (figure 16).

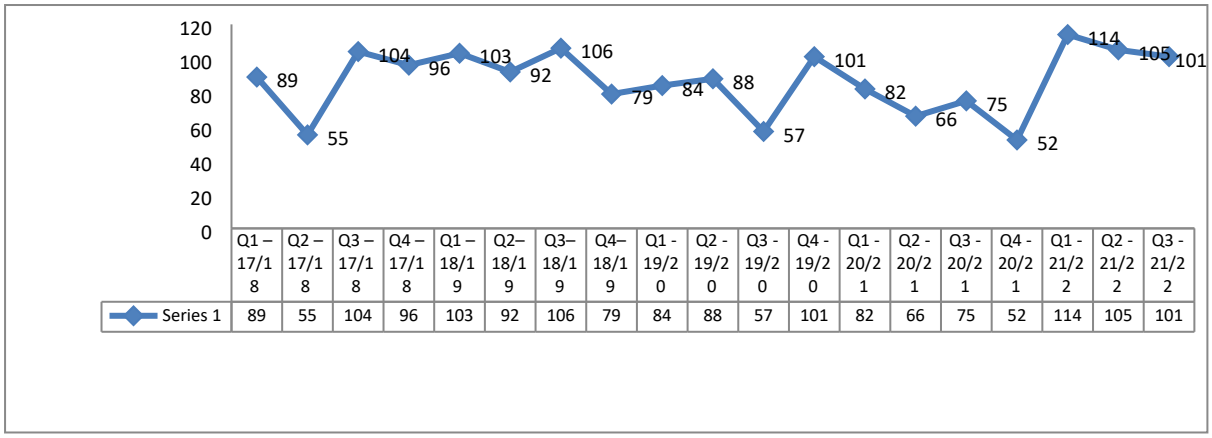


Figure 16

5.12 There has been decreases in incidents across all SBU's except West however these incidents are specifically attributed to small increases across multiple sites.

5.13 SBU Learning Disability and Forensic accounted for 37% (37/101), of the total incidents of service user to service assaults reported in quarter 3 (figure 17).

SBU	No Harm	Low Harm	Mod Harm		Sev Harm	Totals
West	15	15	**0**		**0**	30
LD&F	20	17	**0**		**0**	37
E&N	17	15	**2**		**0**	34
Essex	0	0	**0**		**0**	0
Totals	52	47	**2**		**0**	101

Figure 17

5.14 In line with the Trust's annual plan there were 2 incidents of moderate harm involving service user assaults on other service users an increase of 1 on the previous quarter. Both incidents occurred within the East & North Mental Health Services for Older People. All incidents of moderate harm are reviewed and reported through the Moderate Harm Panel to the Safety Committee.

5.15 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.

5.16 Current Respect Issues:

- 5 New Trainers successfully completed Train the Trainer course in December.
- Respect Recovery Plan agreed:
    - New training venues sourced.
    - Ongoing recruitment of further full-time trainer.
    - Training being addressed.
- Ongoing Data collection / dissemination for both internal / external review.
- Quarterly / annual restrictive practice data collated for special commissioning groups.
- Weekly safety meeting with PICU.
- LTS weekly governance / oversight.
- Task & Finish Group arranged for 'Spitting'.

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.

6.2 The Trust took the decision to continue to collect data on the Safety Thermometer parameters 'at a single point in time' in the absence of an alternative national replacement. Pressure Ulcer and falls incident data is routinely and accurately recorded on the Trust's incident Management System.

6.3 The data provided below does not represent the total number of incidents, but incidents reported at a single point in time each month from a limited number of wards.

6.4 In the quarter, data collection was impacted by the clinical / staffing demands that services experience as a result of the Omicron variant and other winter pressures.

6.5 Safety Thermometer single data:

- Pressure Ulcers - there were no recorded pressure ulcers.
- Falls – there were 3 recorded falls, 2 were no harm, 1 was low harm.
- Urinary tract infections (UTI) - there were no recorded UTIs.
- Catheters – there were 2 recorded cases where a urinary catheter was in place during the last 72 hours (3 days).
- VTE – there was 5 recorded cases of service users being at risk with VTE prophylaxis commencing.

Pressure Ulcers

6.6 There was 1 reported pressure ulcer incidents, a reduction from 7 in quarter 2. This was a category 2 pressure ulcer Category 1 and 2 pressure ulcers are not reported nationally. There were no category 3 or 4 pressure ulcers.

6.7 The Tissue Viability Nurse post remains vacant, despite being advertised, which remains a risk. This has been mitigated by the Physical Health Nurse and Matron in older aged adults using their expertise to support the tissue viability care support worker and provided teaching, advice and review of service users.

6.8 Optimisation of tissue viability and integration of pressure relief during all interactions with service users was an area of discussion at the Physical Health Conference for nurses and health care support workers in November 2021. Places on formal teaching courses from Tissue Viability Nurses at East and North Herts Trust have been sourced and a masterclass for Clinical Matrons is planned.

Service User Slips, Trips, and Falls

6.9 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 reported was 160 compared to 123 in the last quarter. Of these, there were 4 falls resulting in moderate harm and 1 resulting in severe harm.

6.10 The Trust's Falls Policy is under review by a multidisciplinary task and finish group. The scope of the policy is being broadened to cover falls risk in community services. The falls workbook developed by Buckinghamshire Learning Disability physiotherapists has been developed and shared Trust wide.

NEWS2 and Soft Measures

6.11 Recording of physiological observations has been increased to daily in all in-patient settings, twice daily in older aged adults. A repeat audit of NEWS2 charts is in progress; early results show better compliance with complete sets of observations being taken with increased frequency.

6.12 Competence in observing, recording, and acting on physiological observations is the primary focus of the physical health nurse in quarter 4.

Venous Thrombo-embolism

6.13 There were no deaths this quarter that mention VTE on the death certificate. Following 2 SIs in December 2020 and Feb 2021, involving the death of service users from pulmonary embolism, the Trust's VTE policy has been reviewed and found consistent with national guidance. A VTE briefing has been developed for junior doctors emphasising the importance of repeating assessment of VTE if the patient's condition changes. The Physical health nurse is enforcing this.

6.14 The need for a dynamic approach to VTE risk assessment has been highlighted to junior doctors and nursing staff: the need to reassess and mitigate VTE risk whenever a service user's condition or mobility changes. This was shared at the physical health conference in November and will part of the junior doctors teaching in quarter 4.

Physical Health Nurse

6.15 A Physical Health Nurse has been employed to assist in the delivery of the Trust's physical health agenda. Funding has been agreed for three further physical health nurses to deliver the physical health agenda and recruitment will commence in quarter 4.

Service Users Experience of Feeling Safe

7.1 The question "Overall, have you felt safe on the ward?" is asked on our Having Your Say Inpatient surveys. The question enables us to understand 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 us to continuously improve.

7.2 The feeling safe score Trust-wide remained at 85% compared to quarter 2. The number of responses rose to 150 compared to 119 in quarter 2.

7.3 There were no surveys received from FHAU in the quarter. This has again been raised with the team and they are being encouraged to ask young people and their families to complete HYS surveys. The CAMHS Involvement Worker is now spending more time at Forest House speaking to the young people about their experiences and it is hoped this will also increase the number of surveys.

7.4 The feeling safe score for Acute 24/7 services in the quarter was 86% (110 responses) compared to 87% (84 responses) in quarter 2. Of particular note, Robin Ward returned 103 surveys in Q3 and scored 90% for feeling safe. The other acute inpatient wards who scored above the 85% target, were Aston Ward (100% 1 response) and Thumbswood (100% 2 responses). Those units below target were: Albany Lodge (5 responses 60%), Owl Ward (4 responses 50%) and Swift Ward (1 response 0%). The Experience Team have started to visit the units to encourage service users to give feedback about their experiences, however, this has been challenging due to staff sickness in the team.

7.5 There were 40 responses in the quarter to the feeling safe question in Learning Disability and Forensic services compared to 35 in quarter 2, the score was 83% compared to 80% in Q2. 4 Bowlers Green, Dove Ward, Astley Court, Astley Court EATS Team, and Hampden House all scored 100% for feeling safe. Beech Unit scored 60%, Broadland Clinic 0% (1 response), Warren Court 71% and The Beacon 50%.

7.6 Figure 18 below shows the thematic emotional analysis for all comments given for Having Your Say and compliments for the last 3 years. Any comment given related to "safety" are mapped as a positive or negative comment. We can see from the graph that there is a slight downward quality trend for the "feeling safe" emotion.

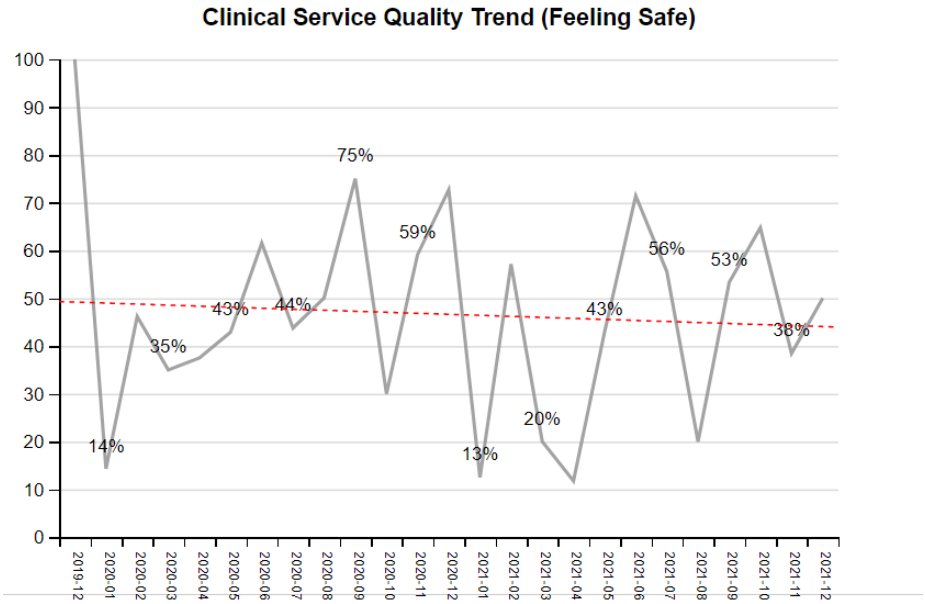


Figure 18

7.7 There were 439 compliments received Trust wide in the quarter compared to 502 in quarter 2. 19 compliments mentioned the word "safe".

"I cannot thank The Orchards enough. If this unit was not here, I do not know what I would have done. Absolute distress needs a place of safety and no judgement and that is what they provided. Having been a Nurse in the NHS for 16 years, I know how hard it is…Teresa and all of her team have been invaluable to me."

7.8 In the last quarter there were 6 complaints where the description of the concerns contained the word "safe", "unsafe" or "safety". Adult Community Mental Health Services (ACMHS) Borehamwood, Logandene, Lambourn Grove, FHAU, ACMHS Bishops Stortford and ACMHS Welwyn received complaints regarding safety in the quarter.

7.9 There were 5 PALS enquiries recorded for the quarter relating to "safe", "unsafe" or "safety". These enquiries related to ACMHS Cheshunt, ACMHS Watford, Swift ward and Wren ward. One enquiry did not relate to Trust services.

7.10 During the quarter, the Experience and Involvement Teams have been recruiting more Experts by Experience interested in being involved in Peer Experience Listening. During the next quarter, a new virtual listening skills training programme will be created which we hope will enable the Post Incident Peer Listening Projects at the Broadland Clinic to go ahead. The Peer Observation Project on the older peoples' inpatient units remains on hold until Experts by Experience can resume visiting.

8 Safeguarding

Safeguarding Children

8.1 Children's lives continue to be disrupted by the pandemic. Schools have reopened; however, there is continued disruption to children's lives with some schools as they are

sent home to isolate if they have been in close contact with someone with the virus, and after school activities not always running as before.

8.2 Figure 19 illustrates a continued increase in child safeguarding incidents across the Trust from Quarter 1 onwards. Overall, numbers of concerns have gone up since the beginning of the pandemic, demonstrating that the needs of vulnerable children and their families have intensified, for both mental health and social care support.

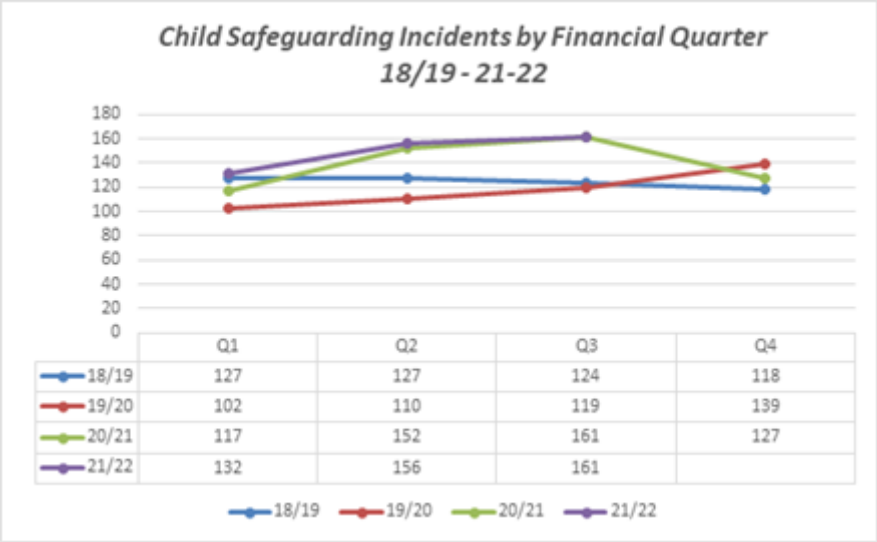


Figure 19

8.3 Figure 20 illustrates a continued increase in child safeguarding incidents across the Trust from Quarter 1 onwards. Overall, numbers of concerns have gone up since the beginning of the pandemic, demonstrating that the needs of vulnerable children and their families have intensified, for both mental health and social care support.

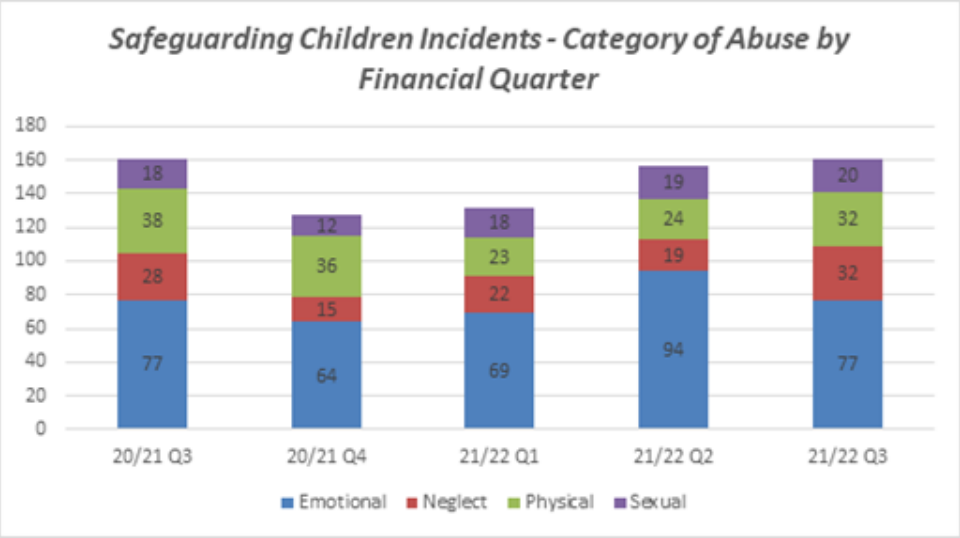


Figure 20

8.4 Figure 21 illustrates the numbers of incidents reported by specific service areas in the quarter. As with previous quarters, the CAMHS Crisis Assessment and Treatment Team have made the most referrals to child safeguarding services, owing to the demographic of their service user group. It is notable, however, that referrals from FHAU have increased from 3 in quarter 2, to 14. This is likely to be a reflection of the

increased acuity and level of need which has been building in this service user group since the start of the pandemic and accounts for the increase in physical abuse incidents in the quarter.

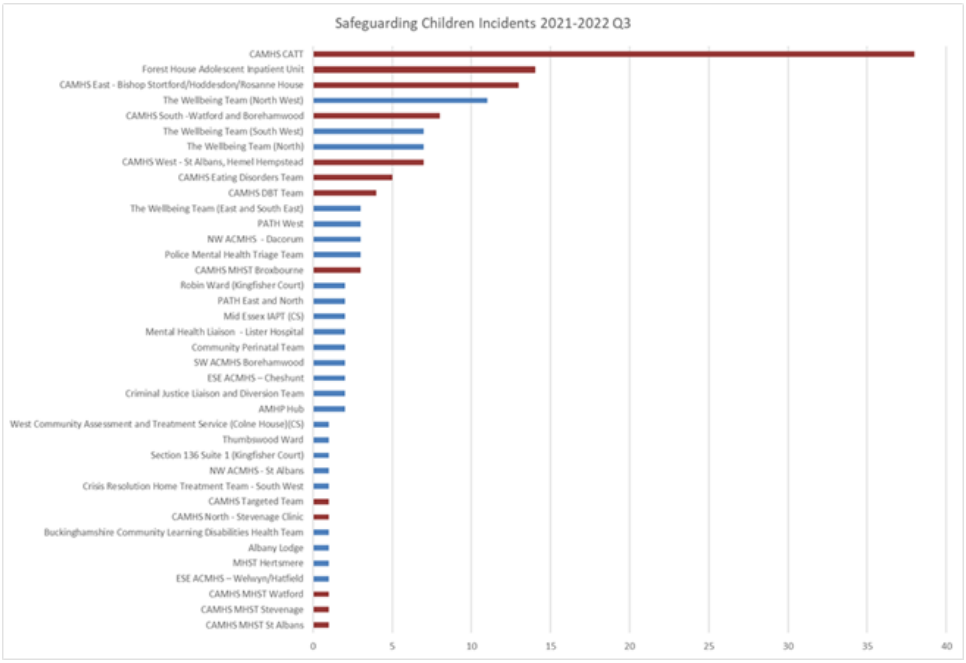


Figure 21

Key- Adult services *CAMHS/ MHST-*
Community Peri-Natal Team

8.5 The safeguarding team have been monitoring the number of safeguarding children and adult and referrals made by the Community Peri-Natal Team. Figure 22 shows there were two safeguarding children referrals made in the quarter, which is a decrease of one since quarter 2. There was one safeguarding adult referral made in the quarter, which is consistent with quarter 2.

Figure 22

8.6 There was an increase in the number of safeguarding children referrals made where domestic abuse was a component. Domestic abuse was present in 37 referrals (23% of referrals), compared to 28 (18%) in quarter 2 (figure 23). The prevalence of domestic

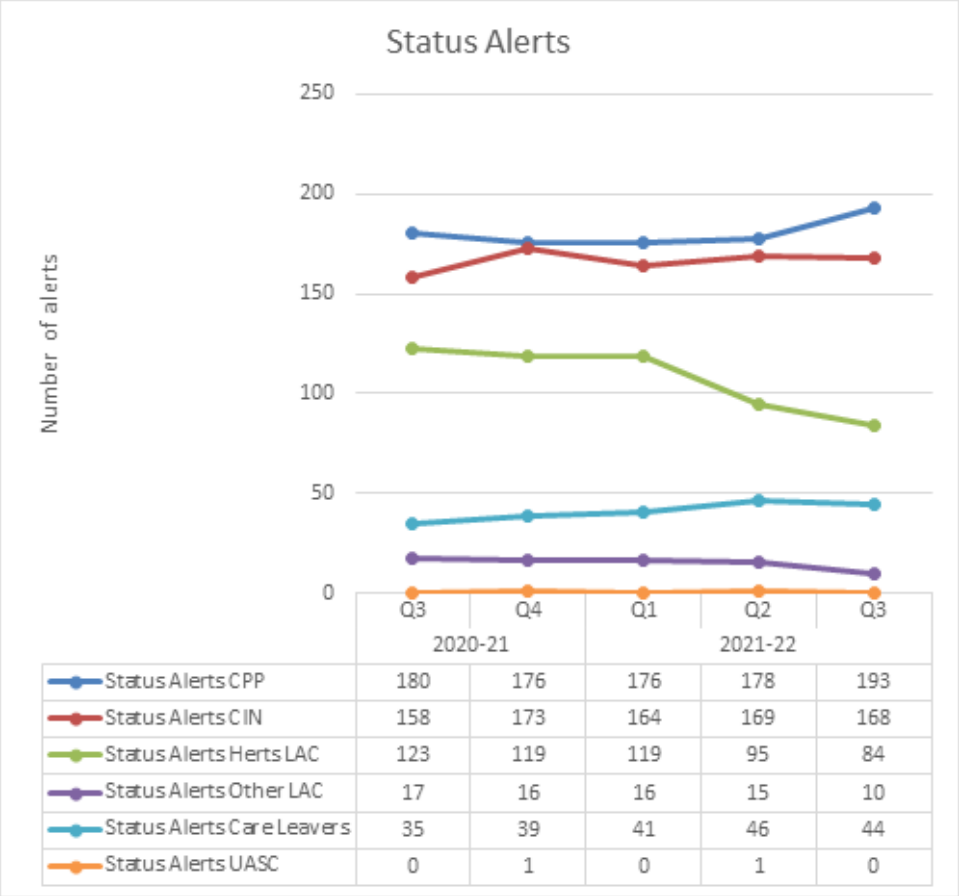
abuse has increased nationally throughout the pandemic and it is therefore not surprising that it is present in nearly one quarter of all children's referrals.

2021-22	Total No. Safeguarding Children Referrals	No. Safeguarding Children Referrals with Domestic Abuse Present
Q1	132	26 (20%)
Q2	156	28 (18%)
Q3	161	37 (23%)

Figure 23

8.7 96% of referrals were accepted for assessment by children's services in the quarter. This is compared to 94% in the last quarter and 91% in quarter 1 2021-22. This demonstrates a continual improvement in the quality of referrals made by Trust staff.

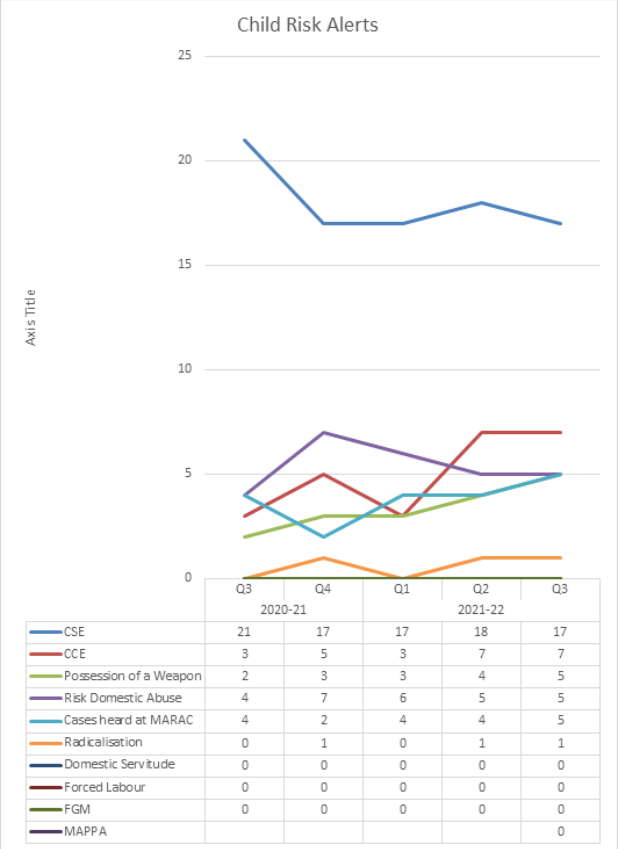
8.8 The safeguarding children report on SPIKE demonstrates the number of Paris records with a safeguarding alert at the end of each quarter. Figure 24 shows the status of the child. There was an increase in the number of children placed on a child protection plan in the quarter, this is the highest figure over the past year. Child in need numbers have remained consistent. The number of Herts CLA has decreased from 119 in quarter 1 to 84 in the quarter. The CLA alert was updated at the end of quarter 2 which may account for the decrease in alerts, however the Q3 data includes the old and new alert data. There was little change to the number of care leavers or unaccompanied asylum-seeking children (UASC).



	Q3 2020-21	Q4 2020-21	Q1 2021-22	Q2 2021-22	Q3 2021-22
Status Alerts CPP	180	176	176	178	193
Status Alerts CIN	158	173	164	169	168
Status Alerts Herts LAC	123	119	119	95	84
Status Alerts Other LAC	17	16	16	15	10
Status Alerts Care Leavers	35	39	41	46	44
Status Alerts UASC	0	1	0	1	0

Figure 24

8.9 Figure 25 shows child safeguarding risk alerts on Paris records from quarter 3 2020-21 to quarter 2 2021-22. Child sexual exploitation is the most common risk alert used by CAMHS. There was an increase in the number of CCE alerts from 3 in quarter 1 to 7 in quarters 2 and 3. The number of young people with possession of a weapon alert increased by one each quarter of 2021-22. 10 children have either the risk of domestic abuse or case heard at MARAC alert on their record. There were 0 alerts activated for FGM, forced labour, domestic servitude, or MAPPA in the quarter.



	Q3	Q4	Q1	Q2	Q3
	2020-21		2021-22		
CSE	21	17	17	18	17
CCE	3	5	3	7	7
Possession of a Weapon	2	3	3	4	5
Risk Domestic Abuse	4	7	6	5	5
Cases heard at MARAC	4	2	4	4	5
Radicalisation	0	1	0	1	1
Domestic Servitude	0	0	0	0	0
Forced Labour	0	0	0	0	0
FGM	0	0	0	0	0
MAPPA					0

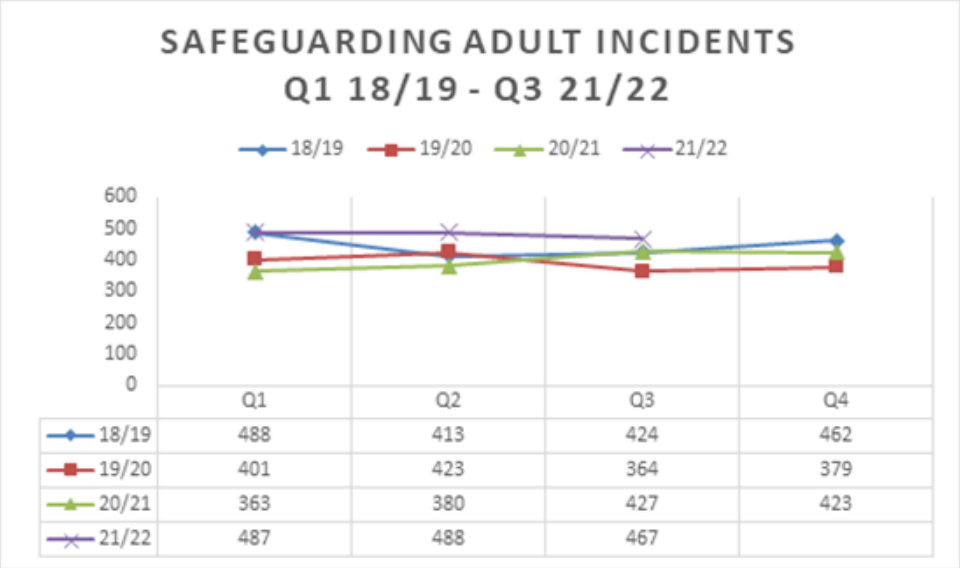
Figure 25

8.11 There was 1 alert add for risk of radicalisation during the quarter. A 15-year-old boy open to CAMHS west was referred to Channel Panel in August 2021. The case was heard at Channel Panel on 29th September 2021 and was not taken on as it was felt he needed support managing relationships and that could be provided by CAMHS and Specialist Adolescent Service Hertfordshire (SASH).

Safeguarding Adults

8.12 Figure 26 illustrates the total number of Adult Safeguarding Adult incidents raised by staff across the Trust from quarter 1 2018 to quarter 3 2021 drawn from the Datix incident reporting system.

8.13 There has been an increasing trend in numbers of incidents throughout the financial year, which could be linked to the increase in need seen by adult mental health services as the pandemic continues. The quarter showed a small drop which was also in line with a small reduction in the number of incidents reported to the Trust in Hertfordshire as statutory safeguarding concerns. One of the biggest drivers in terms of incidents is often physical abuse reported by inpatient units linked to mental disorder and acuity, and Figure 2 (below) demonstrates that there was an increase in that category of abuse in the last quarter although it has reduced somewhat in the quarter.



	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	488	467	

Figure 26

8.14 Figure 27 shows safeguarding adult incidents by Category of Abuse. Domestic abuse continues to be the second highest category of abuse recorded across the Trust. This is a particular focus for the Corporate Safeguarding Team in terms of training in order that staff feel confident in responding to such disclosures.

8.15 There has also been a slight increase in the number of self-neglect concerns raised by staff for service users in their care, from 26 to 33 in the quarter. The Corporate Safeguarding Team will continue to monitor this trend which may be linked to supply issues with social care support which have been reported in the past quarter.

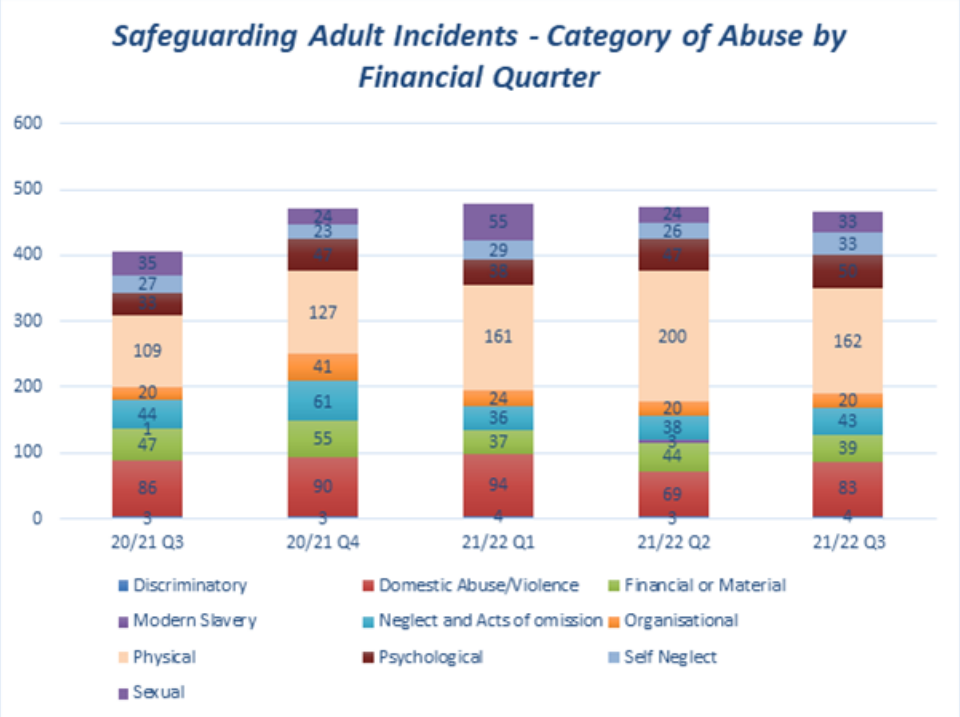


Figure 27

Statutory Safeguarding Adults in Hertfordshire

8.16 Figure 28 relates to Safeguarding activity within the Trust in Hertfordshire, specifically, to concerns raised to, and enquiries undertaken by Trust investigating teams (ACMHS and Mental Health Services for Older People). In Hertfordshire, Trust has responsibility to investigate adult safeguarding concerns for people with a functional mental disorder as part of our delegated duties from Hertfordshire County Council.

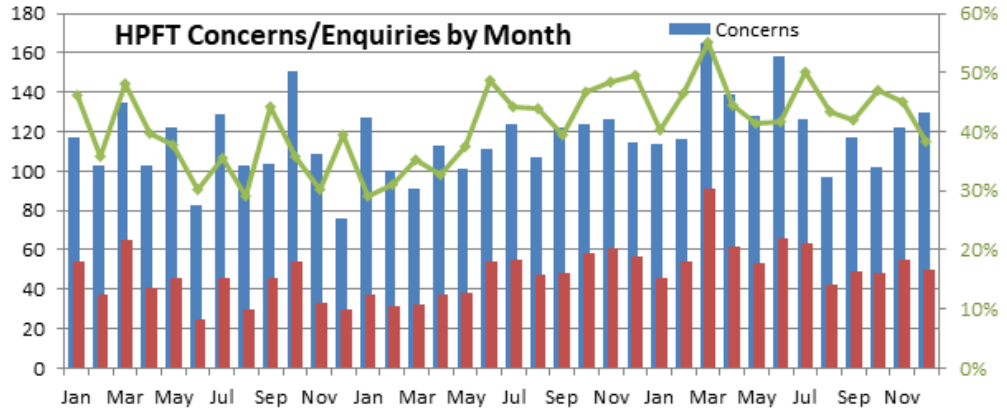


Figure 28

8.17 Following the previously reported spike in the number of safeguarding referrals raised to the Trust in quarter 4 and quarter 1 2021 (notably, in March and June), numbers have begun to decrease to more usual levels of between 100 to 120 concerns received per month. Following a deep dive, the Corporate Safeguarding Team were not able to identify any specific reason for the upwards trends in March and July.

8.18 The 'conversion rate', that is the number of concerns that are 'converted' to a Section 42 enquiry is on the Safeguarding risk register, for continued monitoring, after a low in 2020. This continues to be relatively stable at between 40% to 50% on average. The conversion rate was discussed at the December 2021 Hertfordshire Safeguarding Adults Board, where the Hertfordshire County Council Operations Director for Adult Disability reported to the Chair that the local authority are reassured around decision making within the Trust, and confirmed that that two organisations will be working jointly together to ensure continued oversight of the conversion rate.

8.19 Figure 29 gives a breakdown of the decisions made around Safeguarding concerns. In the Trust there is always a slightly higher proportion of decisions to go to an 'other' enquiry. These enquiries are preventive, where if there was to be no Safeguarding then the person's needs may increase. Frequent audits and deep dives have demonstrated that decision making is generally in line with process and this is linked to the fact that often the Trust is not clear about the extent of an individual's care and support needs when they are first referred, but it is apparent that abuse is taking place.

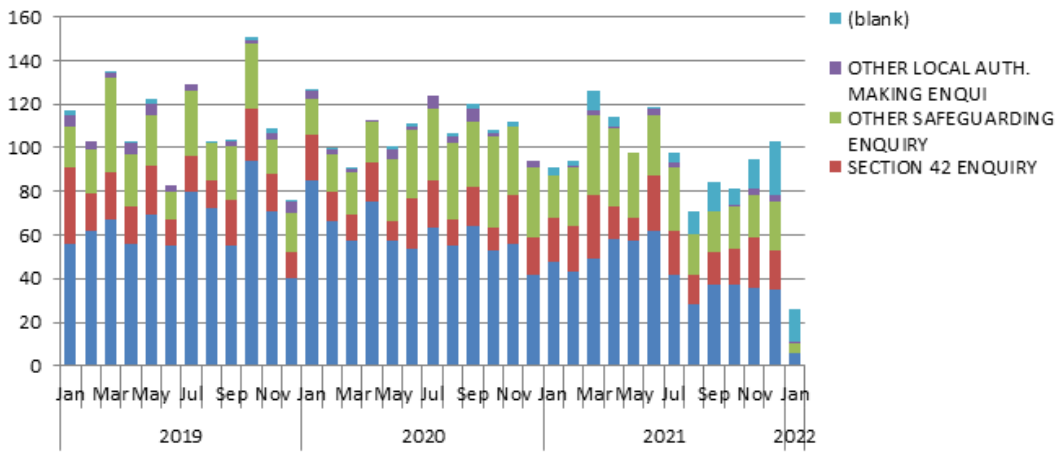


Figure 29

Safeguarding Practice Development

Work with Criminal Justice Liaison & Diversion Team (CJLDT and Youth Offender Service (YOS) to improve liaison between the services

8.20 Following a Serious Incident investigation completed by the Consultant Nurse Safeguarding Children, a meeting was arranged with the CJLDT and the YOS to explore how communication between the teams could be improved.

8.21 A meeting took place on 30th November 2021 between CJLDT, the police and CCG to understand how the police share information with children's services regarding children in custody. The CCG is undertaking a broader piece of work to understand the role of health in custody (for children & adults) & a meeting will be arranged in January/February 2022 to explore this.

MASH Practitioner's Business Case

8.22 The business case was presented to the Trust Management Group on 18th November 2021 and was agreed in principle. The Head of Safeguarding & Social Care will explore the funding options with the Executive Director of Service Delivery and Service User Involvement.

8.23 Domestic Abuse Alliance's App

A paper was presented to the Trust Management Group on 18th November 2021 and was agreed in principle, to explore the introduction of the Domestic Abuse Alliance's WEPROTECT app to HPFT, which provides free legal advice to victims of DA. Questions were raised about the quality of the legal firms used by the alliance and further assurance required before launching the app. A meeting has been arranged for 25th January 2022 with the Directorate Manager Mental Health Legislation, safeguarding team and DA Alliance to seek these assurances

8.24 Care Leaver CQI

A care leaver pathway document was presented to the Trust Management Group in November 2021 and was agreed in principle. However, due to the operational pressures currently being experienced by front line services, a decision could not be made to offer

an initial assessment to all care leavers. This work will be considered as part of the wider transformational work underway.

8.25 Supervision CQI

The Trust wide project chaired by the Deputy Director for Nursing and Quality is ongoing. The project will review staff training, the supervision policy, templates and recording of supervision. A new supervision case note was launched on Paris in the quarter, to ensure safeguarding and clinical supervision relevant to the service user is documented in the patient records. The Supervision App was launched in December 2021 for all staff to record managerial, clinical, safeguarding and professional supervision. This system supersedes the use of Discovery.

8.26 Joint meeting between CAMHS and Children's Services

The Service Manager/ Practice Development Lead in HCC will now assist the consultant nurse to arrange monthly meetings between CAMHS and children's services, to discuss and reflect on cases, share learning and to improve networking across the services.

8.27 Mandatory Training Compliance

Low compliance rates for Safeguarding children's levels 2 and 3 were added to the corporate risk register in quarter 4 2020/21. The decrease was due to the ongoing work to introduce the safeguarding training passport, where the levels of training assigned to staff were amended in quarter 4 202/21. Figure 30 illustrates that compliance has steadily increased since quarter 4. SGC L2 remains at 91% (a further 13 staff have completed training in the quarter) & SGC L3 has dipped to 89% as 8 staff have become non-compliant.

Training	2020-21 Q4	No. non-compliant	2021-22 Q1	No. non-compliant	2021-22 Q2	No. non-compliant	2021-22 Q3	No. non-compliant
Preventing Radicalisation	93%	163	95%	129	95%	129	95%	136
SG Children Level 1	93%	233	97%	113	97%	101	97%	105
SG Children Level 2	81%	495	90%	249	91%	248	91%	235
SG Children Level 3	79%	164	88%	101	90%	85	89%	93

Figure 30

8.28 Prevent and Channel Panel

The Trust continues to be core members of Channel Panel in Hertfordshire and send two representatives to most meetings. The Trust made no referrals to Prevent in the quarter, however, they remain key partners in providing a response to concerns and the representative at Channel continue to ensure that there is liaison between services and Prevent when an individual known to the Trust is 'adopted' at panel. In November 2021 the new Hertfordshire Channel Panel Information Sharing Agreement was published, and the Trust have signed up to this (Executive Director of Quality and Safety).

Domestic Abuse

8.29 MARAC

In Q3, a Specialist Safeguarding Practitioner, worked alongside partner agencies to compile a paper for the Hertfordshire Domestic Abuse Partnership Board outlining the separate roles of the health (including mental health) representatives at MARAC. The paper was presented by the CCGs Associate Director for Adult Safeguarding and was well received by the Board.

8.30 Audits

There were 2 main safeguarding audits. A deep dive audit into decision making around cases which did not proceed to Section 42 enquiry found that 91% of the forms sampled did indicate where the service user was felt not to meet Care Act Thresholds for Section 42 enquiry. A safeguarding children referrals audit found that 96% of cases had a discharge letter sent to the GP and 93% of cases had a discharge letter sent to the social worker.

8.31 High Profile Safeguarding Cases

The Trust is currently involved a variety of reviews including three Safeguarding Adults Reviews and Partnership Case Review. 2 Child Serious Case Reviews have been completed and are awaiting publication. The Trust are currently involved in 5 domestic homicide reviews. The Trust is not currently involved in any Care Leaver Death Reviews.

9 Conclusion

9.1 Part B has provided an overview of incidents reported in quarter 3, 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 deaths that were thought to be as a result of suicide, was 17 compared to 15 in the previous quarter and 11 in the same reporting period the previous year. Several of these deaths have occurred in the North-West Quadrant and a task and finish group has commenced to address this and extra support provided for the teams.

9.3 The Trust's Suicide Prevention group continues to work to reduce suicides and work will continue in the next quarter including learning from colleagues on the Gold Coast who have made great strides in reducing deaths through suicide.

9.4 The Trust has made progress with the SI recovery work with all SI reports submitted within timescale , with further work required in quarter 4 regarding the outstanding action plans.

9.5 Violence and Aggression continues toward staff and service users continues to be a concern and a CQI project group has been set up to address this.

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

9.7 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 4, in consideration of the learning and the detail provided in part B. This is not a full account of the work that has taken place as the Trust's 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 3.

2. Learning from Incidents

2.1. The monthly Learning Events continue throughout the quarter, facilitated by the Deputy Medical Directors, enabling learning from SWARMS, incidents and SIs including positive practice to be shared and discussed. Topics have included suicide data, risk formulation and clozapine monitoring and risk of constipation. Both Hertfordshire CCG's , British Transport Police, Acute Trusts and neighbouring Mental Health Trusts have sent representatives to reflective learning sessions following serious incident investigations and feedback has been extremely positive and has improved collaborative working.

2.2. The Health and Safety team has been bolstered with the creation of a new Patient Safety Officer

Suicide prevention

2.2 Work continues with partner agencies including Public Health, Acute Trusts, CCGs and the police to develop a Suicide Prevention Pathway with evaluation measures incorporating learning from the Gold Coast in Australia with meetings being held fortnightly.

2.3 Work is ongoing with partner agencies using Wave 4 national funding on developing system wide suicide awareness/prevention training.

2.4 Delivery of Simulation Training ongoing with suicide risk case scenarios for front facing HPFT teams in the acute and crisis pathway being prioritised with links to the suicide prevention staff competency framework requirements.

2.5 Plan for development of additional online training resource on suicide risk formulation using principles of simulation for use by teams.

2.6 Clinical Directives on Suicide Data and Prevention Initiative Screening and Assessment Questions with the need for safety planning and use of the Stay Alive App have been sent to Clinical Directors and Heads of Nursing by the Deputy Medical Director.

2.7 Joint initiative with Samaritans to follow up individuals who have had a single contact with HPFT in final stages of going live with Pilot teams identified.

2.8 Work is ongoing to commission a Suicide Bereavement Support Service across the ICS supported by a dedicated Project Lead as those bereaved by suicide are known to be at risk of suicide. This work is co-produced by those bereaved or affected by suicide.

2.9 Back to Basics training programme to start in quarter 4 2021/22 with links to work of the simulation faculty to ensure consistent approaches to delivery of risk formulation training.

2.10 The Trust is working with system partners in setting up of Real Time Surveillance in Hertfordshire which will ensure early warning to all agencies of a suspected suicide, monitoring of potential clusters with immediate system response and actions, reports/trend analysis ahead of inquest conclusions, timely signposting to bereavement support.

2.11 A deep dive of unexpected deaths reported as SIs was undertaken this quarter and themes included:

- Inadequate detection of suicide risks - not routinely asking suicide screening questions
- Insufficient enquiry into suicidal behaviours and thoughts
- Over-reliance on the first-hand accounts from the service user and the importance of having a longitudinal view of service user's presentation in crisis
- The quality of risk assessments is not consistent
- There is a lack of Suicide Specific-interventions for service users presenting with suicide risk.

2.11 In response to these findings the crisis teams across the trust have had an immediate change to the way of working and their operational policy to improve the support they provide to service users in crisis.

2.12 A Task and Finish Group has been convened to focus on the increase in unexpected deaths within the North West Herts Quadrant.

Priorities for Quarter 4

Incident management

8.1 Incident reporting training will continue in quarter 4 with portion if the patient safety dashboard.

Suicide Prevention

8.2 The Trust and the Samaritans will be commencing a joint initiative with pilot teams, where contact will be made by Samaritans with a service user to offer some additional support. Work is continuing on developing real time surveillance in Hertfordshire and improving postvention support and timely signposting to support for those affected or bereaved by suicide. A Bereavement Strategy Coordinator which will support the workplan around bereavement support commenced in their role.

8.3 Work will continue with colleagues on the Gold Coast to learn from their zero-suicide strategy and embedding a just culture to inform a suicide prevention pathway in Hertfordshire.

Ligatures

8.4 Ligature audits in community hubs to continue in quarter 4. Working with Surrey and Borders Trist to develop a cost effective app to assess environmental risk.

8.5 The Trust are working with a neighbouring Trust to learn from a prosecution by the HSE following the deaths of 11 service users in their service using ligature anchor points between 2004-2015. A regional ligature forum has been established.

Violence and Aggression

8.6 A CQI project group has been formed to address violence and aggression in the Trust.

8.7 Patient Safety Specialist working with staff side to understand staff experience of Violence and Aggression and what is needed.

8.8 The Police Liaison Group continues to meet and has focused on reviewing the memorandum of understanding and ensuring staff are supported to report assaults and during prosecution if appropriate.

8.9 A project group is set up to focus on reducing risks to staff from service users spitting.

Restrictive Practice

8.10 A RESPECT recovery task and finish group continues to focus on recovering training compliance levels.

HOPE(s) Model

8.11 The HOPE(S) model is an ambitious human rights-based approach to working with people in long term segregation, developed from research and clinical practice. In partnership with Mersey Care NHS Foundation Trust, NHS England and NHS Improvement are funding the model through the NHS-led Provider Collaboratives across England.

8.12 A Matron within Learning Disability services will be commencing a 3-year secondment as a Specialist Practitioner to deliver the HOPE(s) model across the region to lead a system change to reduce long term segregation for people with a learning disability and autistic people across the region.

Sexual Safety

8.13 The Learning from Serious Incidents has been shared across the SBUs via the Sexual Safety Group. There is an improved oversight through data and sharing of learning through analysis of themes. Equally, the Trust Safeguarding Adults from Abuse policy has been updated to include aspects of sexual safety and recommendations from the above CQC report. The Sexual Assault e-learning is now available on Discovery for all staff and the ultimate goal is for this to be mandatory for all clinicians.

8.14 All leaflets are available for service users on what to do if they are worried about sexual safety onwards, and guidance for staff on responding to allegations. There is an active participation from The Corporate Safeguarding Team which represent HPFT at Herts Strategic Sexual Assault Board meetings to improve partnership working across the county.

9 Conclusion

9.1 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.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:** 9b
Subject:	Draft Risk Management Strategy 2022 – 2025	**For Publication:** Yes
Author:	Helen Edmondson, Company Secretary	**Approved by:** Jacky Vincent Executive Director – Quality & Safety (Chief Nurse)
Presented by:	Helen Edmondson, Company Secretary	

Purpose of the report:

To present the Risk Management Strategy for approval by the Board.

Action required:

To formally approve and adopt the Risk Management Strategy.

Summary and recommendations

The Risk Management Strategy has been reviewed, updated, and redrafted to clearly set out the Trust's framework within which the Trust leads, directs, and controls the risks to its key functions. To support this, it purposefully seeks to separate risk management strategy from risk management policy.

Risk Management is an integral part of the Trust's management activity and is fundamental to delivering and embedding high quality, safe and sustainable services for the people we serve, to support good governance, is central to delivery of the Trust's *Good to Great* strategy and to strategic and operational management. The Risk Management Strategy sets out the vision and approach for risk management, its key goals, core framework and processes.

The aim of the strategy is to reinforce and embed a culture throughout the organisation in which risks are actively identified and managed, to ensure that risk management becomes an integral part of the Trust's strategic and operational objectives, plans, practices and management systems, in an environment that promotes individual and organisational learning.

At its meeting held 17 March 2022, the Integrated Governance Committee reviewed and approved the Risk Management Strategy and made a recommendation for the Board to approve.

Recommendation

The Board are recommended to approve the Risk Management Strategy.

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

The deliverables associated with the strategy are core to generating robust ward to board intelligence to support Board understanding of risks within the organisation. It will give high level assurance over the operation of the risk management systems and processes.

Summary of Financial, IT, Staffing & Legal Implications:

N/A

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:

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

Integrated Governance Committee 17 March 2022

Hertfordshire Partnership University NHS Foundation Trust

HPFT

Risk Management Strategy 2022 - 2025

HPFT Strategy

Version	11
Executive Lead	Executive Director Quality and Safety
Lead Author	Company Secretary
Approved Date	17th March 2022
Approved By	Integrated Governance Committee
Ratified Date	TBC
Ratified By	TBC
Issue Date	TBC
Expiry Date	TBC
Target Audience	All Trust Staff

Risk Management Strategy

1. Culture and our approach to Risk Management

1.1. Risk Management is an integral part of HPFT's management activity and is fundamental to delivering and embedding high quality, safe and sustainable services for the people we serve. As a complex organisation delivering a range of services in a challenging financial environment across a wide geography, we accept that risks are inherent to our business. Effective risk management processes are therefore central to providing assurance on the framework for clinical quality and corporate governance.

1.2. Our 'Good to Great' Strategy describes how we are going to deliver our vision of "Delivering Great Care, Achieving Great Outcomes – Together'. Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we will consistently achieve the outcomes that matter to those individuals who use our services, their families and carers by working in partnership with them and others who support them. It also means we keep people safe from avoidable harm, whilst ensuring our care and services are effective, achieve the very best clinical outcomes and support individual recovery outcomes.

1.3. The Trust is committed to a risk management strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its Good to Great strategy and underpinning strategic objectives.

1.4. The Board Assurance Framework (BAF) will be used by the assuring committees and Board to identify, monitor and evaluate risks to the achievement of the strategic objectives. It will be used alongside other key management tools, such as integrated performance reports, quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

1.5. The management of risk underpins the achievement of the Trust's objectives. The Trust believes that effective risk management is imperative to not only provide a safe environment and improved quality of care for service users, carers and staff, it is also significant in the financial and business planning process where investment decisions and public accountability in delivering health and social care services are required.

1.6. The risk management process involves the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals reduce the incidence and impact of risks that they face. Risk management is therefore a fundamental part of both the strategic and

operational thinking of every part of service delivery within the organisation. This includes clinical, non-clinical, corporate, business, and financial risks.

1.7. The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. The risk management strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, supported by effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

1.8. The Trust Board recognises that complete risk control and/or avoidance is impossible, but that risks can be managed and minimised by making sound judgments from a range of fully identified options and having a common understanding on risk appetite.

1.9. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an on-going commitment to improving the management of risk throughout the organisation through:

- **AWARENESS** - Staff will have an awareness and understanding of the risks that affect service users, carers and staff
- **COMPETANCE** - Staff will be competent at managing risk
- **MANAGEMENT** - Activities will be controlled using the risk management process and staff empowered to tackle risks
- **RISK APPETITE** - The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate.

1.10. HPFT will make a public declaration within the Annual Governance Statement of compliance against meeting risk management standards.

2. Purpose

2.1. This strategy describes a consistent and integrated approach to the management of all risk across the Trust.

2.2. The purpose of the Risk Management Strategy is to set out the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, NHS Improvement (NHSI) compliance requirements, key regulatory requirements such as Care Quality Commission standards, and its own strategic objectives.

2.3. The risk management strategy underpins the Trust's performance and reputation and is fully endorsed by the Trust Board.

3. Goals of the Risk Management Strategy

To ensure:

- the Trust remains within its licensing authorisation as defined by NHSI and to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may prevent the Trust from complying with its provider licence and/or NHS Foundation Trust Code of Governance
- compliance with NHSI requirements, Care Quality Commission registration and Health & Safety Standards
- continued development of the Board Assurance Framework (BAF) such that organisation wide strategic risks are identified dynamically
- appropriate support for further development of the organisational safety culture and its effectiveness
- open reporting of adverse events/incidents is encouraged and learning is shared throughout the organisation
- all risks, including business risks, service development risks, and project risks, are being identified through a comprehensive and informed Risk Register and risk assessment process.
- Risk Management Policies and procedures are implemented and monitored effectively
- the Trust can demonstrate compliance with the statutory Duty of Candour and that it maintains a consistent open and honest culture always involving service users and families in investigations where appropriate
- all individuals within the organisation are aware of their role, responsibilities and accountability with regard to Risk Management
- the structure and process for managing risk across the organisation is reviewed and monitored annually

4. An Open and Fair Culture

4.1. All members of staff have important roles to play in identifying, assessing and managing risk.

4.2. To support staff in this role the Trust promotes a fair, open and consistent environment and does not seek to apportion blame. In turn, this encourages a culture of openness and willingness to report mistakes.

4.3. All staff are encouraged to report any situation where things have, or could have gone wrong. However, exceptional matters may occur where an employee has acted illegally, maliciously or recklessly and in such cases appropriate action will be taken in accordance with Trust Policies.

4.4. Concerns regarding unsafe practice may be reported by staff through a confidential route under the “Freedom to Speak Up” policy.

5. Risk Appetite

5.1. The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In

practice, an organisation's risk appetite should address several dimensions including the:

- nature of the risks to be assumed.
- amount of risk to be taken on; and
- desired balance of risk versus reward.

5.1 On an annual basis the Trust will publish its risk appetite statement as a separate document covering the overarching areas of:

- Risk to service users
- Organisational risk
- Reputational risk
- Opportunistic risk

5.2 The statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

5.3 Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

5.4 The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk.

6 Responsibility for Risk Management

6.1 The success of the risk management programme is dependent on the defined and demonstrated support and leadership offered by the Trust Board as a whole.

6.2 Day-to-day management of risk is the responsibility of everyone in the Trust at every level, and the identification and management of risks requires the active engagement and involvement of staff at all levels. Staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework.

7 Compliance & Assurance

7.1 NHS Improvement uses the information collected and received from Foundation Trusts under the *Single Oversight Framework* to assess the risk to continuity of services conditions and, for NHS foundation trust's, non-compliance with the NHS foundation trust governance conditions. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

7.2 The CQC includes risk management as part of its standards (which cover clinical and non-clinical issues). All healthcare providers, including NHS Trusts, must achieve these minimum standards.

7.3 There are different operational levels of risk governance in the Trust:

- Board of Directors
- Assurance Committees (Audit Committee, Integrated Governance Committee and Finance and Investment Committee)
- Executive Team
- SBU or Corporate Governance Meetings
- Department/speciality level
- All staff reporting risks

7.4 Risk Management by the Board is underpinned by a number of interlocking systems of control:

7.4.1 The **Board Assurance Framework** provides a structure and process that enables the organisation to focus on those risks that might compromise the achievement of its most important strategic objectives, to map out the key controls in place to manage those objectives, to confirm the Board has gained sufficient assurance about the effectiveness of these controls and to enable the Board to confirm that its responsibilities are being discharged effectively. All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have the evidence to support this Statement. The BAF brings together this evidence.

7.4.2 The Board Assurance Framework is reviewed bi-monthly, in its entirety, by the Integrated Governance Committee and Trust Board. Every risk on the BAF is assigned to an Executive Director who is responsible for reporting on progress to the Board of Directors. An assurance committee is also identified for each principal risk to assure the Trust Board that it is being monitored, gaps in control and assurance are identified, and processes in place to minimise the risk to the organisation.

7.4.3 The Company Secretary shall work closely with the Executive Leads and appropriate senior managers to ensure that the BAF remains dynamic and is integral to the Business Planning cycle.

7.4.4 The **designated assurance committees** of the Trust Board are the Audit Committee, the Integrated Governance Committee and the Finance and Investment Committee. The Audit Committee monitors the Board Assurance Framework process overall biannually.

7.4.5 It is the responsibility of the assurance committees to report to the Trust Board, any new risks identified and gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/assurance is identified, then this should be reported immediately via the Executive Directors.

7.4.6 The **Trust Risk Register** is the high level operational risk register used as a tool for managing risks and monitoring actions and plans against them.The risk register is a dynamic process in ranking/prioritisation of risks that will change as risk mitigation and resolution takes place. Used

correctly it demonstrates that an effective risk management approach is in operation within the Trust.

7.4.7 Each **Strategic Business Unit** (SBU) will maintain a comprehensive risk register, which will be formally reviewed in full at monthly intervals, with key headlines and top risks presented quarterly to the Executive Performance Review Meetings. The SBU Management Team has responsibility for ensuring that all risks within the SBU are appropriately graded and have sufficient actions in plan to mitigate/reduce the risk.

7.4.8 Each **service and department** will carry out appropriate risk assessments in accordance with the Risk Management Policy. A single framework for the assessment, rating, and management of risk is to be used throughout the Trust and this process is described in detail within the Risk Management Policy alongside how department risk registers are escalated where appropriate to the SBU risk register and to the Trust Risk Register.

7.4.9 In order to identify the risks against delivery of principal objectives and gaps in control/assurance the Trust Board must have a comprehensive Performance Management Reporting framework. The Trust Board must agree its own indicators for Performance Reports which will act as assurance on service delivery and quality. Any significant gaps in assurance or control within the Performance reports must be identified, translated onto the Board Assurance Framework and remedial action agreed.

7.4.10 If at any time performance reporting and risk management processes indicate that the Trust will not meet a current or future regulatory requirement/target, then the Board will notify NHSI via an Exception Report.

8 Risk Management Policy

8.1 The purpose of the Risk Management Policy is to set out the detailed framework, process and approach to enable risks to be systematically drawn together, assessed, prioritised and managed consistently via a single approach everywhere in the organisation.

8.2 The policy will set out in detail:

- Roles, responsibilities and accountabilities for risk management
- The approach to assessing, reviewing and reporting Risk Appetite
- Processes and procedures for the identification, assessment and response to risk
- Governance Framework, processes and procedures for reviewing risk, escalation and de-escalation
- Processes and procedures for risk management performance reporting

- The approach to implementation of the risk management policy, monitoring and reviewing compliance
- Associated policies procedures and documentation

8.3 This strategy should also be read in conjunction with the following Risk Management Policies:

- Risk Management Policy
- Quality Strategy
- Clinical Risk Strategy
- Clinical Risk Assessment and Management of Individual Service Users Policy
- Incident and Serious Incident Requiring Investigation Policy
- Health Safety and Security Policy
- Information Risk Policy

9 Equality Impact Assessment

9.1 The Trust is committed to promoting equality of opportunity for all its employees and the population it serves. The trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. No detriment is intended.

10 Review

10.1 This Strategy has been developed in light of currently available information, guidance and legislation, which may be subject to change. This strategy will be reviewed every three years or sooner if circumstances dictate. Any changes will be reviewed by the Integrated Governance Committee and Audit Committee and any recommendations are submitted to the Board of Directors for formal ratification.

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:** 10
Subject:	Report from Finance & Investment Committee – held on 22 March 2022	**For Publication:** Yes
Author:	Rob Croot – Deputy Director of Finance	**Approved by:** David Atkinson, Non-Executive Director, Chair – Finance & Investment Committee
Presented by:	David Atkinson, Non-Executive Director, Chair – Finance & Investment Committee	

Purpose of the report:

This paper provides a summary report of the items discussed at the Finance & Investment Committee meeting on 22 March 2022.

Action required:

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

To note the four items for approval by the Board.

Summary and recommendations:

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

To receive and note the report.

Recommendations

To note that four items were escalated to the Board for approval:

- Annual Plan for 22/23
- Capital Plan for 22/23
- Finance Report – month 11
- Q3 Performance Report

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 March 2022

1. Introduction

The Finance and Investment Committee (FIC) has met once on 22 March 2022 since the last report to the Board, they met in accordance with its terms of reference and were quorate.

2. Strategic

2.1 Draft Annual Plan 2022/23

The Committee considered a report that set out process for developing the Annual Plan. It was noted that the Plan sets out the Trust's key priorities for the coming year describing how the Trust will continue in its unrelenting commitment to provide Great Care and to deliver Great Outcomes, working together with services users, carers, our staff, and other partner organisations.

It was reported that the Annual Plan had been informed by the national and local priorities in the different health and care systems and by feedback and discussions from stakeholders including our staff, our Council of Governors, our commissioners, and our senior leadership team.

The Annual Plan priorities are formed around the current seven strategic objectives and to reflect the continuing impact of the COVID pandemic and the related challenges, the delivery of the Annual Plan and the improvement and change this will bring builds around the need in some areas to **Restore** performance particularly reducing the current waiting times to access services and rebuild the capacity and resilience of those services that have been most severely affected over the period. To **Reset**, adjusting to live with the ongoing impact of Covid ensuring services remain safe and consistently provide a great experience, realigning our core work programs to best meet the challenges ahead and strengthening our leadership; and where greater change is needed to **Reshape** reviewing and strengthening our care models, further adopt new technologies and integrated working, and embarking on the significant cultural shift required to become an exemplar organisation addressing the significant inequalities in healthcare that persist.

It was noted the alongside the development of this Trust internal plan, the Trust is contributing to the development of overarching system plans for 2022/23 and working with the Hertfordshire Mental Health, Learning Disability and Autism Collaborative to ensure strategic alignment.

The Committee considered the priorities in the draft Plan and asked for consideration to be given to enhancing the following within the Plan:

- The Trust's ambition to be the best we can be as an organisation – to enhance recruitment and retention
- Focus on recruitment & retention
- Enhance references to Freedom to speak-up
- Broaden out references to LD to include Autism
- Outcomes to be shown for all items
- Re. suicide prevention – what's going to be different this year?
- Research to be included as a priority on its own
- Digital investment plans.

It was noted that the Annual Plan would be considered by Board at its meeting at the end of March 2022

2.2 Draft Financial Plan 2022/23

The Committee considered the draft Financial Plan for 2022/23. It was noted that discussions remain ongoing with Commissioners and therefore the draft plan is based upon a number of key assumptions regarding final contract agreements.

The Committee considered the assumptions as set out in the report below, noting the principal items related to: an assumed level of contract income, investment and growth from Commissioners; pay costs reflect staff in post at 31 January 2022; planned investment in staffing reflective of both anticipated contract income for 22/23 and the Trust's workforce plan for 22/23; secondary commissioning activity had been projected forwards on the basis of current demand; non-pay costs in the Plan reflect 2021/22 spend, as adjusted for one-off or non-recurrent items; an assumption that spend on short term non recurrent initiatives will end by 31 March 2022.

Members scrutinised the draft plan and sought additional information, including the wider context of the HWE System Financial Plan.

The Committee noted that the draft Financial Plan had been submitted to NHSE on 17 March and that the current Financial Plan is draft and remains subject to the finalisation of contract negotiations with Commissioners.

The Committee noted that a final Financial Plan would reflect the outcome of contract negotiations to be concluded by mid-April, in line with the national planning timetable.

It was noted that the final Financial Plan for 2022/23 will be approved by the May FIC and Board meetings.

2.3 Capital Plan

The Committee was updated on the draft capital plan. It was noted that the Trust was no longer able to set its own limits on Capital expenditure and in line with this in 2021/22 had received a capital investment allocation via the ICS, reflecting the move to System working. The Committee received the report that set out the capital allocation for 2021/22 for the Trust that had been supplemented in year by additional national and regional funding for Digital investment.

It was noted that nationally capital allocations are planned to reduce over coming years, and they will be distributed to ICS's based on the recognised Kings Fund methodology, which reflects an organisation's asset base and annual depreciation charge.

The Committee considered the Plan as outlined in the report noting the most significant items relating to Safety Suites; Oak Ward Refurbishment, Stevenage Inpatient, Forest House HDU, Lexden and Albany Lodge Refurbishment. The remaining elements relate to backlog Maintenance, Capital, and Digital.

The Committee considered and approved the Plan. Noting that the Plan would go forward for approval by the Board.

2.4 Digital Strategy Update

The Committee received a report that provided an update on the progress of the digital capital investment programme. It was noted that over half of the projects were progressing as planned and are on track to deliver the year end aims. The remaining

projects are experiencing delays due to a number of factors such as: operational pressures; changes in ability of supplier to provide functionality; market research.

2.5 Mental Health and Learning Disabilities and Autism Collaborative

The Committee considered a report and presentation from Ed Knowles, Development Director that set out that the Hertfordshire's Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative continues to develop and deliver. It was noted that work is underway to prioritise its areas of focus and transformational priorities for the year ahead, through discussions with partners and stakeholders.

It was reported that the Collaborative is now being increasingly recognised as the forum through which system issues for Hertfordshire citizens with mental illness, learning disabilities or autism should be discussed and resolved.

The presentation was very well received by Members.

3. Operational

3.1 Quarter Three Performance Report.

The Committee received and considered a report that set out the summary of performance during quarter three against the national, regional and local indicators. It was noted that this had been a challenging period for the Trust, reflecting the wider NHS position at a local, regional, and national level. The second wave of the COVID-19 pandemic resulting from the Omicron variant overlapping with the usually more challenging winter period had a significant impact across all services. The Committee considered the data on the staff absences peaks and the number of concurrent outbreaks across our wards and services. The Committee noted the significant increase in our demand.

It was reported that as a result, performance in quarter three has been lower than anticipated. It was noted that it is anticipated quarter four will continue to be challenging, and as the current COVID-19 surge subsides we will be seeking to recover performance and trajectories for this are being agreed with teams. The Committee welcomed the focus on the needs of our service users and carers and particularly those at higher risk. The Committee considered the recovery trajectories in place.

Particular areas of strong or improved performance in the quarter were: Friends and Family Test; Service User Engagement; 18 Week Standard; access to crisis services; IAPT and recovery and access to assessment by specialist community learning disabilities services.

The Committee discussed areas of concern and focus noted in the report namely: Adults 28-day assessment; 48-hour follow-up post discharge; vacancy and turnover rates; increase in inappropriate Out of Area Placements; the rate of service users with an up-to-date risk assessment and Adults 28 Day Assessment performance. The Committee also considered the actions in place to improve the position in each of these areas.

3.2 East of England Collaborative

The Committee considered a report that provided an update on the progress to date in relation to the Provider Collaborative. For Child & Adolescent Tier 4 Services, for which the Trust is Lead Provider, it was reported that there continues to be a number of beds closed within the region. It was noted there are plans in place for a number of units to reopen to admissions and the number of beds closed was reducing and

there had been an improvement in flow through inpatient services. It was noted that the Trust expects to see continued improvement in the waiting list and bed closure position over the next quarter.

The Committee were updated on the work by the Transformation and Commissioning Team (TACT) in reviewing activity demand as part of their negotiations with NHSE. It was noted that it was difficult to model over the period the provider collaborative has been in operation due to suppressed demand caused by bed closures.

Good progress is being made in both secure and adult eating disorder services in the mobilisation of their transformation initiatives. Both services are expected to go live in March-April 2022. The Patient Flow Hub now expanded to all other providers in the region. The Hub has taken an active role in supporting referrals and flow and is able to produce accurate daily capacity and waiting list positions. The Committee were updated on the discussions that are underway regarding the expansion of the service.

The report provided an update on the current financial position noting that the position has improved overall following a number of adjustments due to late notifications of charges and credits. The provider collaborative is now forecasting a breakeven position overall.

3.3 Finance Report

The Committee noted the report that set out the Trust's financial position to end of February 2022. It was noted that the Trust is on track to deliver against the revised financial plan of a breakeven financial out turn, and that additional national funding had been received for IT projects.

The Committee noted that expenditure continues to reflect the non-recurrent additional pro-active investment in clinical services and continued high spend on secondary commissioning.

3.4 Delivering Value Programme

The Committee received a report that set out the progress with delivery against the Delivering Value Programme for 2021/22. It was noted that the programme was forecast to deliver savings of £4.6m in line with the revised plan for the year.

The Committee considered the Delivering Value Programme for 2022/23 noting that it was a significant stepped increase on saving released in previous years. It was noted that the plan had been developed in consultation with the SBUs and corporate functions. The Committee considered the programme noting that schemes to the value of £10.5m had now been identified, although a number of these schemes did not yet have project initiation governance and Quality Impact Assessments in place. The Committee noted the risk assessment of the DV programme and that a prudent value of £5m had been reflected in the Financial Plan.

It was agreed that Delivering Value would be the subject of a more detailed presentation to the Committee at a future meeting.

The Committee supported the Programme and approved it to go forward to the Board as part of the draft Financial Plan.

3.5 Commercial and Contracts Update

The Committee considered the report that provided an update on the progress on the renegotiation of the Trust's major contracts ahead of the 2022/23 financial year. The

Committee received an update on the six main contracts that account for a majority of the Trust's income. The Committee considered and noted the position with regard to each of these contracts.

- The Committee agreed to authorise the Chief Executive and Executive Director of Finance, in discussion with the Chair of FIC, to sign new or updated contracts with the commissioners as set out in the report, subject to satisfactory conclusion of negotiations with the relevant commissioners.

4 Items to Note

4.1 Committee Planner
The Committee noted the updated planner.

5 Recommendations

5.1 To receive and note the report.

5.2 To note that 4 items were escalated to the Board for approval:

- Annual Plan for 22/23
- Capital Plan for 22/23
- Finance Report – month 11
- Q3 Performance Report

Meeting Date:	31 March 2022	**Agenda Item:** 10a
Subject:	Performance Report Quarter 3 2021-22	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director of Improvement and Innovation	**Approved by:** Hakan Akozek, Director of Innovation and Digital Transformation
Presented by:	Hakan Akozek, Director of Innovation and Digital Transformation	

Purpose of the report:

To inform the Trust Board of the Trust's performance against both the NHS Oversight Framework (NHSOF) targets and the Trust Key Performance Indicators for Quarter 3 2021/22, along with an early insight into Q4.

Action required:

The Trust Board is recommended to:

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

The third quarter of the 2021-22 fiscal year (Q3) has been a very challenging period for the Trust and the wider health and social care system across the country. The second wave of the COVID-19 pandemic resulting from the Omicron variant overlapping with the usually more challenging winter period had a significant impact across all services. At its peak, we saw staff absences at 29% and seven concurrent outbreaks across our wards and services. We have also seen significant increase in our demand such as referrals to adult community services showing a 48% increase compared to pre-pandemic levels.

As a result, performance in quarter 3 has been lower than anticipated with of the 59 Key Performance Indicators monitored in Q3:

- 26 (44%) are maintaining or exceeding performance levels (on target)
- 8 (14%) are almost meeting target performance levels (close to target)
- 25 (42%) are not meeting our performance standards (underperforming)

October 2021 national benchmarking report included in the paper clearly show the pressures we are facing from high demand and acuity are being felt across the system, and whilst we are committed to restore, recover and reshape our services, we benchmark favourably in relation to our peers.

It is anticipated Quarter 4 will continue to be challenging, however as the current COVID-19 surge subsides we will be seeking to recover performance and trajectories for this are being agreed with teams. We will continue to focus on the needs of our service users and carers and particularly those at higher risk, strengthening the Single Point of Access to meet the increasing demand, further recruitment incentives to address the vacancy gaps in key areas and increasing face to face appointments where appropriate. The recovery trajectories for the following key performance indicators are already in place:

- Adult 28 Day Standard
- EMDASS 12 Week standard
- IAPT Treatment
- Risk Assessments

- PDPs
- Sickness
- Mandatory Training
- Data Completeness

The Trust Board is recommended to:

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

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

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

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

N/A

Equality & Diversity and Public & Patient Involvement Implications:

A number of changes have been introduced to the report format to improve accessibility, including a traffic light system to avoid using colour as the only means of conveying information.
Although individual KPIs in this report have equality and diversity implications, these are not part of this report. As a result, the report does not have a direct impact.

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

This report was seen by:

- Executive Team on 16th March 2022, and
- Finance and Investment Committee on 22nd March 2022

Performance Report – Quarter 3 2021-22

1. Background

1.1. The third quarter of the 2021-22 fiscal year (Quarter3, Q3) has been a very challenging period for the Trust and the wider health and social care system across the country. The wave of the COVID-19 pandemic resulting from the Omicron variant overlapping with the usually more challenging winter period had a significant impact across all services. At its peak, we saw staff absences at 29% and seven concurrent outbreaks across our wards and services.

1.2. We have also seen significant change in our demand profile. For example, referrals for our Adult Community Mental Health (ACMH) services have increased by 46% compared to pre-pandemic levels, the demand for our crisis services has seen a step change since April 2021 with a rise of 70% and demand in our Children and Adolescent Mental Health Services (CAMHS) Eating Disorders (ED) growing by 44%.

1.3. There are also indications of increased acuity and complexity with increased caseloads in ACMH services and service users staying in secondary care 38% longer since the start of the pandemic (average of 18 months vs 13 months pre-pandemic) as well as the demand for out of area beds raising 2.5 times.

2. Activity Summary

2.1. The figure below provides a summary of some of the key areas of activity across the Trust during the third quarter. Referrals into the Single Point of Access (SPA) in Q3 2021/22 (16,584) are circa 8% higher than for the same period in 2020/21 but represent a 1% increase on Q2 referrals (16,428).

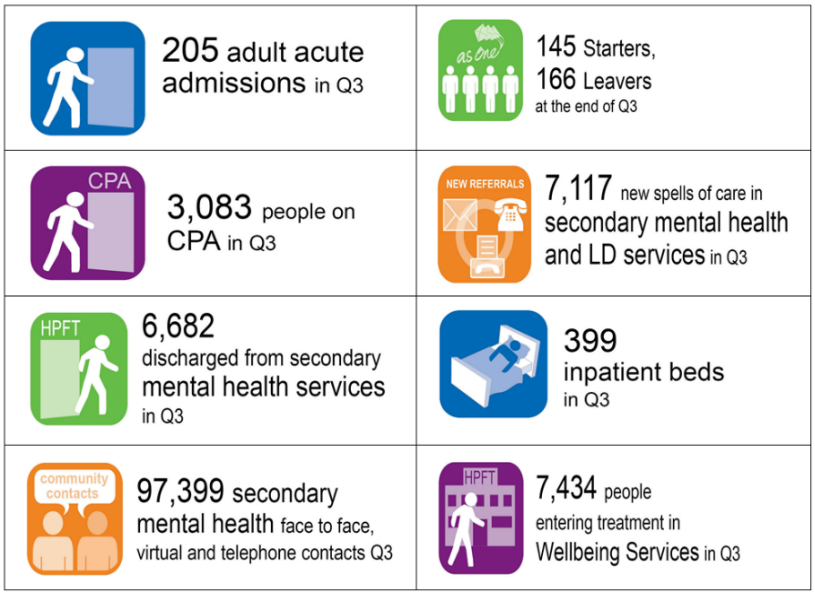


Figure 1 - Summary of Q3 Activity

3. Performance Summary

3.1. Quarter 3 has been a challenging period for the Trust, reflecting the wider NHS position at a local, regional, and national level. Pressures come from continued high demand and acuity, the ongoing COVID-19 Pandemic, and the emergence of Omicron variant.

3.2. Although our services remained open and performed strongly in the context of the challenges experienced in Q3, our overall performance declined compared to the second quarter of the year. The table below summarises the performance across the five domains for key performance indicators with a Q3 target.

Performance Domain	Status	Total # of Indicators	On Target	Close to Target	Underperformed
NHS Oversight Framework		6	5 (83%)	-	1 (17%)
Access to Services		22	9 (41%)	2 (9%)	11 (50%)
Safety and Effectiveness of Services		23	9 (39%)	5 (22%)	9 (39%)
Workforce		4	-	1 (25%)	3(75%)
Finance		4	3 (75%)	-	1 (25%)
TOTAL		59	26 (44%)	8 (14%)	25 (42%)

Table 1 - Q3 KPIs Performance Summary

3.3. The figure below illustrates overall quarterly performance for all metrics since 2015-16, including those that do not have a target and therefore cannot be rated.

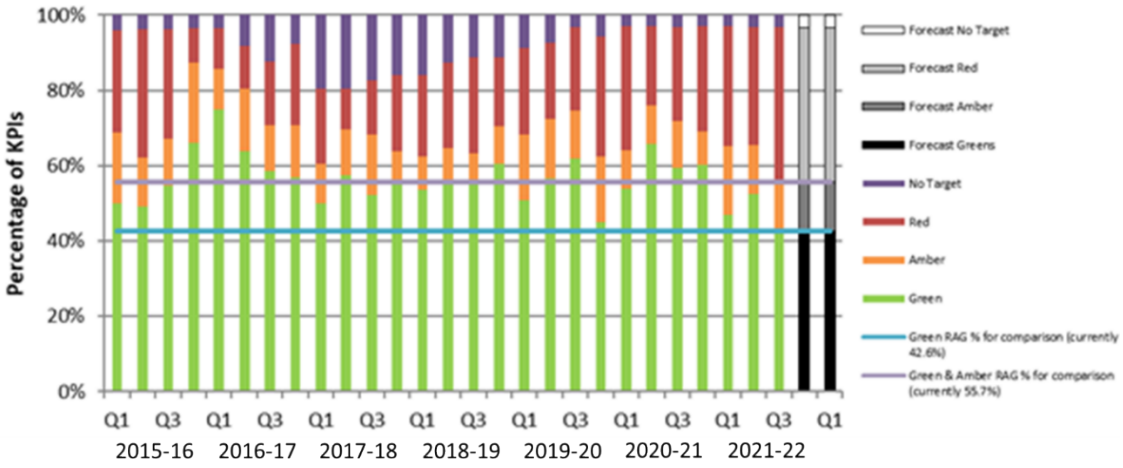


Figure 2 – Trust-wide KPI Performance for all metrics

3.4. Our teams have worked hard across all services to continue to provide quality care. All services remained open to referrals and admissions. Feedback from service users tells us that they feel safe in our inpatient wards (86%) and would recommend our services to friends and family members if they needed them (91%, up from 89% in Q2).

3.5. Workforce remains a key area of focus for the Trust, with a vacancy rate of 14.5% and un-planned turnover of 13%. Net recruitment is slightly down for Quarter 3 with 145 joiners and 166 leavers. Feedback from our staff through pulse surveys, team meetings, and Executive listening events tells us that whilst they are feeling under pressure, they also feel listened too and supported. The Festival of Wellbeing success of the summer

has been extending into Winter and the distribution of winter hampers was well received by staff at Christmas.

3.6. In terms of our financial position, we are on track to deliver the reforecast year-end position of breakeven. This position is supported in-year by short term Covid 19 funding, winter pressure money, and transformation funding. Our strong financial position in-year has allowed us to commission 15 beds at the Priory (Knees worth), which in turn enabled us deliver good bed flow over the Christmas period and into the New Year. We have also continued to invest in-line with our digital and capital investment schemes.

Areas of Strong or Improved Performance in Q3

3.7. **Friends and Family Test**: Our service users told us that they would recommend our services to friends and family, if they needed them, in 91% of cases (target 80%) and 86% of people said that they knew how to get support and advice at a time of crisis (target 83%).

3.8. **Displaying Trust Values:** 85% of our service users told us that they have been involved as much as they wanted in discussions about their care (target 80%).

3.9. **18 Week Standard:** Across all our services 98% of people received treatment within the 18 weeks wait standard (target 98%).

3.10. **Inpatient admissions:** People who need an inpatient admission were seen by Adult Crisis Assessment and Treatment Teams in 97% of cases to see if there was an alternative to admission (target 94%).

3.11. **Crisis:** All service users who needed to access our Adult Crisis Assessment and Treatment Teams in Quarter 3 were assessed within a 4-hour period (target 98%).

3.12. **IAPT:** People using our IAPT services met the recovery criteria in almost 53% of cases (target 50%)

3.13. **LD&F**: People accessing specialist community learning disabilities services we assessed within 28 days in 100% of cases in Q3 (target 98%)

Areas of Concern or Focus

3.14. The Covid epidemic has increased our virtual contacts with service users and reduced the number of appointments where people are seen face to face as illustrated in the figure below. By the end of Quarter 3, we have also seen an **increase in unexpected deaths**, with 52 deaths reported. This is an increase of 7 on the total number of deaths for 2020/21. In response to this, we are implementing plans to bring our workforce back into the workplace and resume face to face appointments.

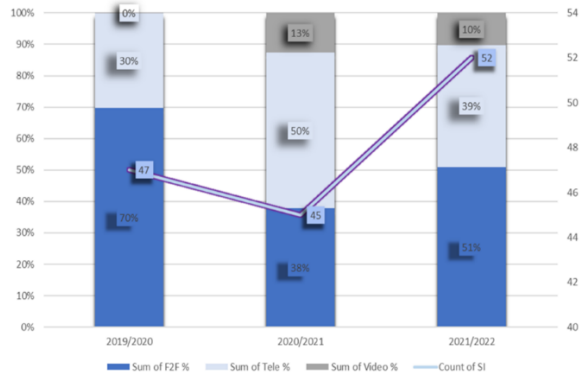


Figure 3 - Contact Type vs Serious Incidents

3.15. **Adults 28 Day Assessment** performance has declined in Q3 with 70% of service users assessed within 28 days of referral against a target of 95%. As at the end of December, the average length of time between referral and assessment is 38 days (95%), 10 days beyond our 28-day Access Standard. This is caused by an increase in new referrals (46% increase), high caseloads (6% increase), and high staff vacancies (up to 34% in some areas). The mitigation in place to manage this in the short term is to focus on our highest risk service users, using the Clinical RAG rating system, where highest priority (Red and Amber) cases are seen first, to prioritise assessments. The medium to long-term mitigation is to further improve the initial assessment and prioritisation process for new referrals by undertaking more assessments at the point of referral into SPA and by accepting trusted referrals directly into treatment.

Indications early in Q4 reveal that current performance is at 58.5% against the 95% target and the average time between referral and assessment has increased to 40 days. A CQI Project is underway to improve the 28-day access position. Actions include reducing the DNA rate and introducing proportionate assessments to improve flow. Recovery is expected by the end of Quarter 1 2022.

3.16. **48-hour follow-up** post discharge position improved in late November and December and our end of quarter position is 88% for December, although the aggregated Quarter 3 position is 78% (up from 72% in Q2). 97% of service users had a follow-up within 7 days of discharge. Our Deputy Medical Director is leading the second phase of a CQI project to address this for Q4. Principal changes include digital workflow improvements which provide automatic alerts to help clinical teams follow up on this critical task.

Early data for Q4 reveal that current performance has improved to 92% against the 80% target with the CQI project that was initiated leading to a significant improvement.

3.17. **Recruitment and retention** remain a key focus for the Trust. During Quarter 3, establishments increased by 53 FTE, reflecting planned service expansion and new funding. Vacancy (14.5%) and turnover rates (21%) have increased month on month during Q3. Our registered nurse vacancy rate (23% vacancies, 213 FTE) and our Allied Health Professionals (AHPs) vacancy rate (26% vacancies, 49 FTE) are a particular focus with recruitment capacity and activity expanded significantly for nurses, Healthcare

Support Workers (HCSWs) and AHPs. Our international nurse recruitment campaign was expanded from recruiting 10 to 50 registered nurses. Despite high levels of recruitment activity, unplanned turnover has meant that overall workforce numbers in Q3 have reduced by 21 (145 starters, 166 leavers).

Indications in Q4 reveal a similar position with vacancy rate at 14% and turnover at 21%.

3.18. **Inappropriate Out of Area Placements** remained constant across Q2 into Q3 due to the temporary expansion in our bed base through the contacting of 15 additional beds from the independent sector. This increase in our bed base was in anticipation of the expected increase in demand for adult beds which is currently being experienced. This increase both for Adult and CAMHS beds, reflects an increase in complexity in the community. The situation in Hertfordshire is reflected nationally, with increased demand and a shortage of beds within local networks leading to an increase in out of area placements.

Indications in Q4 reveal that the current the number of out of area placements is the equivalent of 27 additional beds.

3.19. **Risk Assessments:** The rate of service users with an up-to-date risk assessment has decreased over Quarter 3 to 90% against a target of 95%. The primary reason for underperformance is the large caseloads held by some of our medical staff. The deputy medical directors are leading a CQI to simplify risk assessment recording in PARIS (Electronic Patient Record system) to provide a long-term solution. Improvement is expected in Q4 following the changes made to the risk assessment process in PARIS.

Early data in Q4 reveal that currently risk assessments are at 89%. However, improvement is still expected in Q4 as the simplification of recording takes effect.

3.20. We have been focussing our efforts on producing recovery trajectories for all the red indicators with the following already having recovery trajectories in place:

- Adult 28 Day Standard
- EMDASS 12 Week standard
- IAPT Treatment
- Risk Assessments
- PDPs
- Sickness
- Mandatory Training
- Data Completeness

3.21. Details of Q3 performance against the KPIs and exception reports for underperforming KPIs can be found in Appendices A and B respectively.

4. Benchmarking Summary

4.1. The NHS Benchmarking Network monitors changes in mental health and learning disability services because of the pandemic and publishes monthly reports. October 2021 benchmarking reports show that the pressures we are facing from high demand and acuity are being felt across the system, and whilst we are keen to restore, recover and reshape our services, we benchmark favourably in relation to our peers.

4.2. The benchmarking data reflects the position that we are seeing across the Trust of high bed occupancy in inpatient services, particularly adult services, where we have a below

average number of beds and 100% occupancy. This correlates with our high number of out of area placements. Our length of stay is below the national average, indicating a relatively efficient system of discharge for those who are admitted. We have a below average proportion of admissions under the mental health act, although this has increased by 31% over the last year.

4.3. We are seeing a very high caseload in our community services, 80% above the national average. Referrals per 100,000 are below average into HPFT services. This indicates people staying in treatment for longer due to higher acuity. Our contacts per person on the caseload are in line with national figures, despite the high caseload, and we are partly managing this with a higher-than-average use of non-face to face contacts.

4.4. Conversely, our rate of CRHT referrals were 40% lower than the national average, with an average number of contacts once the person is in the service. Again, we have an above average use of non-face to face contacts.

4.5. This picture suggests a disproportionate pressure on our adult community services. successfully keeping people out of inpatient services and managing increased acuity and caseloads within the community teams, rather than our crisis services.

5. Forecast Summary

5.1. The planning guidance from NHS Improvement and England (NHSI/E) suggests a 10-30% increase on previous baseline figures for CAMHS and ACMH services, but our own experience is that demand has been at the higher end of this range. For Q4 we are forecasting new referrals to exceed the range in planning guidance from NHSI/E, as they did for Q3. SPA and the teams are aware of the potential increase and have contingency planning with these new referral volumes in mind.

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

5.3. There are no overall volume guidelines for Learning Disabilities and Forensic Services (LD&F) over the remainder of 2021/22 and into next financial year. However, volumes for these services 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.

5.4. It is anticipated Quarter 4 will continue to be challenging, however as the current COVID-19 surge subsides we will be seeking to recover performance and trajectories for this are being agreed with teams. We will continue to focus on the needs of our service users and carers and particularly those at higher risk, strengthening the Single Point of Access to meet the increasing demand, further recruitment incentives to address the vacancy gaps in key areas and increasing face to face appointments where appropriate.

5.5. The table below summarises the demand forecast for the fourth quarter of 2021-22.

	Baseline (FY19/20)	Q4 Forecast (HPFT)	Planning Guidance (NHSI/E)
CAMHS	184	240-260	215-254
ACMH	212	300-325	248-296
Older Adults	120	116	No guidance issued
LD&F	9	9	No guidance issued

Table 2 - Demand Forecast for Q4 2021-22

6. Financial Resources

6.1. The Trust continues to report on plan for December with a break-even position. High spend areas continue to be secondary commissioning and pay costs with the planned release of non-recurrent balance sheet flexibilities supporting the underlying deficit run rate at present.

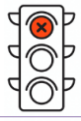
6.2. The underlying deficit run rate has increased in line with demand and acuity levels increasing within the services and specifically funded initiatives but has remained consistent through November and December. This is expected to be supported during 2021-22 to achieve a financial position in line with the break-even plan, but this is not sustainable into 2022-23 and must be addressed through; (i) an increase in commissioning income, or (ii) a reduction in spending (primarily out of area placements) or a combination of the two. The table below summarises the performance against the four financial indicators monitored in Q3 as at the end of the quarter.

Ref	Financial Indicator	Status	Target	Q3
F1	Achieve surplus in year (exc PSF)		£0K	£0K
F2	User of resources		1	1
F3	Number of shifts breaching price cap		0	371
F4	Cash releasing efficiencies (full year effect)		£4.6m	£4.8m

Table 3 - Q3 Financial Performance

7. Quality Account Priority Indicators

7.1. Out of the six quality account indicators reported in Q3, two were close to target with the remaining four underperforming. The table below summarises the Q3 performance for these indicators.

	Ref	Indicator	Status	Target	Q3
Service User Safety	1	The percentage of service users who are followed up within 48 hours after discharge from psychiatric inpatient care during the reporting period.		≥80%	77%
	2	Reduction in the rate and percentage of service user safety incidents that result in moderate or severe harm.	N/A	TBC	Severe Harm 4 (0.29%) Moderate Harm 39 (2.83%) Total incidents 1378
	3	Rate of service users who have a completed risk assessment within the last 12 months.		≥=95%	90%
Clinical Effectiv	4	Reduction on the number of inappropriate out of area placements.		0	2,355

	5	Reduce the readmission rate within 28 days of being discharged from adult acute hospital bed.		5%	6%
	6	At least one outcome measures to be used on all LD F inpatients (HONOS in all inpatient units).		≥80%	49%
	7	Completed annual care plans within LD community services Herts and Essex	N/A	N/A	N/A, Reported Annually
Experience	8	Rate of Service Users saying they have been involved in discussions about their care		≥85%	84%
	9	Appropriate Carer Essential Training undertaken by all staff at all levels	N/A	≥85%	N/A, Reported Annually
	10	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	N/A	≥70%	N/A

Table 4 - Q3 Quality Account Performance

8. Recommendations

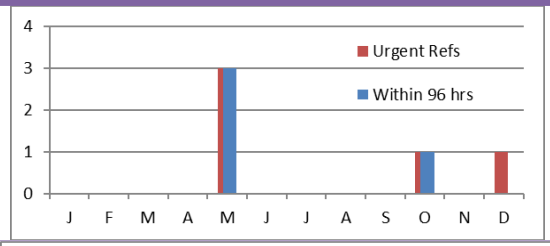
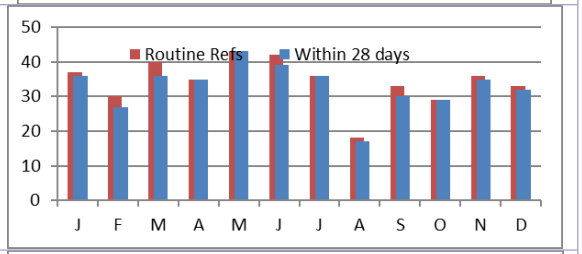
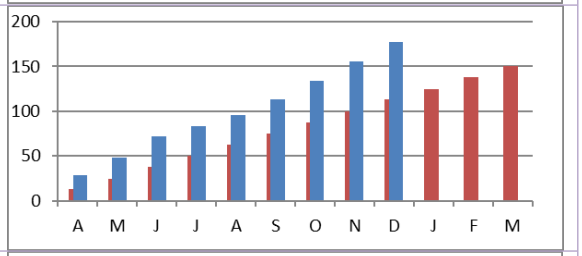
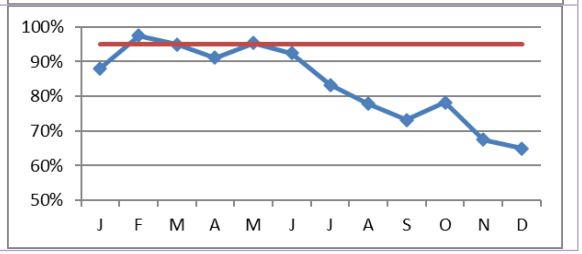
8.1. The Trust Board is recommended to:

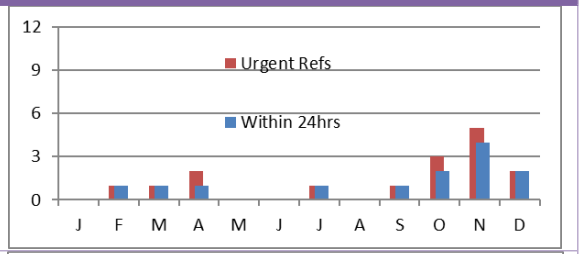
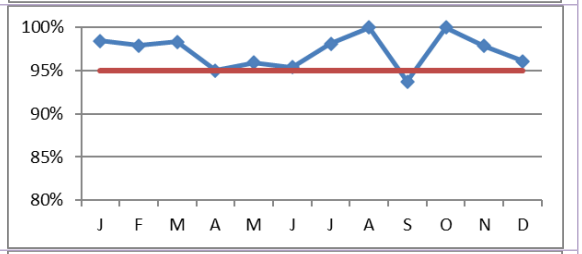
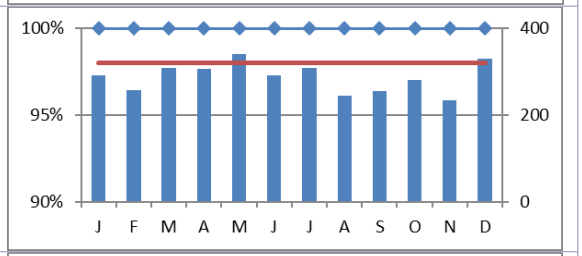
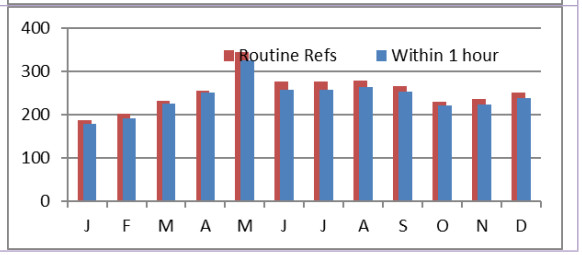
- Critically appraise the information presented.
- Consider the areas of performance noted and evaluate the associated actions.
- Seek any additional assurance or information required.

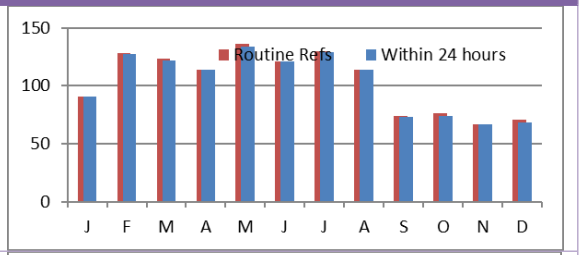
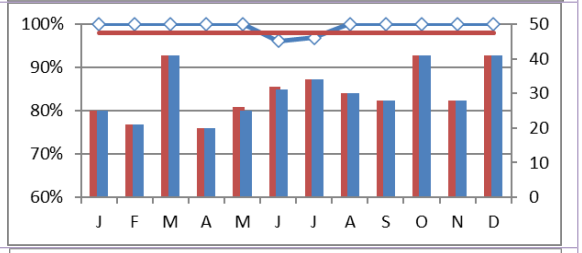
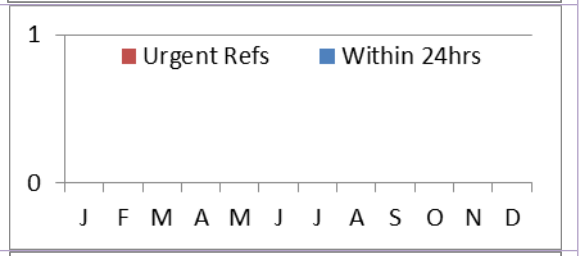
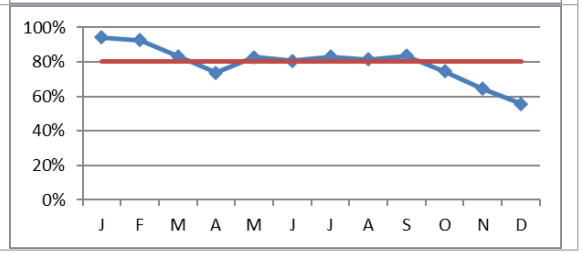
9. Appendix A – Q3 performance against the KPIs

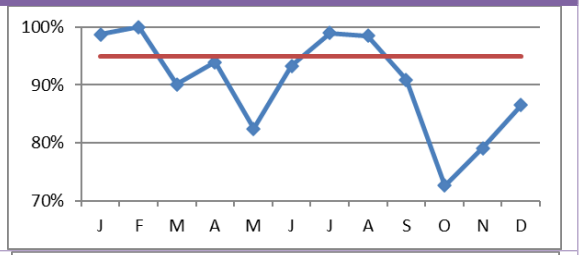
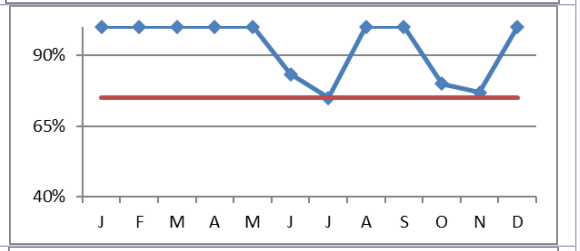
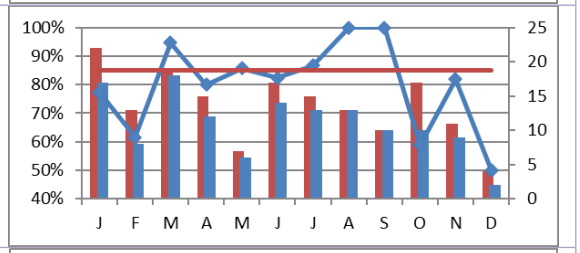
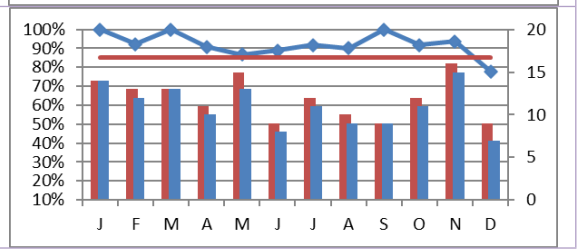
1.1. The table below summarises the Q3 performance against all indicators.

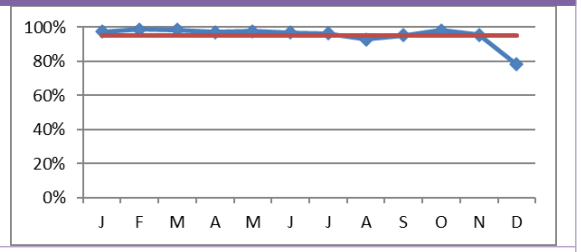
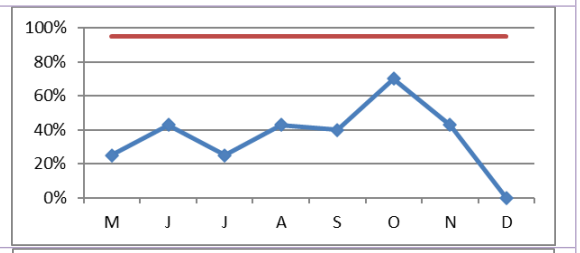
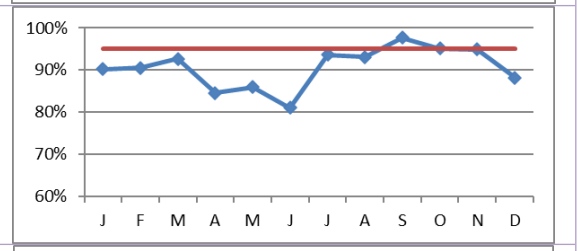
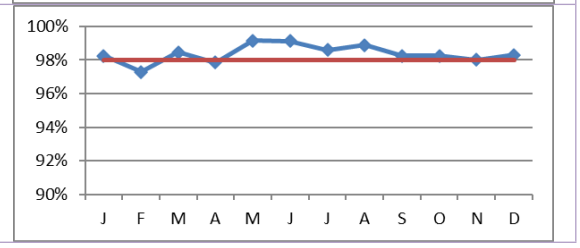
	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	**Trajectory**
NHS Oversight Framework	SOF1	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (UNIFY2 and MHSDS)22		≥60%	86%	55 64	↔	N/A
	SOF3	Data Quality Maturity Index (DQMI) – MHSDS dataset score.		>=95%	98% (Sept)	N/A	↔	N/A
	SOF4	Improving Access to Psychological Therapies (IAPT)/talking therapies Proportion of people completing treatment who move to recovery (from IAPT minimum dataset)		>=50%	53%	1,855 3,495	↔	N/A
		Improving Access to Psychological Therapies (IAPT)/talking therapies Waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks (3-Month Rolling)		>=75%	99%	7,378 7,444	↔	N/A
		Improving Access to Psychological Therapies (IAPT)/talking therapies Within 18 weeks (3-Month Rolling)		>=95%	100%	7,430 7,444	↔	N/A
	SOF5	Inappropriate out-of-area placements for adult mental health services		0	2355 (0)	N/A	↔	N/A

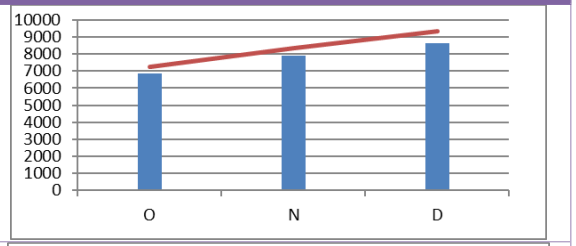
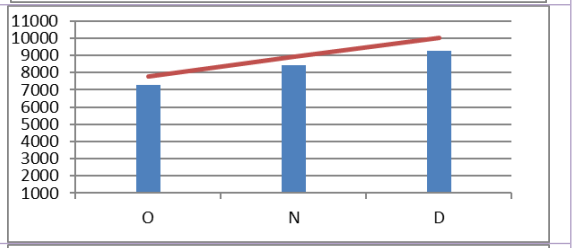
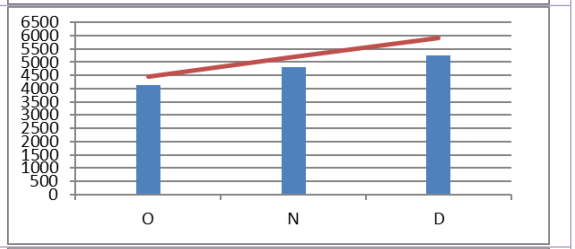
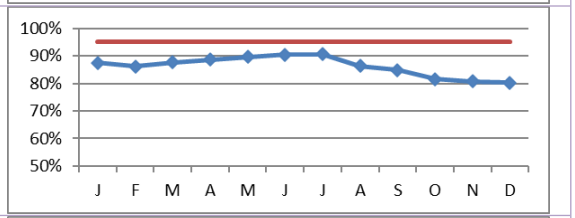
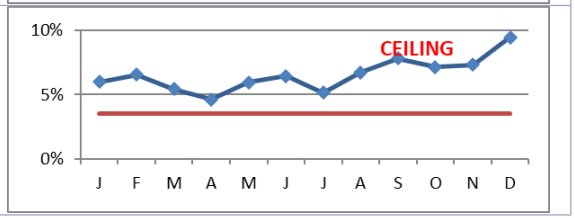
	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	**Trajectory**
Access	A1	Urgent referrals to community eating disorder services meeting 96 hours wait **(Contractual)**		>=98%	50%	1/2	↑	
	A2	Routine referrals to community eating disorder services meeting 28 days wait **(Contractual)**		>=98%	98%	96/98	↔	
	A3	Number of new cases of psychosis **(Contractual)**		150	177	177	↔	
	A4	Routine referrals to community mental health team meeting 28 days wait **(Contractual)**		>=95%	70%	548/783	↔	

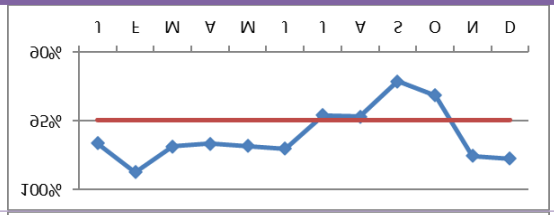
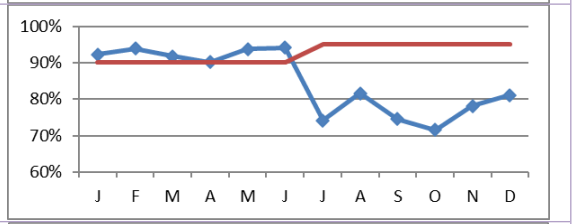
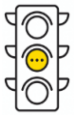
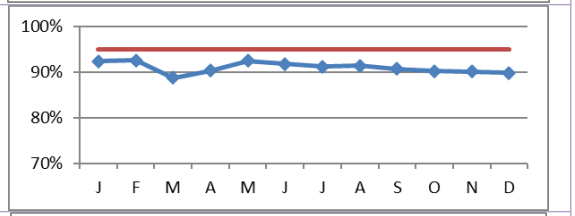
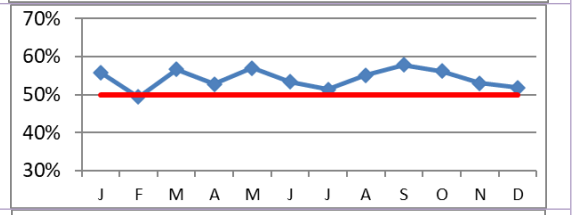
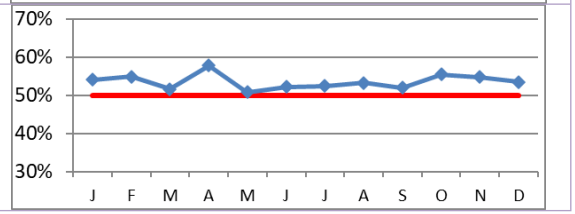
	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	**Trajectory**
Access	A5	Urgent referrals to community mental health team meeting 24 hours wait **(Contractual)**		>=98%	80%	8/10	↔	
	A6	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team		>=95%	98%	158/161	↔	
	A7	CRHTT referrals meeting 4 hours wait **(Contractual)**		>=98%	100%	843/843	↔	
	A8	MHLT Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	N/A	N/A	95%	683/718	↔	

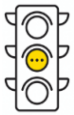
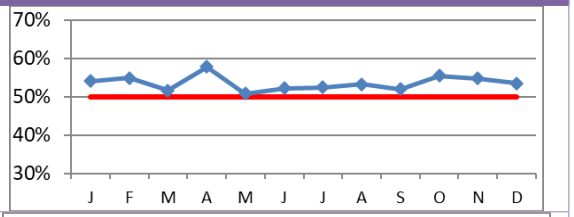
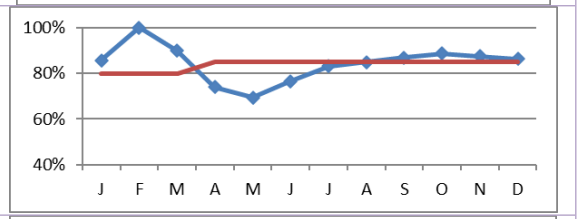
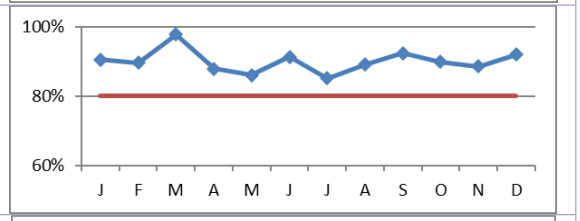
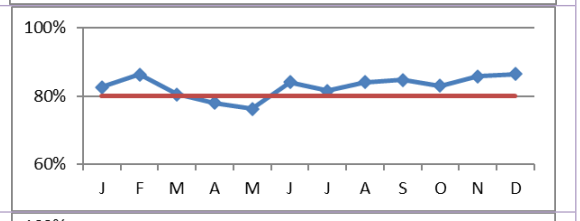
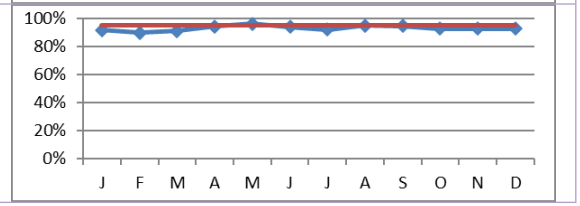
	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	**Trajectory**
Access	A9	MHLT Response times: 24 hours wait for ward referrals (Lister & Watford combined)	N/A	N/A	98%	209 214	↔	
	A10	Routine referrals to Specialist Community Learning Disability Services meeting 28 days wait **(Contractual)**		>=98%	100%	110 110	↔	
	A11	Urgent referrals to Specialist Community Learning Disability Services meeting 24 hours wait **(Contractual)**		>=98%	0	0	↔	
	A12	EMDASS Diagnosis within 12 weeks (Contractual)		>=80%	65%	375 576	↔	

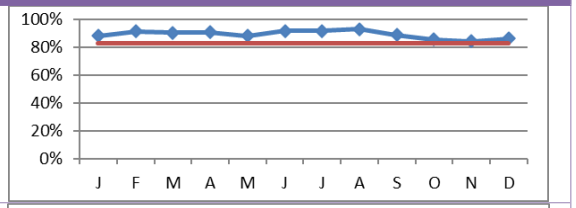
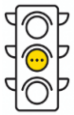
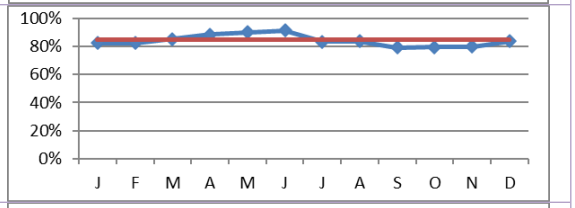
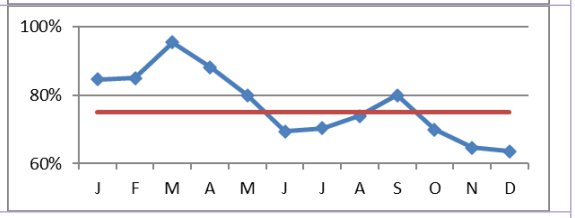
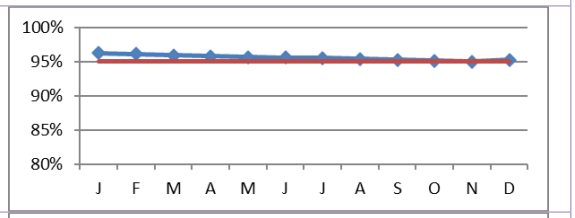
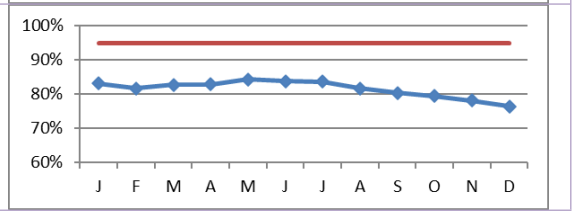
	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	**Trajectory**
Access	A13	CAMHS referrals meeting assessment waiting time standards - **CRISIS (4 hours) (Contractual)**		>=95%	79%	274/346	↔	
	A14	CAMHS referrals meeting assessment waiting time standards - **URGENT (P1 - 7 DAYS) (Contractual)**		>=75%	82%	18/22	↔	
	A15	CAMHS referrals meeting social worker contact waiting time standards - **TARGETED SERVICE 14 DAYS (Contractual)**		>=85%	66%	21/32	↔	
	A16	CAMHS referrals meeting assessment waiting time standards - **TARGETED SERVICE 28 DAYS(Contractual)**		>=85%	89%	33/37	↔	

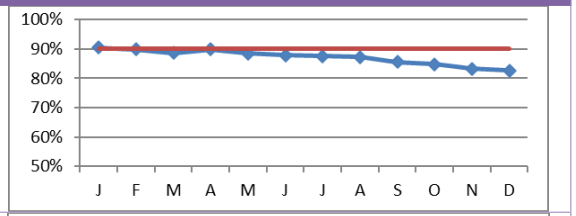
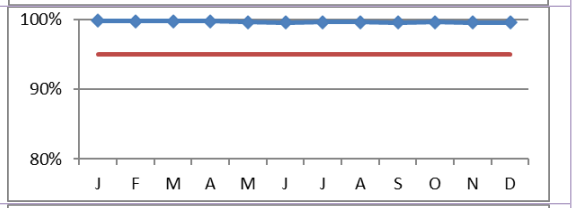
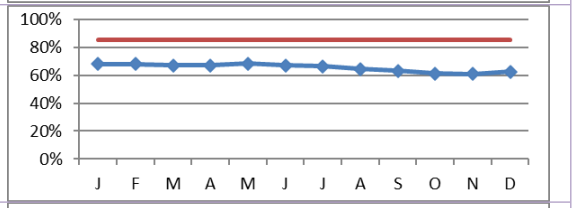
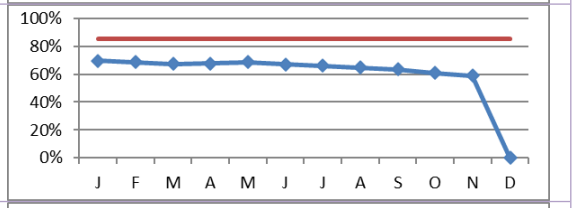
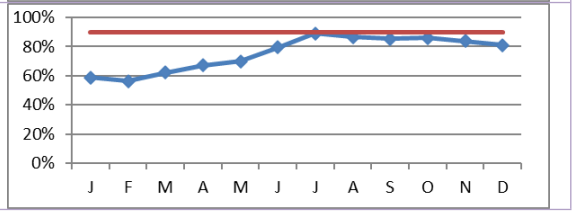
	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	**Trajectory**
Access	A17	CAMHS referrals meeting assessment waiting time standards - **ROUTINE (28 DAYS) (Contractual)**		>=95%	92%	250 271	↑	
	A19	CAMHS Eating Disorders - Urgent referrals seen within 7 Days (Contractual)		>=95%	33%	7 21	↔	N/A
	A20	CAMHS Eating Disorders - Routine 28 day Waited (Contractual)		>=95%	38%	10 26	↔	
	A21	SPA referrals with an outcome within 14 days (Internal)		>=95%	92%	7,569 8,149	↔	
	A22	Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services (Contractual)		>=98%	98%	8,999 9,165	↔	

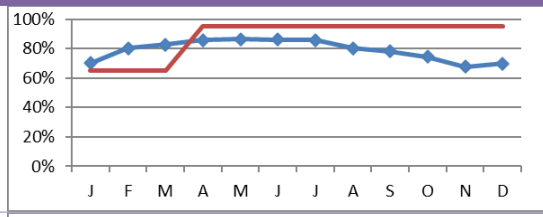
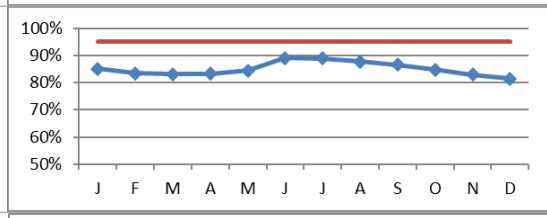
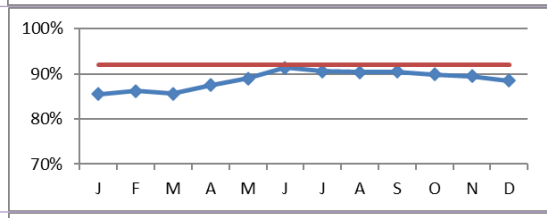
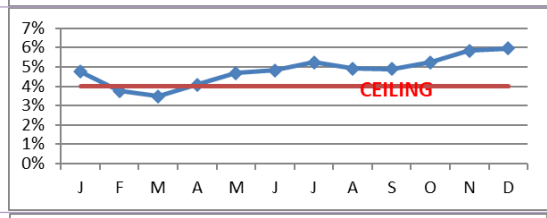
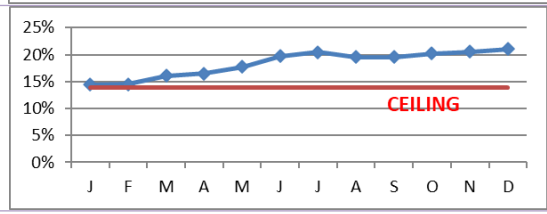
	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	Trajectory
Access	A23	Number of people entering IAPT treatment (ENCCG) **(Contractual)**		9,358	N/A	8,617	↔	
	A24	Number of people entering IAPT treatment (HVCCG) **(Contractual)**		10,044	N/A	9,264	↔	
	A25	Number of people entering IAPT treatment (Mid Essex) **(Contractual)**		5,908	N/A	5,251	↔	
Safety and Effectiveness	SE1	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months		>=95%	80%	1,385 / 1,726	↔	
	SE2	Delayed transfers of care to the maintained at a minimal level		<=3.5%	8%	2,722 / 34,727	↔	

	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	**Trajectory**
Safety and Effectiveness	SE3	Care Programme Approach (CPA): The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care		>=95%	96%	251 261	↑	
	SE4	The percentage of people under adult mental illness specialties who were followed up within 48 hrs of discharge from psychiatric in-patient care		>=80%	77%	208 270	↑	
	SE5	Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) **Seen Only**		>=95%	90%	15,897 17,690	↑	
	SE6	IAPT % clients moving towards recovery (ENCCG)		>=50%	54%	656 1,221	↔	
	SE7	IAPT % clients moving towards recovery (HVCCG)		>=50%	55%	814 1,491	↔	

	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	Trajectory
Safety and Effectiveness	SE8	IAPT % clients moving towards recovery (Mid Essex)		>=50%	49%	385 783	↑	
	SE11	Rate of acute Inpatient's reporting feeling safe **(rolling 3-month basis)**		>=85%	86%	95 110	↔	
	SE12	Rate of service users that would recommend the Trust's services to friends and family if they needed them		>=80%	90%	608 673	↔	
	SE13	Rate of service users saying they are treated in a way that reflects the Trust's values		>=80%	85%	2,340 2,756	↔	
	SE14	Rate of Service Users Saying staff are welcoming and friendly (Rolling 3 months) (Report		>= 95%	92%	49 53	↔	

	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	**Trajectory**
Safety and Effectiveness	SE15	Rate of Service Users saying they know how to get support and advice at a time of crisis (Rolling 3 months)		>= 83%	86%	44/51	↔	
	SE16	Rate of Service Users saying they have been involved in discussions about their care (Rolling 3 months)		>= 85%	84%	41/49	↑	
	SE17	Rate of carers that feel valued by staff **(rolling 3-month basis)**		>=75%	64%	14/22	↔	
	SE18	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	N/A	>=70%	N/A	N/A	↔	N/A
	SE19	Percentage of eligible service users with a PR cluster		95%	95%	11,117/11,669	↔	
	SE20	Percentage of eligible service users with a completed PbR cluster review (target changed from 99% to 95% in April 2017)		95%	76%	8,352/10,926	↔	

	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	**Trajectory**
Safety and Effectiveness	SE21	Data completeness against minimum dataset for Ethnicity (MHSDS)		90%	83%	22,852 27,652	↔	
	SE22	"Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital:		>=95%	100%	165,203 165,912	↔	
	SE23.a	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment)		>=85%	63%	11,611 18,565	↔	
	SE23.b	Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation)		>=85%	61%	11,316 18,565	↔	
	SE24	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services		>=90%	81%	441 544	↔	

	Ref	Indicator	Status	Target	Q3 *Percentage*	Q3 *Numbers*	Q4 Forecast	Trajectory
Safety and Effectiveness	SE24.a	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on Care Programme Approach)		>=95%	70%	648 929	↔	
Workforce	W6	Rate of staff with a current PDP and appraisal		>=95	81%	2,488 3,057	↔	
	W7	Rate of mandatory training completed and up to date		>=92%	88%	34,392 38,882	↔	
	W8	Sickness rate		<=4%	6%	17,336 305,523	↔	
	W9	Turnover rate (Rolling 12 months)		13.9%	21%	696 3,310	↔	

10. Appendix B – Q3 Exception Report

NHS Oversight Framework

2.1. The Trust met five out of the six KPIs in this domain. The table below outlines the performance and planned actions for KPIs currently underperforming.

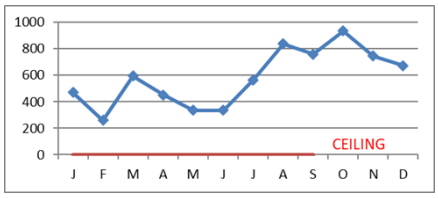
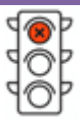
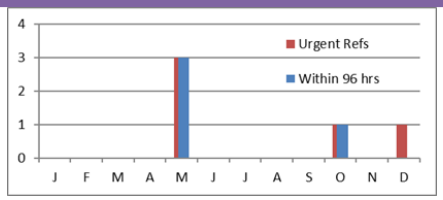
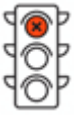
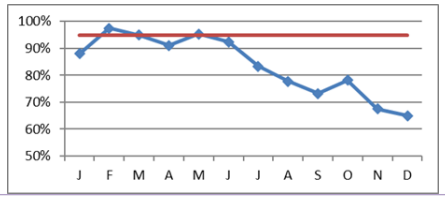
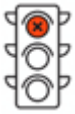
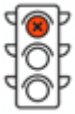
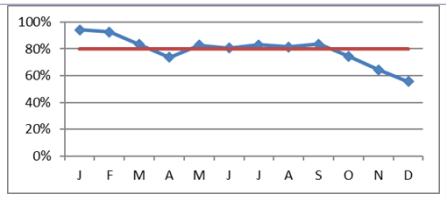
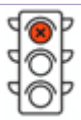
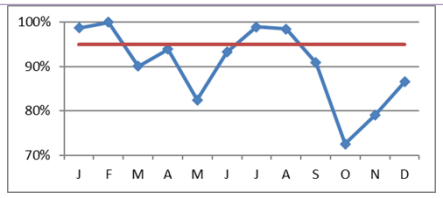
KPI	Status	Trend	Q3 Status/Action
Inappropriate Out of Area Placements (OAPs) for adult mental health services. (Target 620 bed days at end of Q3)			**Q3 Performance: 2,355** **December – 674 bed days** Performance against this target has been variable over the last 12 months, with placement days ranging from 800+ to 200 per month. Trajectory in place to reach 0 placements by end of Q4. 54 above trajectory in Q3. This target is unlikely to be met in Q4. **Action:** 3 main areas for improvement identified: Alternatives to admission; Treatment and Facilitating discharge. Discussions are also taking place with NHSI/E on a more realistic trajectory.

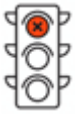
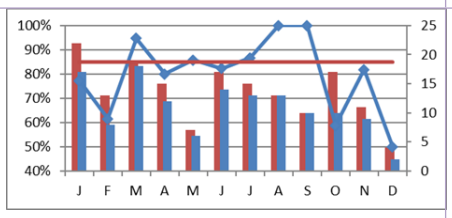
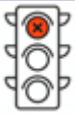
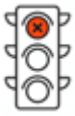
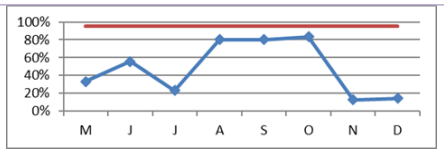
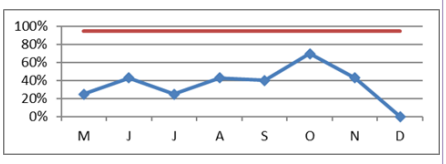
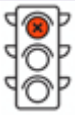
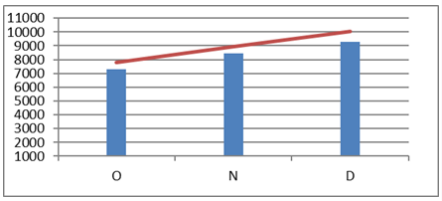
Table 5 – Underperforming NHS Oversight Framework KPIs

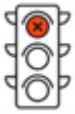
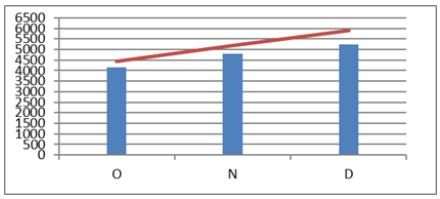
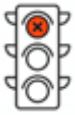
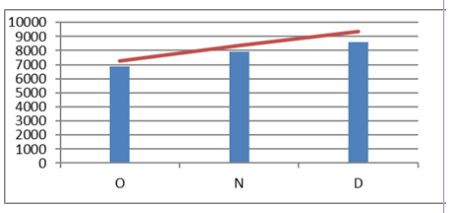
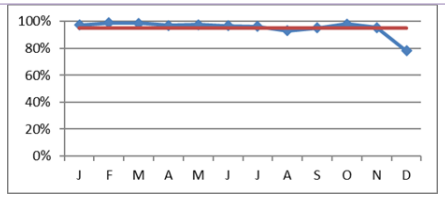
Access Indicators

2.2. The Trust met 9 out of 22 KPIs in this domain. The table below outlines the performance and planned actions for KPIs currently underperforming.

KPI	Status	Trend	Q3 Status/Action
Urgent referrals to community eating disorder services meeting 96 hours wait			**Q3 Performance – 50%** Small numbers of urgent referrals and a 98% target means that one person seen outside of the 24 hour period will result in a failure to meet target. One person was seen outside of 24 hours – in December because they were unable to attend the appointment. **Actions** Eating Disorders Team will continue to endeavour to see all urgent referrals within 96 hours. Recovery was achieved in December 2021.
Routine referrals to Adult community mental health team meeting 28 day wait (Target 95%)			**Q3 Performance – 70%** High caseloads and vacancy rates have contributed to capacity issues. North, NW and SW Quadrants have been particularly affected by capacity issues and are

			likely to continue to fail to meet target until local vacancy issues are addressed. NW have experienced a deficit in medical staffing, whilst SW is holding high vacancy levels of all staff. **Action:** A CQI project is underway to identify areas for improvement and different ways of working that will allow the indicator to be met without any loss of quality for the service user. We have developed a trajectory to recover this service by end of Q1 2022.
Urgent referrals to community mental health team meeting 24 hours wait (Target >=98%)			**Q3 Performance 80%** Small numbers of urgent referrals and a 98% target means that one person seen outside of the 24 hour period will result in a failure to meet target. Two people were seen outside of 24 hours; one in October due to capacity issues in Watford and one in November in Borehamwood. **Actions** ACMHS Teams will continue to endeavour to see all urgent referrals within 24 hours. Recovery was achieved in December 2021.
EMDASS Diagnosis within 12 weeks (Target 80%)			**Q3 Performance 65.10%** Increased referrals and a temporary reduction in staff due to redeployment to inpatient units during the last Covid wave has caused a backlog. **Action:** Recovery plans in place with a detailed trajectory predicting recovery in 18 – 20 weeks- end of Q1.
CAMHS referrals meeting crisis (4 hour) waits (Target 95%)			**Q3 Performance 79.19%** Ability to meet this target is directly related to the number of children and young people presenting to the service. Numbers of referrals have remained consistently high, with an 8% increase in all referrals vs a national 8% decrease. **Action:** Recruitment is underway for vacant posts and agency is

			covering in some areas but proving difficult to source. Trajectory for recovery is under development.
CAMHS Targeted 14-day social work contact (Target 85%)			**Q3 Performance 65.63%** Continuing issues with social worker contact meant that the target was not always met. Breaches were due to delays in getting information back from the children's social workers or being unable to obtain time to discuss the child. **Action:** • Feedback to HCC on difficulties • Exploring possibility of a shared target • Exploring possible recording options. Trajectory for recovery is under development.
CAMHS Eating Disorder Service meeting routine 28 day and urgent 7 day waits (Target 95%)	 	 	**Q3 Performance 28 day – 38.46%; 7 day – 33.33%** Average monthly referral rate has risen from an average of 22 per month to 45 – 50 per month after the first wave of the COVID pandemic and are now averaging at around 30 – 35. Children are also becoming more acutely unwell, whilst they wait to be seen. **Action** Additional resource agreed and joint action plan with commissioners. Medical Monitoring Clinic being set up with an 8A lead and establishment of Practitioner roles that will be open to more disciplines. Trajectory for recovery is under development.
Number of people entering IAPT treatment (Herts Valleys CCG) (Target 10,044)			**Q3 Performance – 780 behind target (92% of YTD target - a 1% decline on Q2)** Insufficient GP and self-referrals coming into the service to achieve access levels. Referral levels are rising slowly, but it is unlikely that the year-to-date shortfall will be regained. Discussions have taken place with Eoin regarding promotion of IAPT services, as this pattern is the same across the region. Plans in place for targeted service promotion. **Trajectory:** Currently meeting 95% trajectory. Trajectory for recovery: Q1: 93 %

			Q2: 93% Q3: 92% (Target 95%) Q4: 100%
Number of people entering IAPT treatment (Mid Essex) (Target 5908)			**Q3 Performance – 657 behind target (89%)** Insufficient GP and self-referrals coming into the service to achieve access levels. Referral levels are rising slowly, but it is unlikely that the year-to-date shortfall will be regained. Discussions have taken place with Eoin regarding promotion of IAPT services, as this pattern is the same across the region. Plans in place for targeted service promotion. **<u>Trajectory:</u>** Currently meeting 95% trajectory. Trajectory for recovery: Q1: 85% Q2: 95% Q3: 89% Q4: 100%
Number of people entering IAPT treatment (East & North CCG) (Target 9,358)			**Q3 Performance – 741 behind target (92%)** Insufficient GP and self-referrals coming into the service to achieve access levels. Referral levels are rising slowly, but it is unlikely that the year-to-date shortfall will be regained. Discussions have taken place with the commissioner regarding promotion of IAPT services, as this pattern is the same across the region. Plans in place for targeted service promotion. **<u>Action:</u>** Currently meeting 95% trajectory. Trajectory for recovery: Q1: 85% Q2: 96% Q3: 92% Q4: 100%
CAMHS referrals meeting routine 28 day wait (Target 95%)			**Q3 Performance 92.25%** Breaches were due to capacity issues, both in CAMHS community teams and in SPA, causing late referral to pass on. Capacity expected to improve as COVID impact diminishes. Trajectory for recovery is under development.

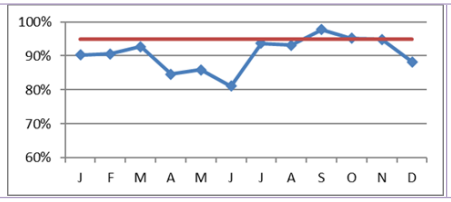
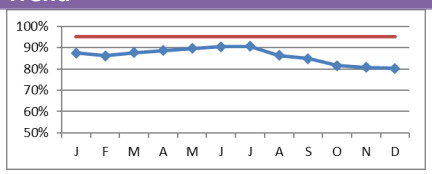
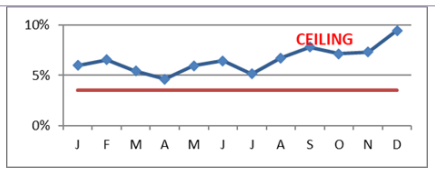
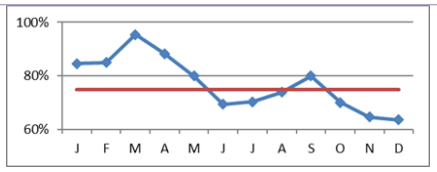
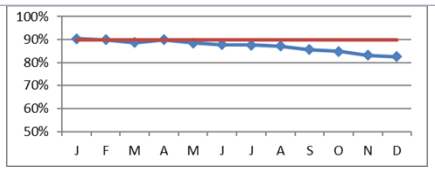
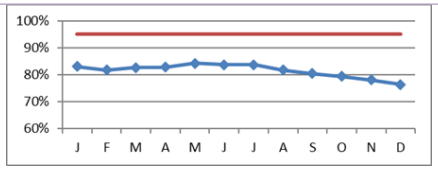
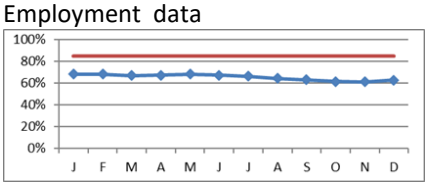
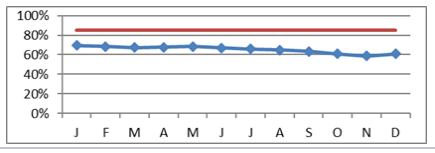
SPA referrals with an outcome within 14 days			**Q3 Performance – 92.88%** Performance against this target has fluctuated over the year, due to capacity issues in SPA. Trajectory for recovery is under development.

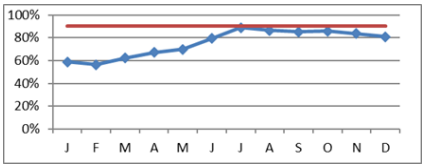
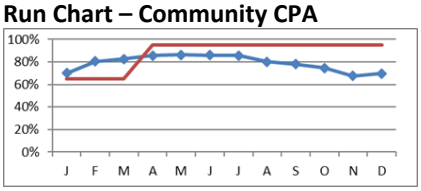
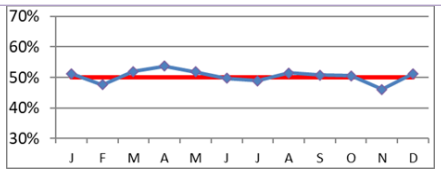
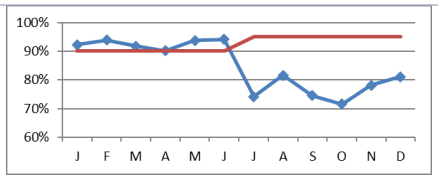
Table 6 - Underperforming Access KPIs

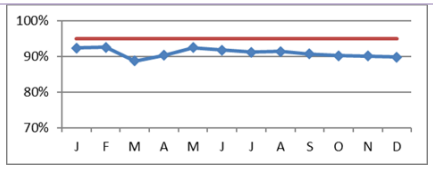
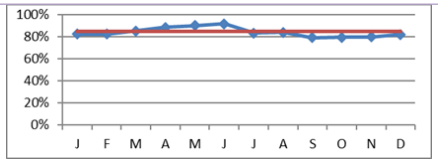
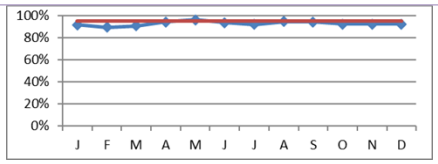
Safety and Effectiveness

2.3. The Trust met 9 out of 23 KPIs in this domain. The table below outlines the performance and planned actions for KPIs currently underperforming.

KPI	Status	Trend	Q3 Status/Actions
CPA reviews within the last 12 months for service users on CPA (Target 95%)			**Q3 Performance 80.24%** CPA Reviews have remained relatively stable throughout the Quarter. E&N SBU require an additional 43 CPAs to meet target and West SBU require an additional 212. Problems in the East and West include capacity issues due to staffing deficits due to vacancies and sickness, high caseloads and service users without a care co-ordinator are impacting the West in particular. **Actions:** 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. Trajectory for recovery is under development.
Delayed Transfers of Care (DTCs) (Target 3.5%)			**Q3 Performance 7.84%** High levels of delay in Adult Acute services due to insufficient placements available for people with complex care needs. Shorter delays in older adults' services, but with higher turnover – some instances of placements not being able to take older adults due to COVID outbreaks. Some instances of delays due to foreign nationals having expired visas and people seeking asylum without papers or funding agreed. **Actions:** Implementing recommendations of joint HPFT / Regional review of practice, including better community and acute engagement through the clinical review meetings. As a result we developed a discharge planning

KPI	Status	Trend	Q3 Status/Actions
			toolset in Q2 that is being implemented in Q3 & Q4. A 6-month acute pathway improvement plan has been commissioned, focusing on 3 main areas for improvement: Alternatives to Admission, Treatment and Facilitating Discharge. Trajectory for recovery is under development.
Rate of carers that feel valued by staff (Target 75%)			**Q3 Performance: 64%** Current response rate is low, affecting the robustness of the data. **Action** HYS is under review and number of responses are expected to increase. Carer Essential Training is underway and there is an audit linked to this with the aim to train 300 adult community staff by March 2022. West SBU working on Carers Needs and Involvement CQI project to improve communication and involvement in care. E&N SBU – carer meetings and surgeries ongoing on older inpatient units.
Data Completeness against minimum dataset for Ethnicity (Target 90%)			**Q3 Performance: 82.64%** Possible decreased focus on data quality during the COVID emergency **Actions:** Target to achieve 95% by the end of Q4, by culture change not achieved.
Percentage of eligible service users with a PBR cluster review (Target 95%)			**Q3 Performance: 76.44%** As focus on PBR clustering declined so did performance and is not currently seen as a priority – it has, however, stayed relatively stable.
Mental Health Services Data Set submissions to NHS Digital Employment & Accommodation (Target 85%)	 	Employment data  Accommodation data 	**Q3 mean performance: 62%** 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. There have been 2 focussed drives conducted by the Digital Support Team over the last 3 months.

KPI	Status	Trend	Q3 Status/Actions
			Actions: 1)Alternative action to Digital Support Team reminder campaign needs to be identified. 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 – this has not yet started. Trajectory for recovery is under development.
Cardio-metabolic checks for people with psychosis (Target 90%; FEP 90%; Community CPA 95%)	 	**Run Chart – FEP**  **Run Chart – Community CPA** 	**Q3 performance:** **FEP = 81.07%** **Community CPA = 69.75%** Performance saw an improvement March 2020 up until July which was attributable to a greater focus in Community Teams on carrying out health checks. The position has since plateaued as a result of capacity issues within the teams and higher sickness rates, particularly within the SW quadrant who continue to face challenges to meet this measure due to ongoing capacity and sickness issues. CPA: E&N currently at 81%. West at 58%, a drop of 10% over the last 4 weeks. FEP has seen a downturn in performance and is not in line with recovery trajectory in Q3. **Actions:** FEP: Individual action plans for PATH Teams, supported by CDs. CPA: Expected to improve as we move out of COVID measures. Trajectory for recovery is under development.
IAPT clients moving toward recovery) Mid-Essex)			**Q3 Performance:49.17%** November performance fell below 50% due to a number of factors coinciding in the month – performance recovered in December and is expected to continue and fully recover by the end of Q4.
Follow-ups within 48 hours of discharge of inpatient care (Target 80%)			**Q3 Performance: 77%** Inpatient units facing recording issues whereby discharges are being not being recorded on time; service users not able to be contacted despite multiple attempts.

KPI	Status	Trend	Q3 Status/Actions
			Actions: 10-point action plan in place to improve performance following CQI project. Early data for Q4 shows significant improvement with a 92% achievement against the 80% target.
Rate of service users with a completed up to date risk assessment (Target 95%)			**Q3 Performance – 90%** Several issues have impacted on performance for this indicator. There are a number of service users in the SW adult Quadrant who have not been allocated a care co-ordinator; service users transferred from ACE in Essex LD Services without risk assessments; the roll over from the initial push on risk assessments at the beginning of the COVID pandemic; but the predominant reason for under performance is the large medical caseload carried by some of the consultants that makes it difficult to monitor and update risk assessments. **Actions:** 1) Local management actions include individual improvement plans with trajectories. 2) Deputy Medical Directors leading a CQI to simplify risk assessment recording in Paris for long term solution. Recovery expected by the end of Q1.
Rate of Service Users saying they have been involved in discussions about their care (Target 85%)			**Q3 Performance: 84%** Current response rate is low, affecting the robustness of the data. **Action** HYS is under review and number of responses are expected to increase. OT and inpatient meetings underway to improve activities and get feedback on what could improve. Initiatives in LD services to get service user views on care.
Rate of Service Users Saying staff are welcoming and friendly			**Q3 Performance 92%** This target has a history of being met. Current response rate is low, which means a single response being the difference between underperforming and meeting the standards. **Actions** • Mutual Help Meetings are being restarted onwards.

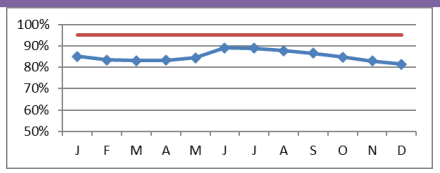
KPI	Status	Trend	Q3 Status/Actions
			• IAPT services are recruiting recently discharged service users for involvement groups, i.e. understanding the experience. • Welcome APP has been launched. Peer support workers being employed in EPMHS to support service users. Work ongoing to recruit more Peer Experience Listeners to understand the experience for service users.

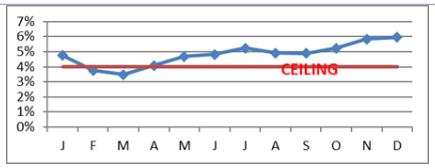
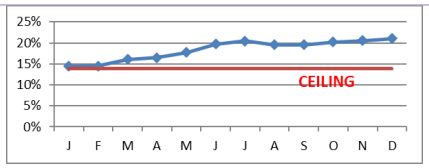
Table 7 - Underperforming Safety and Effectiveness KPIs

Workforce

2.4. Feedback from our staff through pulse surveys, team meetings, and Executive Listening events tells us that whilst they are feeling under pressure, they also feel listened too and supported. The Festival of Wellbeing success of the summer has been extending into Winter and the distribution of winter hampers was well received by staff at Christmas.

2.5. The table below outlines the performance and planned actions for KPIs currently underperforming.

KPI	Status	Trend	Q3 Status/Action
Rate of staff with a current Personal Development Plan and appraisal (Target 95%)			**Q3 Performance: 78.68%** Whilst significant recovery since H1 of 2020/21 has taken place, operational pressures and leave impacted compliance in late Summer 2021 and again during Winter. In addition, significant numbers of people were appraised this time last year when the new approach was launched, which means that large numbers of people were due an appraisal review in Q3. **Actions:** 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. Work is taking place to create an App similar to the new Supervision App to enable real time appraisal recording and also help produce a Trust-wide training needs analysis and improved talent management. It is anticipated that the App will improve compliance.

KPI	Status	Trend	Q3 Status/Action
			Recovery is expected in Q1 of 2022/23
Sickness Rate (Target 4%)			**Q3 Performance: 5.78%** **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 - We continue to offer a range of health and wellbeing support and events covering exercise and diet in menopause, strategies to help manage menopause symptoms, webinars on relaxation, self-care, stress, sleep and burnout, plus activities such as arts and crafts sessions, Pilates, mindfulness, hypno-relaxation, DBT sessions, yoga, wellbeing talks, fitness sessions, and virtual pampering sessions. - All our people were encouraged to take time to rest and connect with family and loved ones during the festive period to help support their wellbeing. However, it should be noted that services are facing increased pressure as a result of the latest phase of the pandemic and as a result of Winter pressures. This in turn may continue to impact on our people and it is likely that this may lead to absence continuing at above our target of 4% during Q4.
Turnover Rate (Target 13.9%)			**Q3 Performance 21.02%** **<u>Actions:</u>** A detailed action plan aligned to our new recruitment and retention (R&R) strategy has been developed in partnership with SBUs, the R&R Group, TMG and the People and OD Group. 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 Retention Pathfinder project commenced in December, supported

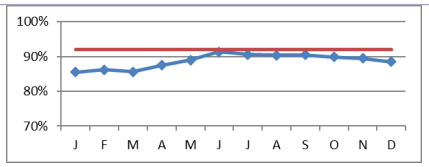
KPI	Status	Trend	Q3 Status/Action
			by NHSE/I for all the trusts in the Hertfordshire and West Essex ICS. This project will help us analyse the workforce data and explore it further to develop an action plan for ICS level actions where it may be beneficial to collaborate. In addition, our flexible working project in partnership with NHSE/I is now underway to further build on our work-life balance offer. Our current flexible retirement offer is well used, and we currently have 77 staff who have returned to work following retirement. We are exploring how we can further support staff with regards promotion and career development within the Trust. Trajectory for recovery is under development.
Mandatory Training Rate (Target 92%)			**Q3 Performance: 89.07%** 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. The position significantly improved from June 2021. **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 and HRBPs proactively support compliance in the SBUs. 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 six further additional trainers having now been trained who will be signed off as competent by end of Q4 to increase trainer capacity, additional venues are being used and weekend training is being run. Due to increased pandemic and Winter pressures in Q3 and 4, it is likely that recovery will not be achieved until Q1 of 22/3.

Table 8 - Underperforming Workforce KPIs

11. Appendix B – Highlights from October 2021 NHS Benchmarking Report

Community Services

11.1. Our referral rates for adult and older adult Community Services are below the national trend. In October 2021 the rate was at 313 per 100,000 population, with the national position at circa 391 per 100,000. The pattern of referrals reflects the national trend, increasing from March 2021 and stabilising.

11.2. Our rate of clinical contacts per patient is at the national average of 50% having contact within the month, despite a far higher average caseload and our number of total clinical contacts per 100,000 population is above the average at 2,674. This is a 7% increase on the same period in 2019-20 and contrary to the national trend which shows an 8% decrease.

11.3. We are partly managing this increase using non-face to face contacts. 53% of our contacts were delivered in a non-face to face format during October vs the national average of 45%. This year, there is a national swing towards non-face to face 88%, compared to a 58% swing in HPFT which demonstrates that we were early adopters of this with our adoption peak in the previous year.

Crisis Resolution and Home Treatment Services (CHRT)

11.4. Our rate of CRHT referrals in October per 100,000 population was 40% lower than the national average at 66 vs 109, reflecting the high community caseloads and acuity of people being managed in the community teams.

11.5. Our clinical contacts per 100,000 population was far closer to the average at 459, vs the national average of 482.

11.6. We deliver these contacts in a non-face to face format in 43% of cases, against a national average of 38%. As for our community teams, we appear to be early adopters of non-face to face ways of working, with a 7% increase of non-face to face contacts in October 2021 vs a 31% increase nationally.

Adult Acute Inpatient Services

11.7. We have a significantly lower number of adult acute beds than the national average. We benchmark at 13.4 beds per 100,000 population, as opposed to a national figure of 20.6. Our beds have increased by 9% since 2019-20 against a national increase of 2%.

11.8. Our bed occupancy rate is high at 100% against a national average of 93%.

11.9. However, our rate of admissions per 100,000 registered population is low, at 10.1 as opposed to the national figure of 16.5. This is a reduction of 17% on our admission rate in 2019-20.

11.10. Admissions under the mental health act per 100,000 registered population is low at 4.3% vs a national average of 7.6%. This is, however, an 8% increase on our numbers in 2019-20. 42% of our admissions are now under the mental act against the national average of 48%. This represents a 31% increase over the last year.

11.11. Our length of stay is below the national average of 36.2 days, at 29 days.

Older Adult Inpatient Services

11.12. Our number of older people's beds are above the national average at 49.5 per 100,000 registered population vs the national figure of 40.7.

11.13. Our bed occupancy rate is also above the national average 88% at 94%. This is a 2% reduction on 2019-20, whereas the national picture has seen a 3% increase.

11.14. Admissions per 100,000 registered population are low, almost half of the national average (6.5 vs 12.4 respectively). This is a 29% decrease on 2019-20. The national decrease was 13%.

Children and Young People's Services

11.15. Total clinical contacts per 100,000 population are below the national average at 1625 vs 1881. This represents an 8% increase on 2019-20, whereas the national picture is an 8% decrease.

11.16. We deliver 54% of our contacts in a non-face to face format, vs the national average of 48%. This is a 58% increase on 2019-20 vs a 107% increase nationally, again reflecting that we were early adopters of non-face to face contacts.

11.17. Our bed occupancy rate is higher than the national average of 74% at 85%.

Learning Disabilities (LD) and Autistic Spectrum Disorder (ASD) Community Services

11.18. We receive a higher than average number of referrals per 100,000 population at 31, as opposed to 18.

11.19. Our caseload is consequently high, at 600 per 100,000 against a national average of circa 200.

11.20. The percentage of our caseload who receive a clinical contact during the month was lower than the national average at 31% vs 41%. However, the total clinical contacts were over double the national average at circa 520 vs 235.

11.21. 60% of our contacts were delivered in a non-face to face format vs 58% nationally.

11.22. Our bed occupancy rates are at 94% against a national figure of 73%.

PUBLIC Board of Directors

Meeting Date:	31 March 2022	**Agenda Item:** 11
Subject:	Financial Position for Month 11 2021/22	**For Publication:** Yes
Author:	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:

This report sets out the Trust's financial position as at 28 February 2022, month 11 2021/22.

Action required:

To note the financial position at Month 11 and the forecast year end outturn for 2021/22.

Summary and recommendations

Overview

- The Trust is on track to deliver against the revised financial plan of a breakeven financial out turn.
- As at 28 February, the Trust reports a break-even position in line with plan for the month of February and for the year to date.

Overall income and expenditure are shown below:

Financial Position to 28 February 2022 £000	February Plan	February Actuals	February Variance	YTD Plan	YTD Actuals	YTD Variance
Income incl. COVID-19	**24,857**	**25,694**	**837**	**268,045**	**270,845**	**2,800**
Expenditure	**24,857**	**25,694**	**(837)**	**268,045**	**270,845**	**(2,800)**
Surplus / (Deficit)	**0**	**0**		**0**	**0**	

*NB the Income and Expenditure for the Provider Collaborative are not included in the above and is identified separately below

Both income and expenditure are above Plan for the month and for the year to date. Monthly performance is summarised below:

- In line with recent months, Income is above Plan due to the receipt of an additional allocation from Hertfordshire Commissioners and the confirmation of additional national funding for IT projects.
- Expenditure continues to reflect the additional pro-active investment in clinical services during H2.
- The spend on Secondary Commissioning remains high in month, (£3.33m). This has decreased circa £0.3m from month 10 but activity levels remain similar to months 9 and 10.

Conclusion

- The Trust remains on plan to deliver a forecast break-even outturn position for FY22.
- Looking forward to 2022/23, it remains important to ensure that the costs associated with non-recurrent investments during H2 cease as planned by 31 March 22.

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 16 March 2022
Finance & Investment Committee 22 March 2022

1. Summary

1.1. As at 28 February, the Trust reports a break-even position in line with plan for the month of February and for the year to date.

1.2. The Trust has pro-actively invested in clinical services during H2 2021/22 to extend capacity and to add additional resilience over the winter period. This investment has been in large part off-set by additional funding from Commissioners.

Financial Position to 28 February 2022 £000	February Plan	February Actuals	February Variance	YTD Plan	YTD Actuals	YTD Variance
Income incl. COVID-19	24,857	25,694	837	268,045	270,845	2,800
Pay	16,840	16,426	414	179,076	178,104	972
Sec Comm.	3,213	3,329	(116)	33,563	35,375	(1,812)
Non-Pay & Overheads	4,804	5,939	(1,135)	55,407	57,367	(1,960)
Total Expenditure	24,857	25,694	(837)	268,045	218,609	(2,800)
Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**	**0**

1.3. The table above shows a break-even position in month and for the year to date, with individual variances to Plan as follows:

- Income is above Plan by £837k in month. This is due to the receipt of additional non-recurrent investment in IT projects;
- Pay costs are behind Plan in month due to ongoing challenges in recruitment, particularly to clinical roles;
- Secondary commissioning costs remain above Plan - by £116k – in month due in large part to exceptionally high demand for services; and,
- Non-Pay and Overheads are above Plan by £1,135k for the month of February. This reflects the planned application of IT funding received in month.

2. Income

2.1. Year to date income now reflects an additional £2m non-recurrent allocation from Hertfordshire Commissioners and an additional allocation for IT projects of £856k.

3. Expenditure Position including Key Variances

Pay

3.1. Pay reports below Plan by £972k for the year to 28 February:

- Substantive Pay costs are c£3.3m below Plan for the year to date, this reflects the ongoing difficulty in recruiting to clinical posts

- Temporary staffing (Bank and Agency) now reflects 17% of total pay spend in February, an increase from 15% in Q1 and Q2, as a consequence of the above.

Secondary Commissioning

3.2. Secondary Commissioning expenditure reports above Plan for the year to date by £1.8m, and above plan by £116k in month. There has been sustained increase in activity in recent months due to exceptional demand for Acute, PICU and Older Adult external placements and high acuity requiring high levels of observation, at additional cost. PICU bed usage has increased slightly in month as has Acute activity. Expenditure on Social Care and Rehab placements is now also reflecting increasing demand and placement numbers.

3.3. The Trust has seen an increase in the average number of Acute Adult placements from 9 in month 3 to 41 in month 11.

3.4. Prior to the Pandemic, the Trust typically had between 15 and 20 service users in placements out of area, across all services. During month 11 an average of 47 service users (across all Care Groups) were in placements out of area. The Trust is not commissioned, (outside of Pandemic measures) for the current volume of out of area placements.

Overheads and Non-Pay

3.5. Expenditure on Non-pay and Overheads is above Plan by £2.8m for the year to date. This now reflects provisions for the contractually agreed investment in the refurbishment of The Stewarts and the deployment of the recently received investment in IT projects.

4. Provider Collaborative

4.1. The Provider Collaborative (PC) was established in July 2021 (Month 4) and continues to report a break-even position in month and for the year to date. However, the forecast outturn position is now also reflective of a break-even position, (Month 10 reported a £549k forecast outturn deficit). PC Income and Expenditure for HPFT is as follows:

£'000s	February	Year to Date
Income	**(3,367)**	**(30,235)**
Expenditure	**3,367**	**30,235**
Variance	**0**	**0**

4.2. The cost of tier 4 CAMHS services continues to over-spend, albeit at a reduced level compared to previous months, but is off-set by underspends on both Adult Secure and Adult Eating Disorder services.

5. Transformation Funding

5.1. The position reported above reflects the Trust's investment and expenditure of £8m non-recurrent transformation funding, (SDF at £4.47m and SR at £3.5m).

6. Delivering Value Programme

6.1. The Trust's revised Financial Plan for 2021/22 included a DV target of £4.6m, reflective of planning guidance issued in year.

6.2. Savings of £4.1m have been realised over the 11 months to February, with a forecast outturn of £4.6m for the full year.

6.3. Quality Impact Assessments have been completed and approved for all 2021/22 schemes.

7. Forecast Outturn

7.1. The following table sets out a break-even forecast outturn for the year to 31 March 2022.

	Year to Date			Full Year		
Financial Position to 28 February 2022 £000	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast Outturn**	**Variance**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Income incl. COVID-19	268,045	270,845	2,800	293,229	294,740	1,511
Income - Provider Collaborative	30,368	30,235	-133	33,148	33,148	0
Pay	179,076	178,104	972	196,250	195,201	1,049
Secondary Commissioning	33,563	35,375	-1,812	36,873	38,693	-1,820
Provider Collaborative	30,368	30,235	133	33,148	33,148	0
Non Pay	20,624	20,129	495	22,487	21,727	760
Overheads	34,783	37,238	-2,455	37,619	39,119	-1,500
Surplus / (Deficit)	-	-	-	-	-	-

7.2. This position reflects significant additional income which has been pro-actively applied to enhance clinical service capacity and resilience over the second half of the year.

8. Conclusion

8.1. The Trust is forecasting to deliver a break-even revenue position for the year ending 31 March 2022.

8.2. To ensure the Trust exits 2021/22 in a balanced financial position it is important to ensure that expenditure linked to short term investments ceases as planned by 31 March 2022.

8.3. Members are asked to note the financial position as at 28 February 2022.

Meeting Date:	31 March 2022	**Agenda Item:** 12
Subject:	Gender Pay Gap	**For Publication:** Yes
Author:	Maria Gregoriou, Associate Director of People	**Approved by:** Janet Lynch, Interim Director of People and Organisational Development
Presented by:	Janet Lynch, Interim Director of People and Organisational Development	

Purpose of the report:

To inform the Board of the 31 March 2021 snapshot gender pay gap data as required for statutory reporting, and the report which will be published on the Trust's public facing website.

Action required:

The Board are asked to receive the report and approve the publication of the public-facing report on the website.

Summary and recommendations:

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

Attached are two reports:

- The first report, Gender Pay Gap Data for Statutory Reporting, is a summary of the data required for statutory reporting requirements which includes the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile. This is the data which will be submitted via the Government portal.

- The second report, Gender Pay Gap, is a written statement which includes the data analysis to be published on our public facing website as required under legislation.

In summary HPFT has:

1. A mean gender pay gap of 9.92% for the snapshot period as at March 2021, which is a modest reduction from 10.10% in 2020.

2. The gender pay gap across the Agenda for Change workforce is 1.25%, which is significantly reduced from 5.54% from 2020.

3. There have been some reductions in the pay gap across the Trust. Analysis of the other staff groups indicates that the Trust gender pay gap may be attributed to non-Agenda for Change pay grades, as follows:

- At VSM level, our mean gender pay gap is 7.67% (an increase from 0.44% in 2020)
- Our medical staff have a mean gender pay gap of 8.08% (a significant decrease from 10.85% in 2020)
- Our mean bonus pay gap is 24.40%; a significant decrease from 38.52% in 2020. The reduction is largely due to clinical excellence awards, where there has been a reduction from 23.95% in 2020 to 17.87% in 2021. There were 2 fewer male consultants receiving the CEA payment and 1 less female consultant compared to 2020.

A new gender pay gap action plan will be co-produced with our Women's Network and other staff networks to ensure that we can build on the improvements made.

The Board is asked to receive this report and approve publication of the data report as required by legislation.

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

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

Summary of Financial, IT, Staffing & Legal Implications:

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

Fulfils our statutory obligations under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

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

PODG – 2nd March 2022; Executive Team 23rd March 202

Hertfordshire Partnership University NHS Foundation Trust

Trust Board
Gender Pay Gap Report
For the period ending 31st March 2021

1. Introduction

1.1 This is the fourth Gender Pay Gap report for Hertfordshire Partnership University NHS Foundation Trust, and supports the workforce data that the Trust uses to monitor diversity and informs our decision-making regarding workforce inequalities.

1.2 The workforce at HPFT is predominantly female, which is in common with the wider NHS. HPFT has a good track record of promoting diversity within the workforce. The Trust uses this data to recognise that inequalities continue to exist and drive the actions that we take to address those inequalities.

1.3 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which came into force on 31st March 2017, has made it a statutory requirement for organisations with 250 or more employees to report their gender pay gap annually by 31st March, as at 31st March the previous year.

2. Purpose of this report

2.1 This report sets out the information that the Trust is required to publish and some further information that has shaped our current action planning. These actions are included as next steps at the end of this report. The Trust will continue to build on the progress it is making in promoting diversity and equality within the workforce and living our values of being welcoming, kind, positive, respectful, and professional.

3. Background to Gender Pay Gap Reporting

3.1 Since the 31st March 2017, it has been a legal requirement for public sector organisations with more than 250 employees to report annually on their gender pay gap.

3.2 The first report was published in 2018, and was informed by 'snapshot data' as at 30th March 2017. The second and third reports were published in 2019, and 2020 and were informed by 'snapshot data' as at 31st March for each previous reporting year. This year's report is informed by 'snapshot data' as at 31st March 2021.

3.3 The report must include:

- ✓ The mean and median gender pay gaps
- ✓ The mean and median gender bonus gaps
- ✓ The proportion of men and women who received bonuses
- ✓ The proportions of male and female employees in each pay quartile

3.4 The definitions set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and NHS Employers guidance on the definitions of ordinary and bonus pay have been followed in preparing this report.

3.5 The gender pay gap shows the difference in the average pay between all men and women in the workforce. The gender pay gap is different to equal pay. Equal pay deals with pay

differences between men and women who carry out the same, or similar, jobs or for work of equal value. It is unlawful to pay people unequally on the basis of gender. It is possible to have pay equality but still have a significant gender pay gap.

3.6 The Gender Pay Reporting regulations were specifically introduced to facilitate a national shift towards greater equality in the average hourly earnings of men and women. This is influenced by a range of factors, including:

- ✓ Women historically working in lower-paid occupations and sectors and occupying less senior roles
- ✓ Women taking time out and / or working part-time due to unequal sharing of caring responsibilities
- ✓ Historical stereotyping and workplace cultures that were unsupportive

3.7 Across the UK in 2020, the Office for National Statistics reported that the mean gender pay gap for full time employees was 7.4%, down from 9% in the previous year, whilst for all employees it was 15.5%, down from 17.3%. (Source – The Office for National Statistics, November 2020).

3.8 The Trust is committed to the principle of equal opportunities and equal treatment for all employees regardless of sex, race, religion or belief, age, marriage or civil partnership, pregnancy / maternity, sexual orientation, gender reassignment or disability. On this basis, the Trust has a clear policy of paying employees equally for the same or equivalent work, regardless of their sex (or any other characteristic set out above). The Agenda for Change pay framework is designed to support NHS Trusts in ensuring NHS employees are paid equally and this is fully embedded within the Trust.

3.9 The Trust has a largely female workforce, like many other NHS organisations, with 73% of the workforce being female, and 27% male.

4. Definitions and Scope

4.1 There are six measures that must be included in a gender pay gap report – these are:

- ✓ The mean gender pay gap
- ✓ The median gender pay gap
- ✓ The mean gender bonus gap
- ✓ The median gender bonus gap
- ✓ The proportions of men and women who received a bonus
- ✓ The proportions of men and women in each quartile pay bands

4.2 The gender pay gap is defined as the gap between the mean or median hourly rate of pay that male and female colleagues receive.

4.3 The mean pay gap is the difference between the average hourly earnings of men and women – i.e. the hourly gap divided by the average for men equates to the mean gender pay gap.

4.4 The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women – it takes all salaries in the sample, lines them up in order from lowest to highest and picks the middle-most salary.

4.5 This report is based on rates of pay as at 31st March 2021 and any bonuses paid in the year 1st April 2020 to 31st March 2021. It includes all workers in scope as at 31st March 2021. In scope means all staff employed under a contract of employment including those under

Agenda for Change terms and conditions, Medical and Dental terms and conditions and Trust contracts for very senior manager roles (VSM).

4.6 As a Foundation Trust, HPFT is empowered to determine the rates of pay for VSMs. The VSM roles in the Trust include the Chief Executive, Executive Directors and a small number of other senior managers.

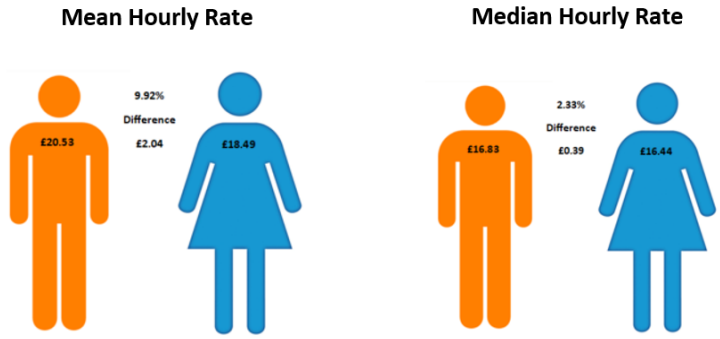
4.7 Only staff employed by the Trust at the snapshot date of 31st March 2021 are included in this report. This includes the Trust's bank staff. All data is taken from the Electronic Staff Record system (ESR).

5 HPFT Gender Pay Gap and Pay Quartiles by Gender

5.1 The Trust's Gender Profile

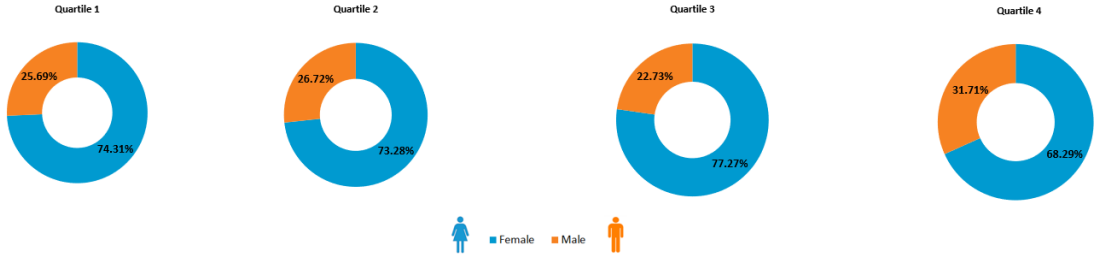
5.2 The Trust's Mean Gender Pay Gap and Median Gender Pay Gap

Our Mean Gender Pay Gap and Median Gender Pay Gap are illustrated by the graphic on the following page.



5.3 The Trust's Staff by Earning Quartiles

This diagram illustrates the proportions of men and women in each quartile of the Trust's pay bands. For clarity, Quartile 1 is our lowest pay band quartile and quartile 4 is our highest pay band quartile.



5.4 The calculation of hourly rate of pay includes 'Full Pay Relevant Employees'. This means any employee who was employed on the snapshot date of 31st March 2021 and who was paid their usual full basic pay. That full basic pay includes;

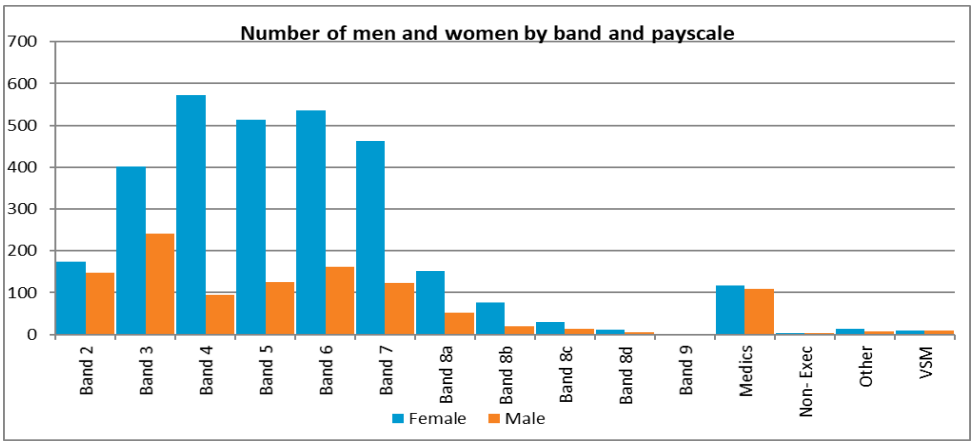
- ✓ Basic Pay
- ✓ Paid Leave – including annual leave, sick pay, maternity, paternity, adoption and parental leave (except where the employee is paid less than usual or is in the nil pay element of maternity leave)
- ✓ Area and other allowances
- ✓ Shift premium pay (which is defined as the difference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

5.5 It does not include any of the following elements:

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

5.6 At HPFT, there is a mean gender pay gap of 9.92% and a median pay gap of 2.33%. The staff earnings by quartiles helps explain this gap further as it highlights that in the first three categories, the workforce genders at HPFT are broadly representative of the overall workforce profile. However, in the 4th category, women are underrepresented by approximately 5% against the overall workforce profile position, whilst still being the larger group within the category. Historically, there is higher male representation at a senior level in the NHS overall. It is also worth noting that the Trust employs more women than men in every category, including the 4th quartile group, which is where our highest earners are grouped.

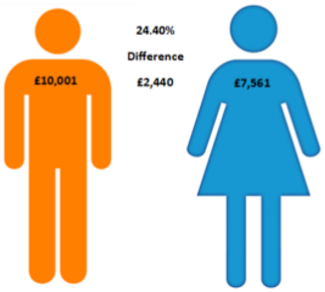
5.7 The Trust's gender profile by Band is shown on the following page:



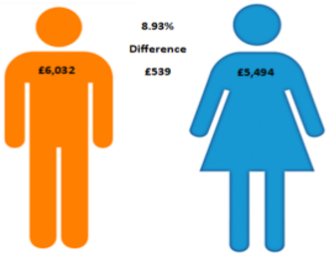
6 Bonus Pay and Gender Pay Gap Bonus Pay

6.1 The Trust's Mean Bonus Gender Pay Gap and Median Bonus Gender Pay Gap

Mean Bonus Pay



Median Bonus Pay



6.2 The proportion of men and women who received a bonus

Gender	Number paid a bonus	Total Employees	% receiving a bonus
Female	30	3070	0.98%
Male	33	1119	2.95%

6.3 Within the Gender Pay Gap Regulations 'bonus pay' means any remuneration that is in the form of money relating to productivity, performance or incentive – within the Trust our consultants can be nominated for Clinical Excellence Awards (CEA payments, which recognise and reward those Consultants who perform over and above the standard expected for their role). The Trust also had a performance related pay scheme, applicable to executive directors only, which is no longer in place, and there was a refer a friend payment scheme also in place during the reporting period.

6.4 The regulations set out that bonus pay does not include ordinary pay, overtime pay, redundancy payments or termination payments.

6.5 For bonus pay, all staff are included that were employed at the snapshot date of 31st March 2021 27 male Consultants and 21 female Consultants were awarded CEA payments, 3 male and 3 female VSM contract holders were awarded performance related pay and 1 male and 3 females received a refer a friend incentive payment.

6.6 The mean gender bonus pay gap is 24.40% in favour of males, who earn on average £2,440 more than their female colleagues. This equates to a median bonus pay gap of 8.93% In comparison to the March 2020 equivalent report where the mean gender bonus pay gap was 38.52% in favour of males who earned on average £4,396 more in bonus payments than their female colleagues. This resulted in a median bonus gender pay gap was 51.78% for March 2020.

7 Conclusion and Next Steps

7.1 HPFT has a mean gender pay gap of 9.92% and a median pay gap across all staff groups of 2.33%.

7.2 HPFT has a mean gender bonus pay gap of 24.40% and a median gender bonus pay gap of 8.93%

7.3 In March 2020, the Trust's snapshot data revealed a mean gender pay gap of 10.10% and a median gender pay gap of 4.11%. In respect of the mean bonus, the Trust reported a gap of 38.52% and a median bonus gap of 51.78%

7.4 The positive change to the Trust's gender bonus gap can, in part, be attributed to the actions taken because of the March 2020 data, which resulted in an action plan for the Trust – which focused attention on:

- ✓ Ensuring female medical staff are encouraged to apply for the CEA awards
- ✓ The implementation of family friendly processes and flexible working practices to encourage female returners and to better support those with caring responsibilities in the workplace
- ✓ Increased rigour in the negotiation of starting salaries within the medical workforce combined with greater flexibility in awarding progression points for part time staff

7.5 The Trust recognises that it has further work to do in positively impacting the gender pay gap position and has developed a draft revised action plan to support this ongoing work. The draft revised action plan will reviewed through PODG to ensure that we focus on those things that our data and insight are telling us need attention. In this coming year, we intend to focus on:

- ✓ Develop a talent management and succession planning process to provide balance in the promotion, succession planning and development opportunities.
- ✓ Provide career coaching for staff and self-confidence sessions to increase the confidence for women to apply for promotion
- ✓ Exploring how we can promote senior level vacancies to our female staff and explore how we can better support female talent at all levels throughout HPFT.
- ✓ Continuing the application of rigour in the negotiations of starting salaries for medical staffing posts and afford greater flexibility for part time workers to progress.

8 Recommendations

8.1 The Board is asked to receive this report and approve publication of the data report as required by legislation.

Hertfordshire Partnership University NHS Foundation Trust

Trust Board
Gender Pay Gap Report
For the period ending 31st March 2021

1. Introduction

1.1 This is the fourth Gender Pay Gap report for Hertfordshire Partnership University NHS Foundation Trust, and supports the workforce data that the Trust uses to monitor diversity and informs our decision-making regarding workforce inequalities.

1.2 The workforce at HPFT is predominantly female, which is in common with the wider NHS. HPFT has a good track record of promoting diversity within the workforce. The Trust uses this data to recognise that inequalities continue to exist and drive the actions that we take to address those inequalities.

1.3 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which came into force on 31st March 2017, has made it a statutory requirement for organisations with 250 or more employees to report their gender pay gap annually by 31st March, as at 31st March the previous year.

2. Purpose of this report

2.1 This report sets out the information that the Trust is required to publish and some further information that has shaped our current action planning. These actions are included as next steps at the end of this report. The Trust will continue to build on the progress it is making in promoting diversity and equality within the workforce and living our values of being welcoming, kind, positive, respectful, and professional.

3. Background to Gender Pay Gap Reporting

3.1 Since the 31st March 2017, it has been a legal requirement for public sector organisations with more than 250 employees to report annually on their gender pay gap.

3.2 The first report was published in 2018, and was informed by 'snapshot data' as at 30th March 2017. The second and third reports were published in 2019, and 2020 and were informed by 'snapshot data' as at 31st March for each previous reporting year. This year's report is informed by 'snapshot data' as at 31st March 2021.

3.3 The report must include:

- ✓ The mean and median gender pay gaps
- ✓ The mean and median gender bonus gaps
- ✓ The proportion of men and women who received bonuses
- ✓ The proportions of male and female employees in each pay quartile

3.4 The definitions set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and NHS Employers guidance on the definitions of ordinary and bonus pay have been followed in preparing this report.

3.5 The gender pay gap shows the difference in the average pay between all men and women in the workforce. The gender pay gap is different to equal pay. Equal pay deals with pay

differences between men and women who carry out the same, or similar, jobs or for work of equal value. It is unlawful to pay people unequally on the basis of gender. It is possible to have pay equality but still have a significant gender pay gap.

3.6 The Gender Pay Reporting regulations were specifically introduced to facilitate a national shift towards greater equality in the average hourly earnings of men and women. This is influenced by a range of factors, including:

- ✓ Women historically working in lower-paid occupations and sectors and occupying less senior roles
- ✓ Women taking time out and / or working part-time due to unequal sharing of caring responsibilities
- ✓ Historical stereotyping and workplace cultures that were unsupportive

3.7 Across the UK in 2020, the Office for National Statistics reported that the mean gender pay gap for full time employees was 7.4%, down from 9% in the previous year, whilst for all employees it was 15.5%, down from 17.3%. (Source – The Office for National Statistics, November 2020).

3.8 The Trust is committed to the principle of equal opportunities and equal treatment for all employees regardless of sex, race, religion or belief, age, marriage or civil partnership, pregnancy / maternity, sexual orientation, gender reassignment or disability. On this basis, the Trust has a clear policy of paying employees equally for the same or equivalent work, regardless of their sex (or any other characteristic set out above). The Agenda for Change pay framework is designed to support NHS Trusts in ensuring NHS employees are paid equally and this is fully embedded within the Trust.

3.9 The Trust has a largely female workforce, like many other NHS organisations, with 73% of the workforce being female, and 27% male.

4. Definitions and Scope

4.1 There are six measures that must be included in a gender pay gap report – these are:

- ✓ The mean gender pay gap
- ✓ The median gender pay gap
- ✓ The mean gender bonus gap
- ✓ The median gender bonus gap
- ✓ The proportions of men and women who received a bonus
- ✓ The proportions of men and women in each quartile pay bands

4.2 The gender pay gap is defined as the gap between the mean or median hourly rate of pay that male and female colleagues receive.

4.3 The mean pay gap is the difference between the average hourly earnings of men and women – i.e. the hourly gap divided by the average for men equates to the mean gender pay gap.

4.4 The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women – it takes all salaries in the sample, lines them up in order from lowest to highest and picks the middle-most salary.

4.5 This report is based on rates of pay as at 31st March 2021 and any bonuses paid in the year 1st April 2020 to 31st March 2021. It includes all workers in scope as at 31st March 2021. In scope means all staff employed under a contract of employment including those under

Agenda for Change terms and conditions, Medical and Dental terms and conditions and Trust contracts for very senior manager roles (VSM).

4.6 As a Foundation Trust, HPFT is empowered to determine the rates of pay for VSMs. The VSM roles in the Trust include the Chief Executive, Executive Directors and a small number of other senior managers.

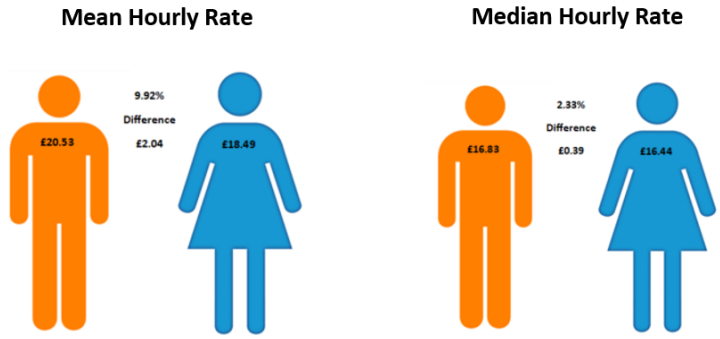
4.7 Only staff employed by the Trust at the snapshot date of 31st March 2021 are included in this report. This includes the Trust's bank staff. All data is taken from the Electronic Staff Record system (ESR).

5 HPFT Gender Pay Gap and Pay Quartiles by Gender

5.1 The Trust's Gender Profile

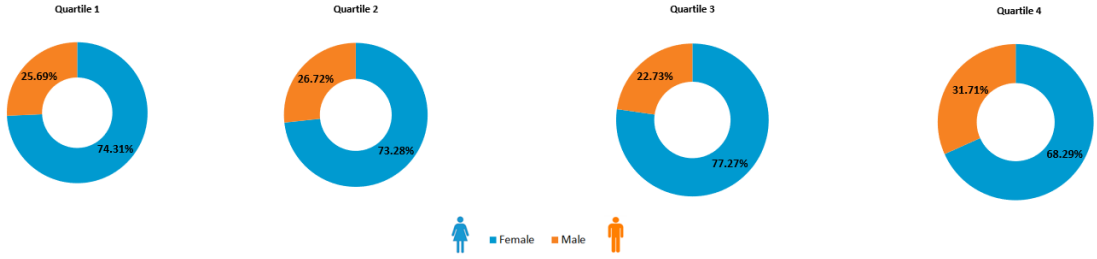
5.2 The Trust's Mean Gender Pay Gap and Median Gender Pay Gap

Our Mean Gender Pay Gap and Median Gender Pay Gap are illustrated by the graphic on the following page.



5.3 The Trust's Staff by Earning Quartiles

This diagram illustrates the proportions of men and women in each quartile of the Trust's pay bands. For clarity, Quartile 1 is our lowest pay band quartile and quartile 4 is our highest pay band quartile.



5.4 The calculation of hourly rate of pay includes 'Full Pay Relevant Employees'. This means any employee who was employed on the snapshot date of 31st March 2021 and who was paid their usual full basic pay. That full basic pay includes;

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

5.5 It does not include any of the following elements:

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

5.6 At HPFT, there is a mean gender pay gap of 9.92% and a median pay gap of 2.33%. The staff earnings by quartiles helps explain this gap further as it highlights that in the first three categories, the workforce genders at HPFT are broadly representative of the overall workforce profile. However, in the 4th category, women are underrepresented by approximately 5% against the overall workforce profile position, whilst still being the larger group within the category. Historically, there is higher male representation at a senior level in the NHS overall. It is also worth noting that the Trust employs more women than men in every category, including the 4th quartile group, which is where our highest earners are grouped.

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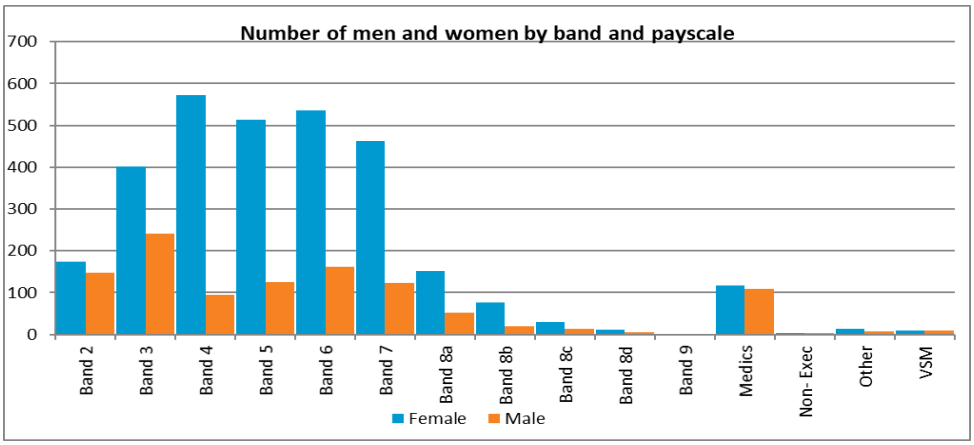

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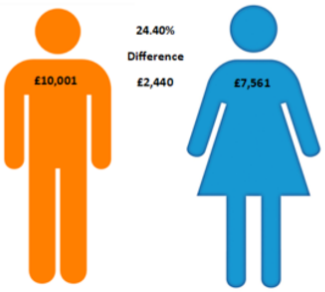

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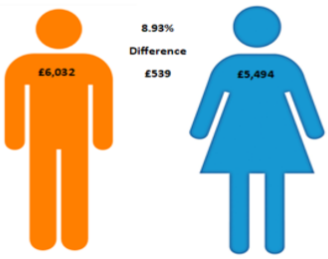

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Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	30 March 2022	**Agenda Item:** 13
Subject:	National Community Mental Health Survey 2021	**For Publication:** Yes
Author:	Sarah Damms, Managing Director, West SBU	**Approved by:** Sarah Damms, Managing Director, West SBU
Presented by:	Sandra Brookes, Executive Director of Service Delivery & Customer Experience	

Purpose of the report:

To provide the Board with an update on the actions taken regarding the outcomes of the 2021 National Community Mental Health Survey.

Action required:

To note the contents and areas identified for improvement.

Summary and recommendations:

The 2021 Community Mental Health Survey is part of the NHS Patient Survey Programme, in line with the NHS Outcome Framework. It is a major source of data for the Care Quality Commission (CQC) under the inspection regime, via intelligent monitoring. The survey is co-ordinated by the Patient Survey Co-ordination Centre, based at the Picker Institute Europe, on behalf of the CQC.

The Board received a paper in December 2021 setting out the 2021 survey results and the proposed actions to make improvements in areas where scores were in the bottom range. These areas were:

- Service users report receiving help and advice finding support to find work
- Involvement in deciding which Talking Therapies to use, and more involvement generally in decision making
- Ensuring care and support planning takes into account service users' needs in all areas of their life
- Service users feel that decisions about care were made in partnership between them and the person conducting the assessment
- Service users report that the purpose of medications was discussed with them

A Task and Finish Group is overseeing activity in six areas:

- A launch of the Welcome App
- Communication with all community teams about the survey results, with key messages to highlight the areas for improvement
- A launch of the Individual Placement Scheme
- Expansion of additional methods to obtain feedback from users of community services
- A review of our approach to ensure that service users are made aware of potential side effects of medication and prompts to staff to ask about medication
- Developing a communications plan to run through to June 2022 for service users, outlining how to seek help, how to provide feedback, what we are doing with their feedback and how they can be involved in service development

Both the Welcome App and Individual Placement Scheme launch in April. There has been a

delay in the roll out of the communications plan, although this will be compensated for through additional activity. Workshops are planned throughout April and May on Community Mental Health Transformation, which will reflect the national and local ambitions for improving mental health care, as well as acknowledging the changes that we will be making in response to formal and informal feedback, which includes the Community Survey.

Strong links are being made within services to triangulate feedback from the Community Survey and other feedback the Trust receives with our improvement and transformation programmes, including the Community Mental Health Transformation (CMHT) programme. The CMHT programme includes workstreams on personalised care and support planning, shared decision making and improving service user experience. It is anticipated that involvement of service users, carers and staff in these programmes will have a positive impact on people's experience of receiving care.

In addition, links have been made with those Trusts noted by the CQC as best performing in the survey to learn from best practice and inform the work of the Task and Finish Group.

The Task and Finish Group will continue to work through the period that the Survey is open, overseeing activity in the six areas and monitoring progress through gateway reports on uptake in April and May. The Task and Finish Group reports to the Trust Management Group.

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

Links to Strategic Objectives 2. We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience.
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care.

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

N/A

Equality & Diversity /Service User & Carer Involvement implications.:

The National survey includes a sample of service users from adult and older peoples' community mental health services who used services between 1 Sept – 30 Nov 2020.

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

The Trust is required to participate in the National Community Mental Health survey, the basic sample of which is covered under Section 251 of the NHS Act 2006.

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

TMG – February 2022

Update on actions taken since the National Community Mental Health Survey 2021 results

1. Background

The Community Mental Health Survey is part of the NHS Patient Survey Programme and is co-ordinated by the Patient Survey Co-ordination Centre, based at the Picker Institute Europe, on behalf of the Care Quality Commission (CQC).

The survey of people who use community mental health services involves 50 providers in England - mental health trusts and community interest companies with mental health functions.

People aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the Trust between 1 September and 30 November 2020.

A paper was provided for the Board in December 2021, with an overview of results from the 2021 Community Mental Health Survey and the proposed actions to improve on areas where the Trust had scored in the bottom 20 per cent range.

2. Areas identified for improvement

A review of the 2021 results identified the following areas as key to ensuring that our service users receive a holistic assessment and are involved in personalised care planning, as well as being able to make informed decisions:

- Service users report receiving help and advice to identify support to find work
- Involvement in deciding which Talking Therapies to use, and more involvement generally in decision making
- Ensuring care and support planning takes into account service users' needs in all areas of their life
- Service users feel that decisions about care were made in partnership between them and the person conducting the assessment
- Service users report that the purpose of medications was discussed with them

3. Proposed actions for 2021/22

A task and finish group has been working on the following actions:

- A launch of the Welcome App
- Communication with all community teams about the survey results, with key messages to highlight the areas for improvement
- A launch of the Individual Placement Scheme
- Expansion of additional methods to obtain feedback from users of community services
- A review of our approach to ensure that service users are made aware of potential side effects of medication and prompts to staff to ask about medication
  Developing a communications plan to run through to June 2022 for service users, outlining how to seek help, how to provide feedback, what we are doing with their feedback and how they can be involved in service development

In addition, contact was made with the three NHS Trusts noted as best performing by the CQC to understand what made the difference in their organisation. Their feedback was that the following factors all appeared to contribute to improved survey results:

- Making explicit links between transformation programmes and the themes of the Community Survey makes it easier for service users to recognise change
- A consistent approach over a number of years to implementing and embedding personalised care and support planning
- Using outcome measurement tools such as DIALOG
- Good engagement between the Trust and service users outside of the survey

We remain in contact with two of these high performing Trusts with the express purpose of learning from each other

4. Progress on actions

4.1 Launch of the Welcome App

The Welcome App has been developed and is due for launch in April. The app provides service users with information that will be useful for them to know prior to each appointment (e.g. Initial Assessment; CPA review; interventions) so that they can prepare for their appointment and consider key areas that they wish to discuss with a clinician. This will include prompts about employment. medication, social circumstances and physical health. We anticipate that it will help service users feel more confident in engaging in personalised care and support planning and challenging staff when this is not happening.

4.2 Communications with community teams

Feedback to the community teams has been co-ordinated through local Quality and Risk Meetings and core management meetings, led by Managing Directors and Service Line Leads, with a focus on:

- The processes necessary to ensure that service users are clear who is leading their care
- Providing information to service users on the purpose of their review and what to expect
- Reminding all staff of the importance of considering a person's employment status, accommodation, social circumstances and physical health needs in all assessments and reviews.

Each of these areas are reflected in the ambitions of the Annual Plan, the transformation plans for Adult Community Services and with strong links to the Connected Lives programme, the programme for delivery of high-quality social care assessment and interventions across the Trust.

During Q4, we held a series of engagement events and workshops with staff across Community MH Services to explore how confident staff feel with the principles of personalised care and support planning and making explicit links to the results of the community survey. By embedding personalised care and support in the teams, there will be a related positive impact on the way in which staff engage with service users during sessions and appointments, taking note of all areas of an individual's life and involving them in decisions about care and interventions. This will contribute to service users recognising this as a theme consistently running through their interactions with staff.

4.3 Launch of the Individual Placement Scheme (IPS)

The IPS is now embedded across Adult Community Mental Health Services and will launch on 1 April with dedicated clinics and regular promotion. The launch will focus on capturing referrals for target service users - according to the national specification - and on encouraging staff to think about employment as a core part of their assessment and engagement with staff.

We have various communications materials in place, including a screensaver for IPS, posters and leaflets and a campaign to use the '5 R's' (found in Appendix 1) in community services to promote staff confidence. We will also promote awareness of asking questions about work opportunities as part of the launch.

Service User workshops are under development, with the first one planned for April. These will raise the visibility of the importance of employment in people's lives and the availability of IPS to all service users in the Trust, not just those referred to the IPS Employment Service.

4.4 Expanding methods of receiving feedback

Our Experience Team have been working on the launch of a programme to be undertaken over the next year to complete a review of the "Having Your Say" survey, explore the way we seek feedback and undertake a full coproduced review of the needs of our service users, carers and operational teams in relation to providing feedback. This review will look at the questions we ask as well as the ways that service users and carers can give feedback. The programme will include staff members and Experts by Experience from across our services.

The project will report to the Quarterly Feedback Group to ensure oversight and maintain momentum for the project and the activities undertaken. Engagement with Experts by Experience and the communications coming out of the project will all contribute to service users experiencing positive engagement with the Trust.

"You said, we did" posters, which were paused due to the Covid pandemic will be reinstated in Q1. This will ensure that service users, carers and visitors have sight of the feedback given and the actions being taken to improve the quality of our services.

4.5 Review of approach to discussing medication

Due to capacity within services, there has been limited progress in this area to date. However, there is a planned expansion of pharmacists working in community services, with the aim of supporting service users directly and offering specialist advice to clinicians. There is currently a review of all literature available for service users and its accessibility, along with targeted communications for staff.

4.6 Communication plan

We will use the results and feedback from the 2021 survey to shape the content, tone and reach of our communications. We need to refresh and remind staff, service users, families and carers about the variety of community services, support and help available, how to access it and the benefits it brings. For staff, we will highlight key information to look out for and actions they can take to help ensure everyone who uses community services feels empowered and has a greater sense of being at the centre of the care they receive. Key messages, both internal and external, will include:

- The various opportunities in place for people to give feedback on our services
- Making the survey an opportunity to influence and shape our services
- Ensure staff are aware what the survey will tell us and the actions we will take as a result
- What we will be doing to encourage service users to take part
- How staff can help drive responses and understand the value of the exercise

Communications activity		
Audience	**Activity**	**When**
Community Team Leaders	Email message with key points and reminders	From April 1 Repeat messaging April 30, May 31. June 7.
Internal screensavers	Series of screensavers reminding staff of key messages to include in conversations with service users	From April 1- June 15
Electronic Display Screens in ACMHS hubs	Reminder screensaver	Completed March 10 (to remain until June 15, subject to

		revisions)
Social Media	Images and key messages for Trust social media accounts	Posts to go out a fortnightly interval in the lead up to June 16 from April 1.
Website	Public story encouraging service users to participate in the survey	From April 1
Press release	Public story encouraging service users to participate in the survey	From April 1
Internal – intranet	Story to encourage staff to ask service users to take part	From April 1

Examples of the communications going to staff and to service users can be found in Appendix 1. Because there has been a delay in the formal communications starting, there will be a compensatory increase in activity.

5. Conclusion

The positive progress in a number of the enablers is noted, such as the workshops for Personalised Care and Support and the Individual Placement Scheme, as well as communication with staff through existing meetings and structures.

Further work is required to improve the engagement and communication with our service users, which is being closely monitored. Workshops planned for April and May, focusing on Community Mental Health Transformation, are another opportunity for working with service users to share the our improvement plans.

We anticipate that this work will result in some improvements in the 2022 Community Survey results and also lay the foundations for an improved experience of care in the period being monitored in the 2023 Survey. With the proposed improvements to the ways in which we engage with service users and receive feedback and demonstrate action on those areas, the Trust will have more immediate access to what service users and carers are saying about their experience of care.

The Task and Finish Group will continue to meet until the end of June when the survey closes. It will monitor uptake of the Community Survey by service users (which is reported to the organisation in April and May and will monitor activity in the identified areas for action and impact of the promotional activities. This Group reports to the Trust Management Group.

Appendix 1 – examples of communications to be used

Community Hub Digital Display and social media

Communications for ACMHS staff

5 Rs

Supporting patients' employment aspirations:
What is our role as clinicians?

HOW TO CREATE CHANGE

1. **RAISE** work issues with patients early in the treatment pathway in a sensitive and acceptable manner
2. **RECOGNISE** the risk factors of being out of work
3. **RESPOND** effectively to the straightforward work problems that patients identify
4. **REFER** patients who have more complex difficulties to the appropriate specialist service
5. **REVISIT** work issues at intervals during treatment

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:**	14
Subject:	Annual Staff Survey	**For Publication:**	Yes
Author:	Sandy Hastilow, Head of Organisational Development/Louise Thomas, Deputy Director of People and OD	**Approved by:**	Janet Lynch, Interim Director of People and OD
Presented by:	Janet Lynch, Interim Director of People and OD		

Purpose of the report:

The 2021 National Staff Survey results will be published on 30 March 2022 but remain under embargo until then. The results will be therefore be presented at the Board meeting on 31 March 2022.

Action required:

To receive the presentation and discuss the outcomes.

Summary and recommendations:

The Board is asked to discuss the survey outcomes.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for: Finance

Equality & Diversity and Public & Patient Involvement Implications:

The survey results include a range of demographic data which will be anlaysed and any differences in experience experience highlighted and acted on.

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

N/A

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

SLT 9th March 2022/ IGC 17th March 2022

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:** 15
Subject:	Draft Annual Plan 2022/23	**For Publication:** Yes
Author:	Paul Ronald Director of Performance Improvement and Simon Pattison, Deputy Director of Strategy	**Approved by:** Paul Ronald, Director of Performance Improvement
Presented by:	Paul Ronald Director of Performance Improvement	

Purpose of the report:

To set out the latest draft of the 2022/23 Annual Plan for consideration by the Trust Board prior to final approval on completion of contractual and funding discussions during April.

Action required:

To review the draft plan and supporting commentary and fully consider whether it captures the key priorities for the Trust for the period ahead.

Summary and recommendations to the Committee:

Summary

Each year the Trust develops an Annual Plan to set out our key priorities for the coming year describing how the Trust will continue in its unrelenting commitment to provide Great Care and to deliver Great Outcomes, working together with services users, carers, our staff, and other partner organisations.

The development of this plan has also been informed by the national and local priorities in the different health and care systems that the Trust operates in and by feedback and discussions from all our stakeholders and is built upon the presentation and discussions at the Board workshop in February.

The Plan was presented and discussed at the March Finance & Investment Committee and is in the process of being updated to reflect this feedback and the ongoing work that is being done. Key points of note in consideration of this draft Plan are.

- It is formed around the current seven strategic objectives.
- to reflect the continuing impact of the Covid pandemic and the related challenges, it is built around a delivery framework of **Restore Reset** and **Reshape**.
- The plan is being developed in conjunction with overarching systems plans for 2022/23 and particularly the Hertfordshire Mental Health, Learning Disability and Autism Collaborative to ensure strategic alignment and maximise effectiveness.
- The plan recognises the interdependencies between the various objectives, and this is built into the detailed delivery plans underpinning the objectives set out. Continuing to attract and retain our workforce, developing our working with systems partners and advancing our digital and service transformation programs will be key to our success

Work is continuing to finalise the Annual Plan detail to ensure the correct balance of ambition

within the current environment and to triangulate the final detail across the objectives. The final version will reflect this final review and feedback from Board and crucially will reflect the Contract negotiations and the current discussions with the ICB.

Whilst not yet finalised some of the key developments which the delivery of this Plan will provide include.

- Implementing a system wide suicide prevention strategy
- Significant progress in addressing health inequalities and in much greater engagement with communities
- Very focused service transformation across services improving access, crises support and within the acute pathway
- A new co-produced Equality Diversity & inclusion strategy and further steps in ensuring we can attract retain and grow our workforce
- Further advancements in our use of technology to improve care
- The first steps in delivering our sustainability commitments building this with our staff and partners
- Progressing further our role and influence with system partners to improve services

The full detail of the priorities is provided in Appendix 1, and this is the further supported by the detailed milestone plans agreed with the senior lead for each priority and the outcome metrics which reflect the positive change that each priority will deliver. These milestone plans and outcome metrics which are still being finalised will be reviewed as part of the Trusts performance framework.

Recommendation

The Board members are asked to consider the draft plan and provide comment and further points for consideration to ensure that the Annual Plan describes in full the ambition of the Trust to deliver our vision of 'Delivery Great Care, Achieving Great Outcomes – Together' over the next period.

Relationship with the Annual Plan & Assurance Framework:

This is the updated Annual Plan for 2022/23.

Summary of Implications for:

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

Development of the draft plan has been informed by engagement with users and carers through the Service User Council and the Carers Council.

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

The Annual Plan includes commitments to improve quality and safety and transform the social care services delivered by the Trust.

Annual Plan 2022-23

1. Introduction

Our Annual Plan for 2022-23 describes how the Trust will continue in its unrelenting commitment to provide Great Care and to deliver Great Outcomes, working together with services users, carers, our staff, and other partner organisations. In renewing this commitment and setting out the underpinning priorities we recognise and have reflected that much has changed in the last two years and that there is much that remains the same. Our approach is therefore to energise and build; developing the plan collectively with our leadership team building upon successes, recognising areas of new or increased challenge, and leveraging the new opportunities that the focus on system collaboration will bring. In doing this we have established a delivery framework of Restore, Reset and Reshape which will see us:

Restore, recharge, and revitalise our services and support systems to address the impact on service users, carers, staff, and the whole population. We will reduce the current waiting times and rebuild the capacity and resilience of those services that have been most severely affected over the period of the pandemic.

Reset, moving on from the emergency response of the past two years we will adjust to live with the ongoing impact of Covid ensuring our services remain safe and consistently provide a great experience. To do this we will adapt and strengthen our leadership capability and we will realign our core work programs to best meet the challenges ahead; and

Reshape, the Trust has made significant strides in transforming services. For our progress to both continue and gather pace, we will review and strengthen our care models, further adopt new technologies and integrated working, and embark on the significant cultural shift required to become an exemplar organisation in relation to both diversity and inclusion and in addressing the significant inequalities in healthcare that persist.

These are substantial ambitions and will be undertaken within the wider context of major systems change as the new ICS system is established from July 1st, 2022, the next steps in the establishment of the East of England Provider Collaborative and the ongoing challenges of recruiting training and supporting the future workforce requirements. The successful delivery of our ambitions will not be easy, but we are an organisation that has always set far reaching ambitions that best meet the enduring commitments the Trust has set itself which are captured below.

Figure 1 – Trust underpinning commitments

2. Background

Given this level of change and the level of uncertainty that this will naturally bring, the Trust will build its detailed plans within the context of its existing Good to Great Strategy and the seven underpinning strategic objectives which has served the Trust so well over recent years.

This strategy is depicted below built upon our obsession with our people, with improving what we do, in working productively with partners, and in providing the highest quality of care (experience, effectiveness, and safety).

Figure 2 - Good to Great Triangle

Further the five values chosen to represent the Trust (Welcoming, Kind, Positive, Respectful and Professional) will continue to underpin our attitudes and behaviours to our service users, carers, and our colleagues. Our values and the related behaviours framework were coproduced through close working with service users, carers and staff and we are immensely proud that our staff are constantly recognised as living those values

The detailed development is further informed by the national and local priorities in the different health and care systems that the Trust operates in. These include the NHS England Delivery Plan for mental health for 2022/23, the national NHS learning disability priorities, work in our local system such as the current consultations on developing new Mental Health and Dementia strategies for Hertfordshire and the refresh of the Hertfordshire Learning Disability 'Big Plan'.

We are working with the Hertfordshire Mental Health, Learning Disability and Autism Collaborative on the overarching systems plans both to ensure alignment and effectiveness in delivering on our commitments. The MHLD&A has set out its draft areas of focus and responsibility and these are being linked into our Annual Plan. Contract discussions with our commissioners are continuing and again the outcome of these discussions will be reflected into the final approved plan, particularly in areas where additional investment is needed or where there are changes to service development plans.

Importantly our plans are informed by feedback and discussions from stakeholders including our staff and service user and carers groups, discussions within the Hertfordshire and West Essex Integrated Care System, our Council of Governors, our commissioners, and our senior leadership team.

3. Strategic Objectives 2022/23

The Trust has the following seven strategic objectives, which have provided the foundation to its annual planning over the last six years. Whilst we are likely to see for the reasons outlined elsewhere a greater and faster level of change, the objectives below remain robust, giving not only direction and focus but providing a familiarity and confidence to our senior leadership team during the year ahead:

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 us support will feel positively about their experience
3. We will improve the health of our service users through the delivery of effective, evidence-based practice
4. We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support, and treatment
5. We will improve, innovate, and transform our services to provide the most effective, productive, and high-quality care

6. We will deliver joined up care to meet the needs of our service users across mental, physical, and social care services in conjunction with our partners.
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

Continuing our recent progress in developing and growing our workforce, our work within the new system environment and our progress of our digital strategy will be key enablers across all our strategic objective's actions and those interdependencies are recognised within the detailed underpinning delivery plans.

4. Our Commitments for 2022/23

Included within our detailed plans for next year the following are highlighted.

Our Service Users

The continuing focus on the needs of our service users for quality (safety, outcomes, experience) services. There is significant investment and / or service transformation across our services with priorities being in relation to social care, crisis support and in CAMHS services. There will also be a redesign of the adult community pathway, including the SPA model, to ensure it provides earlier assessment and identification of risk.

COVID-19 has intensified social and health inequalities. The pandemic has had a disproportionate impact on BAME groups, older people, and disadvantaged communities. These are communities that do not always feel able to easily access our services, so we will strive to provide inclusive services engaging with all the communities we serve, as a critical part of our plans to address health inequalities.

We will continue to improve our services through our targeted program of transformation, including meeting our Long-Term Plan commitments for our Early Intervention in Psychosis; Individual Placement and Support, Community Perinatal, IAPT and community mental health services working with partners to make our services the best they can be.

Learning from the findings from the recent community survey we will further improve our engagement and working with carers to support the critical role they have for our service users.

The pandemic has brought increased focus on our work to improve the physical health care of those suffering a mental health need or with a learning disability and the coming year will see us make a further step change in this area.

We will continue to take a zero tolerance to suicides and work with public health & other partners to deliver the system Suicide Prevention Strategy

Supporting our people to recover and grow

Throughout the last two years our staff have consistently achieved extraordinary things for service users, but safety and health and wellbeing matter just as much for our people. If we don't look after ourselves, and each other, we cannot deliver safe, high-quality care.

COVID-19 has spurred the NHS on to put much greater focus on this, and we will continue to build on the great work progressed in 2021/22 recognising that as we come out of the pandemic its impact on our people will continue for some time to come. Many people are tired and in need of rest and respite. Evidence tells us that those in caring roles often wait until they are very unwell before raising their hand. We will keep offering people support to stay well at work, further developing our seasonal wellbeing program based on recent feedback and relaunching our benefits plan & long service awards

We will continue to build upon the successful recruitment activities prioritising our Health Care Support Worker and medical staff recruitment and retention plans and inducting this year's cohort of newly qualified nurses. We will evaluate the success of our recent recruitment and retention initiatives and build on those that have worked well.

We will take further action to ensure all our people feel they are treated equally and are able to contribute to the care we provide to our services users. Central to this will be the co-production of our new belonging and inclusion program which will provide a significant cultural reset to further embed our values. Early steps will include introducing inclusion ambassadors, an extended reverse mentoring scheme and support for staff networks

Responding to and managing with Covid and economic hardship

Covid will continue to be a presence in our communities (albeit at a much-reduced rate) during the coming year and will increase the demand for our services. People's mental health will also be adversely impacted by the many impacts of the Covid response, the continuing risk of economic recession and the huge domestic financial pressures of price inflation and reducing disposable incomes.

During the coming year we will focus rigorously on maintaining our standards of infection prevention and control to maintain the safety of our service users and our people. We will continue to support the vaccination programs both for covid and flu learning from this year with an earlier implementation and a dedicated team.

Through our service transformation program and the delivery of our Long-Term Plan commitments, we will work with our commissioners to address short term increases in demand while we better understand the medium- and long-term impacts on the demand for our services.

Partnerships & joined up care

With the pending establishment of Integrated Care Boards in the NHS and the 3 place based partnerships in Hertfordshire and West Essex, alongside an explicit obligation for organisations to work in partnership to achieve the ICS aims, we will see collaboration and systems working accelerate during the coming year. In Hertfordshire we will, through the MHLD&A Collaborative, focus on further improving outcomes for those with mental health needs and / or learning disability. In Norfolk, together with other local providers and local commissioners we will be progressing our plan to provide improved and integrated learning disability services and in Essex we will continue to work in partnership with Essex Partnership University NHS Foundation Trust to transform learning disability services.

We will also continue to develop and grow the East of England Provider collaborative to ensure a joined-up approach to transforming specialist mental health care and services for those with Learning Disabilities, taking the lead provider for CAMHs Tier 4 services.

Organisational infrastructure

We will continue to drive forward the Trust's digital strategy building upon the experiences of the last year which has seen the NHS go further and faster in the successful adoption of technology. We will iimplement digital solutions to improve effectiveness, safety & experience including mobile end user equipment, ePrescribing and Medicines Administration (ePMA) in inpatient services, and eReferrals (eRS) in SPA and the piloting of digital wards.

We will also reset our program of work to "Release time to care" by automating or digitising agreed administrative processes and in making processes easier for staff and building upon the positive elements of remote working. We will continue to work collaboratively with partner organisations on projects such as the shared care record.

We will continue to invest in our estate to provide the proper environments for our service users and staff with a particular focus on supporting staff return to sites in a safe manner whilst maintain our IPC standards and we will take our first steps in implementing our green strategy. We will work with Hertfordshire and West Essex ICS and the NHS regional team to secure the funding and approval for the new inpatient facility that is needed in East Hertfordshire.

We will further progress our continuous quality improvement approach and focus our efforts on tackling the priority operational challenges faced. We will continue to progress the work with partners on Population Health management to provide a richer understanding of the population's health needs using segmentation to address current inequalities and to remodel provision

5. Current Environment

In setting our Annual Plan we recognise the challenges faced both internally and within the wider system. However, many of these challenges do mean we have to seek to go further faster and in setting our plans we are seeking to balance our ambitions against the current needs of our populations. The current contract and funding discussions with the ICB in Hertfordshire and West Essex will be key in finalising our Annual Plan detail as additional short-term funding is required to recover those areas where service levels cannot currently be consistently met, to meet the current extra demand on services and to reshape our service models to what is required going forward.

Service Overview

Over the past two years and particularly during the last six months, the Trust has seen significant changes in the environment in which it operates. In particular.

- Increased service demand leading to longer wait times – this is from the impact of pandemic on our service users/ carers and the wider population (Mental health prevalence).
- Changes in complexity of demand- again arising from the increased societal stresses, the disruption to social support networks and the lack of contact and connection with health and other key agencies.
- Higher Clinical Risk management agenda - this is shown in the increased number of Serious Incidents, people being sectioned under the Mental Health Act, and service risks.
- Local system service capacity and capability – the emergence of major commissioning gaps, alternatives for complex cases (Low secure / PICU), social care, children/ young people need).
- Workforce supply and retention issues.
- Emergent financial challenge – linked to the above demand & complexity but amplified by the phased removal of COVID funding (£5m a year) and the additional local efficiency requirement.
- Opportunities to use technology to improve care.

Financial Overview

The Trust is confident of delivering financial balance for the current year against an initial Plan of £1m deficit. This reflects the extension of the COVID funding throughout the year at higher levels than planned. This resulted in a surplus in the early part of the year before additional costs were incurred from early Q2 to meet increased service pressures. The Trust was able to meet these cost pressures for the year using £5m of exceptional in year non-recurrent funding.

The Trust current financial plan for 22/23 shows a significant deficit and reflects:

- A current underlying monthly run rate deficit of c £550k which will form the unadjusted entry position into the new financial year driven by the significant increase in the level of inpatient beds being purchased to meet the additional inpatient demand and the additional staffing costs from supporting patients who are more unwell than previously.
- A reduction in COVID income of £5.6m from 2020/21 levels.
- The tariff efficiency requirement which will be deducted from opening contract values (estimated at £3.9m) which is 1.9% in total including an additional 0.8% ICS adjustment.

In view of these risks then short-term funding support is being sought from the ICS to enable the Trust to be confident in taking forward its plans and in delivering across the three requirements of restoring resetting and reshaping services to meet future need.

Workforce Overview

Our workforce plans are key to our future success and based upon the NHS People Plan principles translated into the actions we require. They focus on how we continue to look after each other, foster a culture of inclusion and belonging, as well as taking the actions necessary to grow our workforce, train our people, and work together differently.

There is much still to do particularly in increasing our workforce. We have throughout the year been successful in recruiting staff with circa 60 new staff recruited each month. However, staff leaving has slightly exceeded this and therefore given the planned headcount growth we have seen an overall increase in vacancy rates to 14.7% and an unplanned turnover of 12.8% which are both above the targets set.

The recruitment prioritised is in registered nursing 24% and in AHPs 23% with additional focus on those service teams where staffing is key to the current level of operational risk. There are a series of actions underway in relation to recruitment and staff experience and these will be taken forward and built upon further within our framework of restoring, resetting, and reshaping.

6. Monitoring and Review

The Annual Plan is split into seven Strategic Objectives with priorities identified for each of the Strategic Objectives with the actions to be taken and outcomes expected clearly defined (see Appendix 1). Underpinning this for each of the priorities there is detailed set of milestones and outcomes set out by quarter.

These Annual Plan priorities and milestones are cascaded via the development of Business Plans for the Strategic Business Units and Corporate Services. These, in turn, will be reflected in team plans through to individual Personal Development Plans. At Trust Board Level, progress against milestones and outcomes are

reviewed on a quarterly basis. Progress is also monitored quarterly with the Strategic Business Units through the Performance Review Meetings. Where it is judged that the achievement of the Plan objectives is at risk or there are other material concerns over the SBU performance then the Performance Review meetings will be held monthly until such times as the performance risks are addressed.

In the event of changing factors (internal or external to the Trust) which are of significance then the Annual Plan may need to be adjusted/updated. This reflects the need to ensure the plan, although produced at the beginning of the year, remains a 'live' reflection of our work and priorities across the Trust. Any changes are likely to be exceptional and reflect events or circumstances unforeseen at the time the Plan was set. Any proposed changes will be presented and approved by the Trust Board. In the current year one variation was made regarding the staff vacancy target to reflect the significant recruitment challenges faced.

7. Conclusion

We are an outstanding organisation and the plans we have set for the coming year reflect our ambition and commitment to continue to be the stewards for mental health and learning disability services in the populations we serve.

The last two years have been hugely challenging for all NHS organisations and whilst great things have been done there is much still to do. Our Good to Great strategy, our trust values and our core commitments will remain, but we will also shape our plans around the need to restore reset and reshape in several areas. This approach will be key in providing our focus and in setting priorities and reflects that many elements of our plan are a continuation and acceleration of existing work. We will address areas where our waiting times and performance has fallen back, and we will redesign our care models in response to the new levels of demand and complexity.

There is also much within our plans which is new. We will be progressing the work of the MHLD&A collaborative within Hertfordshire and West Essex, working with the developing place-based partnerships, and continuing the progress of the East of England Provider Collaborative in transforming mental health and learning disability services together. We will be refocusing our transformation program to accelerate progress in primary mental health care, CAMHs services, crisis support and in social care. We will take significant steps forward in developing our inclusion and belonging strategy and in addressing health inequalities. We will take the first important steps in developing our response to the Net Zero Carbon commitment and to the wider sustainability agenda and we will continue to progress our case for a new inpatient facility in East Hertfordshire.

In doing all of this we will continue to work to ensure our people feel valued and able to thrive, we will continue to manage our resources effectively working with the system to ensure a fair share of resources is provided and we will also put a real emphasis on engaging and working with carers.

These plans will be challenging but are deliverable working with partners and properly supported by commissioners and the wider system.

Hertfordshire Partnership University NHS Foundation Trust

APPENDIX 1

ANNUAL PLAN 2022-23

Our Commitments

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

What are the key priorities?	Actions we will take (What we will do)	Outcomes (What will be different for our service users, carers, and staff)
Embed the Personalised Care Planning approach across all services to ensure the early identification and proactive management of risk	• Strengthen care plans using shared decision making with service users and carers and plans for crisis management and relapse prevention	• Service users, and their carers, will know how to access support when they need it • Service users will feel more confident about their recovery • Staff will feel confident in assessing and managing risk
Keep service users, carers, and staff physically and mentally safe, reducing the harm they experience	• Increase the number of peer experience listeners across all our inpatient and community-based services to ensure the voices of service users is heard in services • Proactively identify and implement the best evidence-based approaches to managing violence and aggression (RESHAPE) • Introduce new approaches to support our service users to manage and reduce their levels of self-harm • Implement the shared learning from the LeDeR programme to keep our service users with a learning disability safe • Introduce a trauma informed approach to care across the organisation	• Changes in services reflect the feedback we receive from users and carers • Service users will experience safe and compassionate care • Carers will feel that their voices and heard and they are able to work in partnership with staff • Service users and carers will feel safe, supported, and informed when they use our services • Service users and staff will experience less incidents of violence and aggression on our wards • Staff will feel safe when they are working on our wards • Staff feel confident to speak up when things go wrong, rather than fearing blame • We will learn from incidents and embed these evidence based approaches in practice • Services will ask less “What’s wrong with you?” and more “What’s happened to you?” • Staff will feel more supported in their caring role.

Ensure the least restrictive practice is appropriately used to support service user recovery	• Based on feedback from users and carers we will review our MOSStogether strategy and update to ensure the least restrictive practice is used across all areas • Continue to upgrade our inpatient facilities with refurbishment of service user environments at Kingfisher Court, Oak ward, Elizabeth Court, Lexden Hospital and Bowlers Green	• Service users will be part of the decision making around restrictive practice • Service users supported with the least restrictive practice to recover & move quickly & safely out of seclusion • Staff have capability & confidence to prevent the need to use restrictive practice

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

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)
Improve service user and carer experience of accessing our services and receiving treatment	• Identify and address the health inequalities experienced by service users and carers in accessing our services • Adapt our services and interventions to respond to the changing clinical presentations of our service users and the needs of their carers • Implement Adult Community MH transformation programme across health and social care and to expand our approach to recovery-based practice and personalisation through our 'connected lives' programme • Introduce and evaluate a new model of care for our adult acute pathway to improve service user and carer experience • Work with partners to review and improve our Single Point Access delivery model for all care groups to ensure our service users and their carers have a positive experience of accessing mental health support	• Service users will have improved outcomes and less reliance on crisis services • More people who need our services will be able to access EIP, Community Perinatal and IAPT services (in line with LTP commitments) • Those who have found it difficult to get the services they need will increasingly find then easier to find and access • Fewer services users will receive care provided away from where they live
Involve our service users and carers in the design and delivery of services and their care	• Coproduce and implement new trust-wide service user and carer engagement plans • Increase engagement with our local communities to ensure the provision of inclusive services • Evaluate and expand our methods of receiving feedback to ensure these are accessible to all our service users and carers • Enhance the experience for carers when they are engaged and involved with our services	• All service users and carers will be able to provide feedback in a way that is best for them • Service users will feel informed, safer and have a better experience • Service users and carers will be able to tell use that they feel that they have positively influenced the design of services
Support our service users to live their lives as independently as possible	• Work with partners to support service users to gain employment & accommodation to support their recovery inc. steps towards employment, education, training, volunteering, IPS • Use our new care and support plans to enable more collaborative planning and shared decision making with service users	• Service users will feel better supported in their recovery journey • Carers will feel informed and fully engaged in the care planning process • Staff will be enabled to support service users in their recovery

	• Expand our Enhanced Rehabilitation Outreach Service offer to improve access and outcomes for service users • In partnership with HCC launch the Intensive Reablement Service at The Stewarts	• Carers will feel their needs have been assessed and that they are supported • Service users and carers will be able to ensure that care plans meet their needs

Strategic Objective 3 - We will improve the health of our service users through the delivery of effective evidence-based practice

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)
Engage with our wider systems' stakeholders and partners to achieve our zero-suicide ambition	• Increase suicide prevention capability within our, ensuring we collectively make every contact with service users count • Work with public health & our partners to deliver the system Suicide Prevention Strategy • Coproduce and implement a standardised Suicide Prevention Pathway and enhanced assessment process to ensure earlier intervention (Reshape) • Increase suicide prevention capability within the wider system workforce, ensuring we collectively make every contact with service users count	• Service users will not feel that suicide is their only option • Service users, and their carers, will know how to access support when they need it • Service users will feel more confident about their recovery • Staff will feel confident in assessing and managing risk
Improve the care, support and outcomes for service users who need additional support or at risk of admission	• Implement our Depression Pathway, evaluate the outcomes for our service users and carers and publicise our findings (Reset) • Strategically lead the coproduction of evidence based, integrated specialised MH pathways inc. all age ED and CYP ADHD pathways (Reshape) • Review CAMHS Inpatient services and develop new service model to improve patient flow, and the outcomes and experience for CYP and their families • Implement clinical effectiveness measures across Adult MH, CAMHS and Perinatal Service	• Service users and carers will have an improved and more consistent experience of high-quality care • Children and young people will have improved access to the care they need when in crisis • Staff will use consistent pathways and measurement of outcomes
Support our service users to be physically healthy by improving the physical health support, intervention and care available	• Ensure all service users are offered physical health checks and receive interventions appropriate to their protected characteristics, co-morbidities, and medications • Embed physical health competencies across our workforce to ensure delivery of consistent high standards of care • Prevent avoidable acute trust attendances / admissions by recognising and responding to physical health acuity and deterioration • Empower our services users to optimise their physical health and to prevent ill-health (weight management, smoking, exercise)	• Service users are supported to work towards their own physical health goals • Service users will experience improved quality and consistency of physical care • Our staff will have the support and skills to better care for the physical health needs of our service users

Expand the amount of research that we do and increase the positive impact of this on service user outcomes	• Publicise our research, audit, and pathway reviews to facilitate peer evaluation and to share learning with partners • Operationalise the HPFT research strategy by increasing investment in research with dedicated research assistants • Increased our collaborative work with partners such as Higher Education Institutes, Academic Health Science Networks, the third sector, patient groups and others • Widening the type and scope of research that we do with greater engagement from professionals with the expansion of professional groups taking part with the aim of improving outcomes for service users	• Expansion of research capabilities and engagement with other professional within the Trust • Improved service user and care engagement with research • Greater inclusion of people with protected characteristics (both staff and service users) within research • Greater incorporation of CQI and PACE activities into research activities and publication of outcomes in professional journals • Develop a culture of evidence based and outcome based practice with HPFT

Strategic Objective 4 - We will attract, retain & develop people with the right skills and values to deliver consistently great care & treatment

What are the key priorities?	Actions we will take (What we will do)	Outcomes (What will be different for our service users, carers, and staff)
Provide our people with access to health and wellbeing support that meets the diverse needs in our workforce	• Continue to coproduce and provide an extensive range of wellbeing activities & approaches accessible to all our staff • Extend the role and involvement of our well being champions in better enabling managers to support well being • Put in place initiatives that our people tell us will help to prevent ill health, promote self-care, and enhance wellbeing for all our diverse staff. • Fully participate and support the ICS wide program of wellbeing initiatives	• Our staff will feel refreshed and ready to continue improving the care we provide and the outcomes we achieve for our service users
Deliver a great employment experience for our people to attract talented individuals and retain our workforce	• Overhaul our attraction and marketing approach to ensure we attract diverse, high calibre staff aligned to our culture and values across the Trust • Expand the range of initiatives to reward, recognise and celebrate our staff • Embed a culture of coproduction and engagement to continuously improve the employment experience of our staff and celebrate our achievements together • Specific targeted recruitment and retention plans for key areas; HSCW, medical, newly qualified nurses, international nurses • Implement refreshed long service strategy • Reset our onboarding process to provide a consistently great experience for new staff	• People will actively want to join the Trust & will choose to stay working in the Trust • Our staff will recommend HPFT as a great place to work and develop • Our staff will know they are valued and that all voices are heard
Ensure all our people feel valued, included, and able to thrive through the development of our just & inclusive culture	• Codesign and implement with our staff our Equality, Diversity, and Inclusion Strategy • Engage with all our people to embed a culture of belonging and inclusion • Overhaul our recruitment and promotion practices to eliminate discrimination and create equality of experience in relation to recruitment, promotion, and career development	• Our staff with protected characteristics will have an equitable positive employment experience within the Trust and there will be consistently proportionate levels of diversity at all levels • All our staff will feel a sense of belonging within the Trust and that they are valued and included • Our staff will not experience discrimination at work

	• Equip our staff with the skills to have positive/ constructive conversations, in line with our values and further strengthen our culture in relation to feedback and living our values • Co-produce a refreshed organisational development strategy	
Develop our people, teams, and leaders, and harness their talents to enable the delivery of great care and great outcomes	• Increase our opportunities for career development and personal growth, taking positive action to address inequities, in order to attract and retain our diverse, talented staff • Support the Trusts clinical transformation through adopting a flexible and innovative approach to workforce design, increasing our agility to respond to the local talent pool • Establish a representative talent pipeline through the implementation of a talent management framework • Further enhance our leadership development support so that our leaders help us to create the best employment experience for all our people and the ability to keep providing great care and great outcomes for our service users • Publish our nursing career development map	• Our staff feel the Trust is the place they can develop their career • We will harness opportunities to introduce new roles and opportunities for developmental posts, such as apprenticeships • Our staff will have more opportunities for flexible and agile working • We will proactively support BAME talent management and leadership development

Strategic Objective 5 - We will improve, innovate, and transform our services to provide the most effective, productive, and high-quality care

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)
Embed a culture of continuous improvement and innovation across the services we provide	• Collate and monitor all our CQI and innovation initiatives and evaluate their impact and the outcomes for our service users, carers, and staff to improve spread of innovation across our organisation • Promote our CQI programme and share our innovations and learning with stakeholders and partners to increase its impact • Increase the CQI coaching capacity in all localities to provide ongoing support for our leaders and teams to improve and innovate their services • Reshape our innovation culture with formal review, testing, evaluation and implementation of new ideas to improve safety and quality of our services • Deliver our key Transformation Programmes • We will achieve our Delivering Value programme	• Our people will feel supported to develop their CQI skills and knowledge to generate & test improvement ideas • Improved safety, outcomes, effectiveness of inventions, timeliness to access service • Enhanced productivity, efficiency and effectiveness and reduced wastage
Continue to introduce new digital capabilities that will enable teams to innovate and improve service user, carer & staff experience as well as the safety and effectiveness of our services	• Implement digital solutions to improve effectiveness, safety & experience including mobile end user equipment, ePrescribing and Medicines Administration (ePMA) in inpatient services, eRS in SPA, pilot digital wards • Release time to care by automating or digitising agreed administrative processes • Expand technology support for annual health checks in Learning Disability services • Digitally empower service users and carers to increase opportunities for self-care (digital library and Virtual Healthcare Assistant) and enhance their engagement with assessment processes • Extend the digital skills assessment to the entire workforce with associated training • Develop and implement a comprehensive set of online performance dashboards to monitor access, safety and quality at all levels of the organisation	• Service users and carers will report an improved experience with our services due to availability of digital options • Care professionals report improved access to information for direct care provision • Staff will report reduced administrative burden, increasing time to care

Reduce our carbon emissions & contribute to the delivery of a net zero NHS by 2028	• Commence implementation of year 1 of the new Trust Green Plan • Launch of the Plan in April 2022 • Recruit champions from service areas • Develop Co-production with Service users and Carers	• Service users, carers and staff will have the opportunity to inform our sustainability agenda • The quality of care will improve as a result of getting right first time more often • Services users will have to travel less as care appointment will be provided closer to home. • Development of technology in service delivery creating greater flexibility in how care is delivered

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

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)
Work with Primary Care partners to improve community services and the care of adults and older people	• Develop a new model of primary care mental health in partnership with GPs and others (including further roll out of the Additional Roles Reimbursement Scheme with participating PCNs, for adults and CYP) • Implement the Primary Care Dementia Pathway following evaluation of the pilot • Work with partners to develop virtual hospital model and implement this in Hertfordshire	• Service users able to access the right care and support at the right time, in the right place to support recovery • More people will be able to access non statutory support that will have a positive impact on their mental health • GPs and other primary care workers will feel able to support service users • Staff will feel able to deliver great care • System partners feel confident making reasonable adjustments to meet the physical health needs of people with learning disabilities, autism or a co-existing mental health problem
Improve access and delivery of care for those people with a learning disability and/or autism across the Trust	• Commence the development of inpatient services for the Essex LD partnership having reviewed the impact of the new Essex LD Partnership Way in Team • Implement the Herts Specialist Residential Services future delivery plans following the formal consultation • Work with local partners and stakeholders in order to enhance intensive support and inpatient services in Norfolk	• Service users and carers will have easier access to services and support • Service users will experience more joined up care across providers • Service users will have high quality care and better outcomes • Staff will feel involved in improving services and empowered to do so
Ensure children, young people, adults, and older people in crisis can access support when they need it	• Work with our system partners to further develop the range of crisis interventions offered, including our Paediatric Liaison Team • Implement Integrated Community Care Model(s) in Older Adults (Health and Social Care) • Implement CAMHS 24/7 crisis pathway with service users, families, and stakeholders, learning from the evaluation of the C-CAT 24/7 pilot • We will work with local authority partners to ensure there are robust pathways for adults with learning disability and autism in crisis	• Service users will have improved access to local services & improved outcomes • Service users will experience reduced waiting times to access crisis support

Work with partners across Hertfordshire to deliver earlier intervention and support for Children and Young People	• Continue with the roll out (Wave 6/7) of Mental Health Support Teams in schools • Implement an integrated Eating Disorder model in conjunction with system partners • Coproduce and remodel our CAMHS community services to offer earlier intervention and support wider system integration	• Children & Young people (CYP) will have earlier access to tier 3 CAMHS services • More CYP will access early help support • CYP will report being satisfied with the services available • Staff will report being able to make improvements & provide high quality services as part of a CAMHS system

Strategic Objective 7 - We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(

What are the key priorities?	Actions we will take (What we will do)	Outcome (What will be different for our service users, carers, and staff)
Foster the further development of the Hertfordshire Mental Health, Learning Disabilities and Autism collaborative in conjunction with Hertfordshire County Council and system partners	• Implement and embed the new governance and organisational structures, with co-production central to these arrangements • Identify the specific inequalities in access and outcomes experienced by our different communities that can be tackled both internally within HPFT and by the Collaborative and implement action plans to address these • Develop plans with our local businesses to strengthen employment support for people with an SMI • Deliver specific pathway improvements for ADHD for Children and Young People • Implement the actions arising from phase 2 of the Hertfordshire Adult Autism review • Initial development of Population Health Management plans associated with agreed targeted priorities at a place and ICS level aimed at reducing specific inequalities and implementing specific PHM interventions	• Service users and carers will experience more joined up care and better outcomes • Service users and carers will feel involved and able to contribute to service developments • Staff will feel motivated and able to deliver great care • We will have a better understanding of the inequalities in access and outcomes faced by service users • We will measurably reduce some of the inequalities faced by specific groups that we identify during the year
Advocate for and ensure mental health, learning disability & autism services are developed across populations we serve	• Represent MH, LD and Autism services at all levels within the emerging system architecture (ICB / ICPs / PBPs) • System influence on future operating ICS model through development of MHLDA Collaborative • Ensure the needs of those with mental illness, learning disabilities and autism are included within system plans and developments • Continue to lead the ICS mental health, learning disability and autism work stream by actively engaging with other place-based parts of the Herts and West Essex local system	• Service users and carers will experience more joined up care • Service users will receive care that meets their needs • Staff will feel able to contribute to service developments • Service users will have access to service that meet their needs
Lead the transformation of services for people with a learning disability and their carers across Herts, Bucks, Norfolk, and Essex	• Evaluate the impact of our Essex LD Partnership transformation programme on service users, carers and staff and coproduce future development plans with stakeholders • Development and agreement of Norfolk Most Capable Provider leadership and delivery model to take forward clinical service transformation plans	• Service users and carers will experience more joined up care and better outcomes • Service users and carers will feel involved and able to contribute to service developments • Staff will feel motivated and able to deliver great care

	• Develop and implement a specialist LD Service transformation programme with Herts / Bucks system partners	
Work with regional partners to develop and deliver new models of care for those with specialist mental health needs and learning disabilities	• Delivery of an agreed Regional CAMHS T4 and Forensic LD transformation plans, to address the key workforce and supply side capacity gaps • Further development and delivery of the regional Patient Flow Bed Management System • Implement and evaluate our Adult Eating Disorders and Community Forensic “alternatives to admission” pilots	• Service users will have increased local choice and provision to support them at home and in their community • Service users and carers will have a better experience and improved outcomes • Staff will be involved and feel able to shape improvements in care

PUBLIC Board of Directors

Meeting Date:	31 March 2022	**Agenda Item:** 16
Subject:	Capital Investment Plan 2022/23	**For Publication:** Yes
Author:	Sam Garrett, Financial Controller	**Approved by:** Maria Wheeler, Executive Director of Finance
Presented by:	Maria Wheeler, Executive Director of Finance	

Purpose of the report:

This paper presents the Trust's Capital Plan for 2022/23, together with an outline plan for the two subsequent years to 2024/25.

Action required:

To receive and approve the Capital Plan for 2022/23.

Summary and recommendations to FIC:

This paper sets out:

- The Capital Plan for 2022/23; and,
- An outline Capital Plan for both 2023/24 and 2024/25.

Capital allocations for 2021/22 to 2023/24 are set out in the table below:

Items	21/22 £m	22/23 £m	23/24 £m
Operational Capital	16.1	10.9	9.0
Digital Capital	0.9	2.3	2.0
Capital Disposals	0.0	3.3	0.0
Total	**17.0**	**16.5**	**11.0**

The Capital Plan for 2022/23 reflects a capital allocation of £16.5m, comprising HPFT's share of the HWE ICS allocation at £10.9m. additional national capital of £2.3m, and planned disposals of £3.3m. This paper sets out the plan for how these funds will be deployed.

This paper has been considered by the Executive Team and FIC and members are invited to approve the Trust Capital Plan for 2022/23 .

Relationship with the Annual Plan & Assurance Framework:

Summary of Implications for:

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

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

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

Executive Team 16 March 2022 Finance & Investment Committee 22 March 2022

1. Introduction

1.1 The Trust has had a significant Capital Investment Programme over the last few years which has supported the Trust's Strategic objectives.

1.2 This paper sets out the Trust's Capital Investment Plan for 2022/23, together with an outline Capital Plan for the years 2023/24 and 2024/25.

2. Capital Resources

2.1 As a Foundation Trust HPFT has in the past been able to set its own limits on Capital expenditure. However, for 2021/22 the Trust received a capital investment allocation via the ICS, reflecting the move to System working. The total ICS capital allocation for 2021/22 was £69.5m of which HPFT was allocated £16.1m. This allocation has been supplemented in year by additional national and regional funding for Digital investment (£680k and £250k respectively), resulting in a total capital investment limit (CDEL) of £17.1m for 2021/22.

2.2 Capital allocations nationally are planned to reduce over coming years. Capital allocations are distributed to ICS's based on the recognised Kings Fund methodology are related to organisational asset base and historical surpluses. This methodology has been adopted in Hertfordshire and has resulted in a reduction in HPFT's capital allocation.

2.3 Table 1 below shows the planned System capital allocation for the 3 years 2021/22 to 2023/24, including additional Digital capital provided through the Unified Tech Fund. In year The Trust will dispose of two properties providing capital receipts of £3.3m, increasing the capital available in 2022/23 to £16.5m.

Items	21/22 £m	22/23 £m	23/24 £m
Operational Capital	16.1	10.9	9.0
Digital Capital	0.9	2.3	2.0
Capital Reciepts from Disposals	0.0	3.3	0.0
Total	**17.0**	**16.5**	**11.0**

3. 2022/23 Programme

3.1 The Trust's Capital Allocation for 2022/23 is set out in the table below. This consists of £10.9m operational capital, £2.3m digital UTF capital and capital receipts from disposals of £3.3m. This amounts to an overall capital funding available in year of £16.5m.

System allocation	10.9
Digital capital (national)	2.3
Total (CDEL)	13.2
Sale proceeds	3.3
Total resource available	**16.5**

3.2 The Capital Plan for 2022/23 seeks to balance the completion of existing works, provision of priority new works with maintenance/reactive items, and a significant planned investment in Digital, in line with the Trust's Digital Strategy.

3.3 Table 3 below sets out a summary of the Capital Plan for 2022/23:

Table 3

Capital Plan		22/23 £000
Current Projects - completion / additional phases	Lexden A&T	1,070
	Safety Suites Phase 2	1,685
	Oak Ward Phases 1-3	2,650
	Forest House	227
	Albany Lodge	124
	Subtotal Completion	**5,756**
Priority New Projects	Elizabeth Court	1,000
	Kingfisher Court refurb	600
	Female forensic 4 Bowlers Green	1,074
	CCTV Phases 1&2	900
	Waverley Road refurbishment	250
	Subtotal Proposed	**3,824**
Potential New Inpatient	Stevenage new inpatient unit	250
	Lexden new inpatient unit	250
	Subtotal potential inpatient	**500**
Other	Backlog Maintenance	1,000
	Reactive Operational Capital	1,591
	Trust signage	150
	Digitisation	2,265
	Laptops, mobiles etc	880
	Sustainability	500
	Subtotal Additional	**6,386**
	Total Gross	**16,466**
Disposals	Disposal of The Stewarts	-2,058
	Disposal of Harper Lane	-1,236
	Total Net	**13,172**
	System CDEL	**10,907**
	Digital	2,265
	Total CDEL	**13,172**
	Variance to CDEL	0

3.4 The Plan includes completion of a number of key capital schemes started in 2021/22 including: Lexden A&T refurbishment, Phase 2 of the Safety Suites, and

refurbishments of Forest House and Albany Lodge. The major refurbishment at Oak Ward continues in 2022/23 with the commencement of phases 2 and 3.

3.5 New schemes proposed for 2022/23 include works at 4 Bowlers Green, electrical works at Warren Court, refurbishment work to bathrooms at Kingfisher Court (due to flooding) and Elizabeth Court.

3.6 In addition, there is the continued rollout of the digital transformation programme funded through the Unified Technology Fund.

3.7 The programme includes for the first time a dedicated investment to support the launch of the Green Plan and progress the Trust's plans for Sustainability.

3.8 Further Backlog Maintenance is provided for to ensure the estate is maintained at the highest standard for service users. The plan also provides for reactive capital for smaller but essential works which are required in year.

3.9 The planned disposals in 2022/23, The Stewarts and Harper Lane, are expected to be completed Quarter 1 of the new financial year.

4. Risk

4.1 The 2022/23 Capital Plan is an ambitious programme of works, that will be commence immediately following its approval by the Trust Board. Its completion is subject to the following risks:

- The timely availability of contracting labour
- The timely availability of materials
- The rising costs of materials due to continued supply chain issues
- Access to operational areas at times of high demand

5. Forward Plans for 2023/24 Onwards

5.1 Notified System Capital allocations for 2023/24 and 2024/25 have informed the following outline capital investment plans.

Summary Plan 22/23 onwards £m	23/24	24/25
Main Projects	7.1	7.2
Backlog Maintenance	1.0	1.0
Reactive Operational Capital	1.0	1.0
Sustainability	0.5	0.5
Digitisation & laptops etc	2.8	1.9
Total Gross	**12.4**	**11.6**
Disposals	-1.5	-1.6
Total Net	**10.9**	**10.0**
Total CDEL	**10.9**	**10.0**

5.2 Plans for 2023/24 and beyond are less well developed but are likely to include completion of Oak Ward Phase 3 and other schemes currently under discussion, which include work on an East Herts Hub, Lexden Cymbelline, Norfolk Autism Unit, and Herts HDU.

5.3 New builds at Stevenage and Lexden are still subject to national approval and the availability additional national CDEL resource. These are not included above, but will be incorporated into future plans following national approval.

6. Summary

6.1 The Trust has invested significant capital in recent years and this has made a real and appreciable difference to Trust environments and to the experience of service users, carers, and staff; as well as enabling significant operational change to take place in line with Strategic Objectives and Annual Business Plans.

6.2 The Capital Plan for 2022/23 reflects the priority areas for £16.5m capital investment. Members are invited to approve the Capital Plan.

6.3 Members are invited to note the forward capital Plans for 2023/34 and 2024/25.

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:** 17
Subject:	Hertfordshire Mental Health, Learning Disability & Autism (MHLDA) Collaborative	**For Publication:** Yes
Author:	Ed Knowles – Development Director Herts MHLDA Collaborative	**Approved by:** Karen Taylor, CEO
Presented by:	Ed Knowles – Development Director, Herts MHLDA Collaborative	

Purpose of the report:

This report provides an update on the development and activity of the Hertfordshire Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative. It summarises current thinking about the role of the Collaborative in the context of wider system development including the imminent formalisation of the Hertfordshire and West Essex Integrated Care System and the development of place-based partnerships in South & West Hertfordshire and East & North Hertfordshire.

Action required:

The Board is recommended to note this report and the developing position of the MHLDA Collaborative within the wider structures of the Herts and West Essex ICS.

Summary and recommendations to the Board/Committee [to be amended]:

The attached paper is the latest Hertfordshire Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative update presented to the Collaborative Board in 25 March 2022.

The Collaborative continues to develop and deliver and is increasingly recognised as the forum through which system issues for Hertfordshire citizens with mental illness, learning disabilities or autism should be discussed and resolved. As an example, the ICS formally wrote to the co-chairs of the MHLDA Collaborative at the end of the January, tasking the Collaborative to take responsibility for addressing a system backlog of children and young people waiting for an Attention Deficit Hyperactivity Disorder Assessment.

The Collaborative is identifying its key transformational priorities for the next 18 months. This will include strengthening and progressing existing transformation activity where Collaborative working is at the core of any future model, such as the Crisis Care Partnership and the Primary & Community Mental Health Transformation programme. It will also involve investing project management resource in taking forward new strategic priorities including Collaborative workforce planning for mental health, learning disabilities and autism and identifying how the Collaborative can best support the delivery of Hertfordshire's Special Educational Needs and Disability (SEND) Strategy. Finally, the Collaborative will focus on some specific areas of prevention and positive wellbeing, recognising the importance of managing future demand but also the disproportionate impact of wider determinants of health on people with severe and enduring mental illness, learning disabilities and autism.

Further discussions have taken place regarding the role of the Collaborative within the Hertfordshire and West Essex Integrated Care System (ICS) and its relationship with the geographical Health and Care Partnerships i.e. East and North Herts Health and Care Partnership,

South & West Herts Health and Care Partnership and the West Essex ONE Health and Care Partnership

Collaborative partners have agreed that, in its ambitions, remit and membership, the Collaborative is akin to a place-based partnership, covering Hertfordshire as its geography and focussed on improving outcomes for people with mental illness, learning disabilities and autism. As such, the Collaborative will be recognised alongside the geographical place-based partnerships as one of the four Health and Care Partnerships operating within the ICS. On this basis, any decisions related to the operating framework of the ICS including future models of commissioning, transformation and delivery will need to incorporate the role and responsibilities of the Collaborative.

Discussions are taking place with ICS and Hertfordshire County Council colleagues regarding how the long-standing joint commissioning arrangements, including the pooled budget and joint commissioning team will operate with the new system architecture and specifically how the team and its functions will operate with the MHLDA Collaborative.

Since the last update to Board, key achievements of the Collaborative include:

- further progress on the CAMHS Transformation programme, including the recommencement of Task and Finish Groups and first CAMHS workforce session
- Continued success in our drive to vaccinate people with a learning disability and/or serious/enduring mental illness
- reviewing system demand for Mental Health and Learning Disabilities and developing a clear understanding of the investment required to address immediate pressures and the ongoing higher volume of demand
- the development the Collaborative response to address the backlog and future model of care for children and young people with ADHD
- Work with existing locality structures to ensure a constructive and sustainable relationship between local activity and Herts-wide initiatives

Priorities for the forthcoming period include:

- Convening a working group around Primary and Community Mental Health transformation and specifically the ARRS rollout
- Progressing discussions on the interaction between the Collaborative and the county-wide activity around Drug and Alcohol
- Finalising the business case to address the ADHD backlog
- Considering the outputs of the Autism (Phase 2) review and the key findings of the Safe and Well Reviews
- Progressing recruitment activity to support the delivery of Collaborative priorities

Relationship with the Annual Plan & Assurance Framework:

The activity of the MHLDA Collaborative supports the delivery of HPFT's Strategic objective 7.

Summary of Implications for:

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

No EqIA required – there are no specific equality and diversity issues associated with the recommendations of this paper.

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

Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative

MHLDA Collaborative Board

Meeting Date:	25 March 2022	**Agenda Item: 5**
Subject:	Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative – Development Director's Report	
Author:	Ed Knowles – Development Director	
Presented by:	Ed Knowles – Development Director	

Purpose of the report:

To provide an update to the MHLDA Collaborative Board on key activity, challenges and achievements during March 2022 and upcoming milestones.

Action required:

To note the progress detailed in the report and consider any recommendations for approval.

Summary and recommendations to the Board:

The Hertfordshire's Mental Health, Learning Disabilities and Autism Collaborative has continued to drive forward activity at both a strategic and operational level during March. This has included system-wide discussions on the scale of demand faced by the Collaborative and the resource required to meet it, as well as practical design activity across Collaborative partners to better support children and young people with Attention Deficit Hyperactivity Disorder (ADHD). Significant outreach has taken place to discuss the role of the Collaborative and its priority areas for focus.

Over the last month we have been

- Reviewing system demand for Mental Health and Learning Disabilities and developing a clear understanding of the investment required to address immediate pressures and the ongoing higher volume of demand
- Developing the Collaborative response to address the backlog and future model of care for children and young people with ADHD
- Working with existing locality structures to ensure a constructive and sustainable relationship between local activity and Herts-wide initiatives
- Finalising the short-list of Collaborative transformation priorities for the next 18 months

Our priorities for the next period are to:

- Convene a working group around Primary and Community Mental Health transformation and specifically the ARRS rollout
- Progress discussions on the interaction between the Collaborative and the county-wide activity around Drug and Alcohol
- Finalise the business case to address the ADHD backlog
- Consider the outputs of the Autism (Phase 2) review and the key findings of the Safe and Well Reviews.
- Progress recruitment activity to support the delivery of Collaborative activity

Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative

Development Director's Report – March 2022

1. Collaborative Development

1.1 Hertfordshire's Mental Health, Learning Disabilities and Autism Collaborative has continued to drive forward activity at both a strategic and operational level during March. This has included system-wide analysis on the scale of demand faced by the Collaborative and the resource required to meet it, as well as practical design activity across Collaborative partners to better support children and young people with Attention Deficit Hyperactivity Disorder (ADHD).

1.2 Significant outreach has taken place to discuss the role of the Collaborative and its transformation priorities. These priorities have been discussed and tested with a range of partners and organisation over the course of March, including discussions at the South & West Hertfordshire Delivery Board, East & North Hertfordshire Transformation and Delivery Group and the Collaborative's own Clinical and Professional Advisory Committee. Feedback has focussed on the need to ensure that transformational priorities across the different Health & Care Partnerships are properly resourced and that they complementary of one another and don't result in unrealistic demands on any one partner organisation or sector.

1.3 The final proposed list includes activity to transform service delivery, to design strategic solutions to longstanding complex issues and to lead on prevention and positive health and wellbeing. This will be discussed by the Collaborative as part of agenda item 6b.

1.4 We have successfully recruited to the role of Primary and Community Mental Health Transformation Manager. Further recruitment is planned over the course of March/April to bring in the project and programme management expertise required to push forward the Collaborative's priorities. The Collaborative will also be investing in communications expertise so that it can interact directly citizens, communities and wider stakeholders highlight the activity and achievement of Collaborative partners across the system.

1.5 The 'go-live' date for the Herts and West Essex Integrated Care Board and Integrated Care Partnership is expected to be 1st July 2022, and work is continuing towards the NHSE Gateway process. Hertfordshire County Council is leading the work to develop the Integrated Care Partnership and to establish how it will work with existing structures and with the Collaborative as one of the system's Health and Care Partnerships.

1.6 The appointment of executive directors to the Integrated Care Board is now well underway and we expect an announcement of the outcome of the director level appointments soon. There has been an excellent response to the advert for non-execs, with 40 people applying.

2. Current Pressures, Demand and Response

2.1 Demand across the system remains high and COVID-19 infections are once again starting to rise across the region and the County. Patient flow for people on mental health inpatient pathways remains challenged, with high numbers of discharges delayed due to continuing high demand for onward support including housing, social care and health placements. A number of escalation calls and meetings are in train to improve flow so that patients are supported in the most appropriate settings.

2.2 At the time of writing, there are 68 residential care settings in Hertfordshire with a COVID-19 outbreak, 5 of which have paused any further admissions. These numbers are broadly in line with the figures reported at the February meeting of the Collaborative. 3.8% of the care workforce is currently off work for COVID-related reasons – which represents an increase on February and demonstrates that COVID 19 infections are no longer reducing and continue to put pressure on system capacity.

2.3 The number of children and young people waiting for Tier 4 treatment has been more stable in recent weeks. All Trusts in the East of England Mental Health Provider Collaborative are working through a single point of access, which enables consistent clinical oversight and the best use of the resources. The Bed Management service operated by HPFT on behalf of the East of England Provider Collaborative now comprehensively covers all of the region's CAMHs service.

2.4 In Hertfordshire, the Collaborative has undertaken a review of demand, recognising that the volume of activity that the NICHE report has predicted would be seen in three years' time has already materialised in the first year. This initial review highlights the increased demand for the range of mental health and learning disability services across Hertfordshire. It references the range of activity the Collaborative has put in place to address and mitigate this demand but recognises that more is required and outlines both a short and medium term investment case to not only sustain existing services but also to effectively respond and support more people in the years ahead. This review will be considered by the Collaborative as part of agenda item 6a.

2.5 ***SMI and LD Vaccination Programme***: Our strong performance around booster uptake for people with learning disabilities and severe mental illness continues. At the time of writing 91.5% of the eligible population of people with learning disabilities and 91.6% of the eligible population of people with severe mental illness in Hertfordshire had received their booster jab.

2.6 Our attention remains focussed on those individuals who have not yet received all three doses of a COVID-10 vaccine. Through targeted work with GPs and PCNs we are reaching out to establish the reasons behind why people are not yet fully protected. This is often intensive work for the practitioners involved to support the individual and the families involved. It is likely that a fourth booster jab will be made available although there is not yet confirmation as to eligibility for this 4th booster jab.

3. Transformation Priorities

3.1 As referenced in section 1 of this report, we are in the process of identifying and confirming the specific areas of Collaborative focus and support for the next 18 months. In the meantime, we continue to deliver against existing system commitments and the NHS Long Term Plan.

3.2 **Autism and ADHD for Children and Young People:** On 25 January, the ICS wrote to the co-chairs of the Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative asking it to take responsibility to bring together partners to address a backlog and long waiting times for Attention Deficit Hyperactivity Disorder (ADHD) diagnosis for children and young people. This letter requested the Collaborative to support the necessary data capture to ensure a full picture of demand and to identify the required resource and model to address the backlog.

3.3 Monthly referral, waiting list and caseload data has now been compiled by HCT and HPFT and shared with commissioners. This data will now be produced on a monthly basis and will be able to incorporate follow up/medication information. To ensure a fully comprehensive picture across the county, we are working with East and North Hertfordshire NHS Trust so that they can provide the matching information.

3.4 The longest waits have been actively prioritised by the existing clinical teams within HPFT. Under the sponsorship of Professor Asif Zia, as Co-Chair of the Collaborative Clinical and Practice Advisory Committee, a Continuous Quality Improvement (CQI) process has been convened. This will bring together colleagues from across the Collaborative to develop the robust model to address the backlog as requested in the ICS letter. It will also allow all partners to design a sustainable long-term model that focusses not just on diagnosis but on identification treatment and most importantly outcomes for the young person and their families. The first of the CQI meetings took place on 07 March 2022 with additional clinical, operational, commissioning and governance workstream meetings taking place over the course of March. An update on this work will be provided as part of agenda item 4 – Clinical and Professional Advisory Committee update.

3.5 A business case will be submitted in the next 2 months with a detailed plan of the resource, investment and partnership working required to address the existing backlog. A further business case will follow with regards to the implementation of a new pathway.

3.6 **Autism (adults):** Phase 2 of the neurodiversity review will be complete by the end of the month. Its conclusions and recommendations will be considered at a forthcoming Collaborative meeting.

3.7 ***Crisis**:* Our Crisis Care Partnership continues to lead improvements to our local crisis offer.

3.8 The additional Advanced Mental Health Practitioner Roles sponsored by the Partnership are showing signs of making a positive impact. Early data

suggests that these roles have contributed to a quicker turnaround for Mental Health Act assessments in Watford General Hospital, with an average response time of 4.5 hours compared to the previous average of 7/8 hours.

3.9 Following mobilisation and recruitment activity since the start of the year, the new Stevenage crisis café base is due to open in early April - improving the balance of crisis alternative provision across the county.

3.10 The Crisis Care Partnership has also been responding to escalations from Herts constabulary around waits for patients under s136 detention in Emergency Departments.

3.11 Following an urgent meeting 16.02.22 to consider a request from police to delegate conveyancing for patients under s136 detention, a working group is being stood up under the Crisis Care Partnership to complete due diligence on [proposals and to consider a 4 week pilot of the proposed arrangements. The working group will put forward a proposal for ratification from the two Hertfordshire Clinical Commissioning Groups in April.

3.12 ***Primary and Community MH Transformation****:* The recruitment of the ARRS roles continues. The Collaborative will be convening a work group (first meeting in April) on this element of the Primary and Community Mental Health transformation to ensure that the recruitment and the implementation of these roles best supports PCNs and complements existing practices and processes.

3.13 A key element of this transformation programme is to undertake proactive community engagement with individuals and communities who are underrepresented in services. Within Hertfordshire, a Mental Health Inequalities Group was established in 2021, with representation from statutory, VCFSE and community groups, including those that are focused on addressing ethnic inequalities in mental health. At the last meeting in March, the group reflected on current progress and the future direction of travel.

3.14 The Group agreed that its key areas of focus over the next 12 months will include:

- Establishing Governance structure and interface with system workstreams
- Recruiting Peer Support Workers from underserved communities.
- Providing support in the development of targeted support/roles in line with the community transformation agenda
- Reviewing mechanisms for representation of wider communities to ensure full co-production
- Reviewing Expert by experience involvement ensuring that those directly involved have experience relevant to this area.
- Reviewing available data, identifying, and addressing gaps
- Agreeing priorities based on available data, broader information, and local knowledge.

3.15 We have successfully recruited to the role of Primary and Community Mental Health Transformation Manager. This role will work on behalf of the Collaborative to take forward this transformation activity, identifying the role that all partners will need to play to ensure that people are receiving the right mental health support in the right place and at the right time if we are going to be able to support the numbers of people projected to need support over the next 3-5 years

3.16 ***LeDeR and Transforming Care***: Contractual arrangements are being progressed with North East Commissioning Support (NECS) for the delivery of LeDeR reviews for 2022/23. Leadership and quality groups have been established to oversee the programme and ensure learning from reviews results in action.

3.17 The national Annual Health Check (AHC) target for 2021/22 is for 75% of people aged 14 and over with a learning disability on the GP learning disability register to have had an annual health check each year. Data from regional NHSE team to end January 2022 shows that Herts and West Essex ICS has achieved a 47.5% uptake of AHCs so far for 2021-22. Breakdown by CCG footprint shows East & North Hertfordshire at 46.6%, Herts Valleys at 52.3% and West Essex at 35.7%. At present, the national uptake is 46.6% and East of England 44.8%.

3.18 We have historically seen the majority of AHCs completed in Q4 and will be closely monitoring activity to ensure we are as close to the target as possible. Work continues to improve the quality and the number of health checks provided. A pilot project is underway to trial the role of Learning Disability Care Coordinators in two PCNs which will evaluate the impact of these roles on quantity and quality of AHCs.

3.19 Following individual inpatient reviews the Safe and Wellbeing Review process has moved to ICS panel stage and will be completed in time to meet the end of March deadline. Action has commenced in response to areas of concern raised through the reviewing process. An update on these reviews will be provided at a future meeting of the Collaborative.

3.20 Our local plan for the NHS 3-year funding for Learning Disabilities and Autism was approved by the Learning Disabilities and Autism Strategic Partnership Board in February and submitted to the NHS regional team. Hertfordshire's Transforming Care Partnership will present the plan to the Regional Learning Disabilities and Autism Board on 16th March for sign off.

3.21 ***CAMHS Transformation:*** The CAMHS transformation task and finish groups (Access and Pathways, Front Door and Digital (Website and Access)) – continue to progress with representation from across the whole CAMHS system. Work is now underway to develop the recommendations from the task and finish groups to inform an overarching business case, to deliver our ambitions for a more accessible emotional and mental wellbeing system. Further information on this will be provided as part of agenda item 5.

3.22 The workforce task and finish groups are in the process of identifying interventions and solution to the challenges identified in their February workshop. This includes the potential of working with University of Hertfordshire, who run a doctoral clinical psychology training course (whole life course), to grow the Hertfordshire workforce.

3.23 The Early Help Eating Disorder Specification has been agreed and the CAMHS commissioning team have approached providers with a view to awarding. It is envisaged that this service will commence in late spring/early summer. The HPFT CYP Eating Disorder team have 'reset' their service offer. Baseline data will enable evidence of success and to understand the impact on patient flow.

3.24 Work continues on the development of a local place-based offer of emotional wellbeing support though primary care and educations, the Paediatric Liaison Model and the development on digital interventions.

3.25 The Mental Health Support Teams (MHST) programme is progressing in line with planned expansion across the ICS footprint to meet the LTP ambition. The next wave will introduce 4 new MHSTs in September 2022 covering areas of Dacorum, Three Rivers, North Herts in Hertfordshire, and Uttlesford in West Essex.

4. Regional Specialised Mental Health Provider Collaborative

4.1 NHSEI has set up a regional task and finish group for children and young people's services. The group includes ICS, public health, local authority, patient and carer representatives as well as the Regional Collaborative. The group has a remit that extends from preventative through to Tier 4 services and is expected to develop a set of regional strategic recommendations for the transformation of CYP MH services (0-25) across the East of England. This will consider and include the LTP ambitions and other key national guidance documents. The group is expected to report within six months.

4.2 A business case is being developed by HPFT to develop a specific in-region service for female patients who need secure care and who have a learning disability. This follows the closure of the regions only dedicated accommodation which was provided at St John's Hospital in Norfolk.

4.3 The Regional Provider Collaborative has reviewed progress against the nationally prescribed Quality Maturity Framework. It is assessed as making good progress in line with expectation in its management of quality and governance.

5. Planning for our Population

5.1 The Dementia Strategy 2022 – 27 consultation will be closing on 31 March 2022. Collaborative partners are recommended to respond to the consultation online at:
https://surveys.hertfordshire.gov.uk/s/DementiaStrat2227/

5.2 The draft Hertfordshire Mental Health Strategy consultation is still open and available online at: https://surveys.hertfordshire.gov.uk/s/mhconsultation/

5.3 Alongside wider promotional activity, an animated short related to this consultation has also gone live on social media. The animated video is available here.

5.4 Responses to the consultation remain low at this time, but it is hoped these promotions will improve this. A direct email approach is being planned for w/c 21.03.22. Collaborative partners are encouraged to respond to the consultation.

6. Inequalities

6.1 In February 2022 a Hertfordshire Gypsy, Traveller and Roma (GTR) Mental Health and Suicide Prevention Steering Group was established. Membership of the group includes representatives from statutory and VCSE sector, alongside representatives of the GTR community.

6.2 The GTR population experience an increased prevalence of mental illness and are at an increased risk of suicide. The community also experience significant barriers to accessing mental health support and services, which are both cultural and practical. The Steering Group will work with the Hertfordshire GTR community to achieve an improvement in mental health wellbeing and access to appropriate culturally competent services with increased confidence in statutory agencies and a subsequent reduction in suicides.

6.3 The purpose of the Steering Groups is to support the work of the health improvement co-ordinator, mental health and suicide prevention, gypsy and traveller communities and develop, review, support and evaluate priorities. The group will promote mental health and suicide prevention initiatives and projects specifically targeted at the Gypsy and Traveller communities in Hertfordshire, ensuring they align to the needs of the specific population being appropriate and responsive to their needs.

6.4 The current objectives of the group are:

- To support and facilitate the work of the Health Improvement Co-ordinator MH & SP (Gypsy & Traveller Communities) and overall outcome.
- To agree key priorities and action plan for the target population.
- Provide links and contacts with a range of partner agencies and key members of the G&T communities.
- To evaluate the impact of the agreed projects in promoting good mental health and preventing suicide in the G&T communities.
- Improve understanding and confidence between services and the G&T community.
- Refresh objectives in line with a review of the priorities, as the role is developed within the context of improving mental health and preventing suicides, in the G&T communities.

7. Conclusion

7.1 This report has provided a summary of the key developments and activity overseen by our Collaborative since its last meeting in February.

7.2 The last month has seen the Collaborative continue to develop a clearer understanding of the scale of the challenges it faces but also its role in addressing them – from convening Collaborative partners to address a specific service redesign proposal to drawing upon our community partners to best understand and address inequalities in access, experience and outcomes.

7.3 Over the course of the next month, with the Collaborative transformation priorities agreed, we will continue to push ahead and develop the Collaborative's capability and insight so that it can fulfil its role within the system and champion improved outcomes for the Hertfordshire citizens.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	31 March 2021	**Agenda Item:** 18
Subject:	Report of the Audit Committee: 10 February 2022	**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 10 February 2022.

Action required:

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

Summary and recommendations to the Board:

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

Matters of Escalation

The amended Terms of Reference are recommended to the Board for approval.

Committee ask the Board to formally note the appointment of RSM to provide the internal audit and counter fraud services and the one year extension of KPMG's contract to provide external audit services.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

None

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

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

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

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

Not applicable.

1. Introduction

The Audit Committee was held on the 10 February 2022 in accordance with its terms of reference and was quorate.

It was noted that the formal meeting would be followed by a private meeting between Non-Executive Committee members, internal audit and external audit.

2. Deep Dive – 2021/22 Year End

The Committee received a comprehensive presentation on the preparation of the Annual Accounts for 21/22. The Committee was updated on the financial framework that was in place for 21/22 and planned breakeven for the end of the year. The Committee was updated on the current forecast for the year end including the main elements contributing to this. It was noted that there were likely to be adjustments right up to year end due to the fluid external situation and possible changes in income being received by the Trust.

The Committee was taken through the proposed approach to provisions and the areas that they were likely to cover. Noting that they were likely to be of a similar or slightly higher level that in 20/21 and similar level of deferred income. The Committee received specific detail on the matters relating to COVID and the changes to planning guidance through 21/22. The Committee were assured with regard to the key areas that would be under review as part of the year end process and that the Trust were working closely with external audit to ensure there was a common understanding of key matters.

It was noted that the Value of Money self-assessment had been submitted and was currently being reviewed by external audit.

In response to Tim Bryson's question the Committee discussed the possible risks to the Trust of the new system wide approach to financial planning. The Committee were updated on the current position with regard to contract negotiations with commissioners. It was noted that Trust would have a draft financial plan by mid-March and this would be finalised in April 2022, and the delay was due to the late publication of the national guidance.

3. External Reports

3.1 Internal Audit Progress Report

It was reported that there was good progress with the delivery of the Internal Audit plan for 2021/22 and that there were currently no factors likely to affect the Head of Audit Opinion for 2021/22. It was noted that two audit reports had been finalised since the last Audit Committee, one advisory and the other had a positive opinion. Catherine Dugmore noted the improvements in data quality at the Trust.

3.2 Internal Audit Plan for 2022/23

The Committee considered a report that set out possible areas for 2022/23 internal audit plan. The Committee had a detailed discussion of possible audit areas based on the Trust's strategic objectives and risk areas. Internal Audit welcomed the engagement of the Audit Committee in these discussions. It was noted that the

feedback would be reviewed by the Executive team and the final plan would be brought to the April Committee meeting for approval.

3.3 Counter Fraud Progress Report

The Local Counter Fraud Progress report was presented which provided an update on the work undertaken since December 2021. It was noted that good progress had been made with the proactive work in the plan and there had been a reduction in the number of cases being referred.

With regard to the CFFSR (Counter Fraud Functional Standards Return) position, the Committee noted the progress that had been made and the feedback that the last area to be addressed related to the Trust Fraud Risk Register. It was agreed that a future meeting would receive information on how to continue the improvements in the CFFSR self-assessment.

3.4 Counter Fraud Plan for 2022/23

The Committee considered a report that set out possible areas for 2022/23 counter fraud plan. The Committee had a detailed discussion of possible work areas based on the Trust's strategic objectives, risk areas and mandatory requirements. It was identified that it might be helpful to consider procurement as a future deep dive area for the Committee.

It was noted that the feedback would be reviewed by the Executive team and the final plan would be brought to the April Committee meeting or approval.

3.5 External Audit Plan Report 2021/22

The Committee received a report that set out that plan for the audit of the Trust's financial statements by external audit. The report set out the risk assessment and the planned audit approach. It was noted that the Value for Money risk assessment had not yet been completed and would be reported to a future Committee meeting.

The Committee considered the four risk areas being focused on and noted additional areas of focus relating to IFRS 16 transition. The report set out external audit's position with regard to materiality and the audit fee for the year.

The Committee noted the confirmation of independence in the report. The Committee also welcomed the update that KPMG had been awarded the highest quality standard for audit following an assessment of audit files.

Maria Wheeler outlined the approach to leases under IFRS 16 in response to a question from Anne Barnard.

4. Risk/Governance Matters

4.1. Annual Review of Effectiveness

The Committee received a report setting out the outcome of the self-assessment undertaken by Committee in December 2021. The overall score was an improvement on last year's survey and reported and improvement across a range of statements. The Committee noted and supported the recommendations for development areas.

4.2 Accounting Policies Review

The Committe received a report that set out review of accounting policies that had been undertaken in prepration for completing the 2021/22 financial statements. It was noted that no major changes had been adopted or were expected.

4.3 Review of Terms of Reference

The Committee undertook a review of its terms of reference noting that there had been no significant changes. Following advice from external audit it was agreed to clarify the Committee's responsibility with regard to Losses and Special Payments. Subject to these amendments the terms of reference were recommended for Board approval.

4.4 Update on National Audits

The Committee considered a report that provided an overview of the National Audits that the Trust have participated in over the past year. It was noted that some of the reports received this year were from data that was provided in 2019.

It was noted that the Trust had participated in seven National Audits in the last 12 months, of which four reports have been published. The Committee noted that some of the audits are in a second cycle, which provides the Trust with rich data on how we have performed over the past four years.

It was noted that the report had been discussed at the Integrated Governance Committee meeting in January 2022. It was agreed that future reports would include information on learning and what had been done to ensure improvements are made.

4.5 Update on internal and external audit contracts

Internal audit and counter fraud

The Committee received an update on the outcome of the procurement exercise for internal audit and counter fraud services following the decision at the December meeting to award the contract. It was noted that the two-year contract had been awarded to RSM starting April 2022. The award followed a ten-day cooling off period during which no issues were raised. It was noted that the Trust team have started to work with the RSM teams to develop the internal audit and counter fraud work plans for 2022/23.

External audit

The Committee were informed that at its meeting on 9 December 2021 the Council of Governors, had considered and approved the recommendation to extend the contract with KPMG for external audit services for a further year. The Council of Governors noted that this was the last time the contract could be extended and that a procurement process would be undertaken in 2022.

It was noted that following approval at the Council of Governors the Trust agreed a one-year contract extension with KPMG with a slight increase in fees to recognise the additional technical requirements for the year.

It was reported that support would be sought from Council of Governors at their meeting March 2022 to start the procurement process for external audit services for 2022/23 onwards.

5. Items Noted

5.1 Presentation of Minutes from Other Committees

The Committee recieved the notes from the Finance and Investment Committee meeting held on 17 November 2021. The Committee received the notes of the Integrated Governance Committee meeting held on 11 November 2021.

5.2 Update on 2021/22 Annual Report and Quality Report

The Committee were updated on the planning underway to produce the 2021/22 Annual Report in line with the guidance. It was noted that the national guidance was not yet available but there were not expected to be significant changes. It was noted that the process will be led by the Head of Corporate Affairs and Company Secretary. It was noted that there was not a requirement to produce a Quality Report as part of the Annual Report.

It was agreed that the draft timetable would be updated when the guidance had been received and would include involvement of Non-Executive Directors prior to the final sign off of the Annual Report by the Committee and Board.

5.3 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 a small number remained, Internal Audit noted that this was a positive report.

5.4 Use of Waivers

The Committee recieved the report on waivers in quarter three. It was noted that the largest waiver related to supply of anti-ligature windows, which was a very specialist area and a priority to resolve to support the safety of service users.

5.5 Information Goverance Quarter Three report

The Committee noted the report that provided a summary of the work of the Information Rights and Compliance function in the third quarter of 2021/22, including: Performance in Information Requests casework, including summary of CQI project; Thematic review of Datix reports and incidents; Summary of ICO enquiries and reports across the quarter; Internal Audit and IG Policy Framework; Cybersecurity and Business Continuity Management and DSP Toolkit.

5.6 Quarter Three – Use of the Seal

The Committee noted report detailing the use of seal during the third quarter of 2021/22.

5.7 RSM's conformance with IIA Standards and Code of Practice

The Committee noted that RSM commissioned an external quality assessment (EQA) of its internal audit services in 2021, which is required every five years, in line with the requirements of the International Professional Practices Framework (IPPF) and the Standards set by the Global Institute of Internal Auditors (IIA). The outcome of the EQA was that RSM achieved the highest rating possible.

5.8 Committee Forward Planner 2022

The rolling forward planner was noted. It was noted that the next meeting will focus end of year.

6. Matters of Escalation

It was noted that the amended Terms of Reference would be recommended to the Board for approval.

It was agreed that the Committee report would formally note the appointing of RSM to provide the internal audit and counter fraud services and the one year extension of KPMG's contract to provide external audit services.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item: 19**
Subject:	Annual Review of Audit Committee Terms of Reference	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Helen Edmondson, Head of Corporate Affairs & Company Secretary
Presented by:	Catherine Dugmore, Non-Executive Director	

Purpose of the report:

To update the Board on amendments to Audit Committee Terms of Reference following review at February Committee meeting.

Action required:

To approve the Terms of Reference of the Audit Committee

Summary and recommendations to the Board:

Annually the Audit Committee (a sub-committee of the Board) review their Terms of Reference and refer any changes to the Trust Board for approval. The Board may also review and modify a Sub-Committee Terms of Reference any time.

The Audit committee reviewed its Terms of Reference at its meeting of the 10 February 2021, one amendment has been made relating to the inclusion of the Committee's role with regard to losses ad special payments following feedback from external audit.

The proposed Terms of Reference are supported by the outcome of the Committee self assessment that was also considered by the Committee at its meeting in February.

Recommendation:
Board of Directors asked to approve the Terms of Reference of the Audit Committee as appended to the report.

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

It is good governance that committee's review their terms of reference annually to ensure they remain fit for purpose to ensure the organisation can discharge its statutory functions.

Summary of Financial, IT, Staffing & Legal Implications:

none

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

none

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

Evidence for CQC and External Review of Well Led Domains

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

Audit Committee – 10 February 2022

Hertfordshire Partnership University NHS Foundation Trust

TERMS OF REFERENCE

Audit Committee

Status:	The Audit Committee is a non-executive sub-committee of the Trust Board.
Chair:	**Non – Executive Director**
Membership:	The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of: Open to all Non-Executive Directors but three Non-Executives to attend: • Chair of Audit Committee • Chair of Finance and Investment Committee • Member of Integrated Governance Committee In attendance: Executive Director of Finance Representatives of Internal Audit Representatives of External Audit Head of Corporate Affairs and Company Secretary The Chief Executive will be invited to attend at least once per annum.
Frequency of Meetings:	5 meetings per annum
Frequency of Attendance:	Members will be expected to attend all meetings. If members miss two consecutive meetings, membership will be reconsidered by the Committee Chair (subject to exceptional circumstances).
Quorum:	A quorum shall be two members, including one member from Finance and Investment Committee and Integrated Governance Committee.

1. Remit

1.1 The Audit Committee is a non-executive committee of the Board and has no executive powers, other than those delegated in the Terms of Reference.

1.2 The remit of the Group is:

"To review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the

organisation's activities (both clinical and non-clinical), that supports the achievement of the organisations objectives."

2. Accountability

2.1 A report will be made by the Chair to the Trust Board following each committee meeting. The report will contain:

- A note of all the items discussed by the committee
- Matters for noting by the Board
- Recommendations to the Board regarding decisions to be taken by the Board on governance matters
- Matters for escalation to the Board from the committee
- Annually the committee will report on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the risk management system in the organisation and the integration of governance arrangements.
- Any other issues as agreed by the Chair & Company Secretary.

2.2 The minutes of Audit Committee meetings shall be formally recorded by the Company Secretary and submitted to the Board.

2.3 A report will be included within the annual report describing the work of the committee in how it has discharged its responsibilities. The Committee Chair or nominated deputy will attend the Annual General Meeting at which the annual report is presented.

3. Responsibilities & Duties

The duties of the Committee can be categorised as follows:

3.1 Governance, Risk Management and Internal Control

The Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and compliance with registration requirements), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, Local Counter Fraud and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcement relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as the completeness and accuracy of the information provided.

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of termination.
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- annual review of the effectiveness of internal audit
- consideration of Annual Governance Statement

3.3 External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- consideration and recommendation to the Board of Governors of the appointment and performance of the External Auditor.
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan.
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review all External Audit reports, including agreement of the management letter before submission to the Trust Board and Board of Governors and any work carried outside the annual audit plan, together with the appropriateness of management responses.

3.4 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution,

etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Integrated Governance Committee and any Risk Management committees that are established.

In reviewing the work of the Integrated Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function. The Audit Committee places reliance on the work of the Integrated Governance Committee to review and assess the assurance framework and report any significant control issues. As a result the Audit Committee requires a six monthly update report from the Integrated Governance Committee on these issues (to include the Trust Risk Register).

The Committee will review and approve losses and special payments in line with guidance from NHSE/I and agreed delegated limits.

3.5 Counter Fraud

The Audit Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

3.6 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

3.7 Financial Reporting

The Audit Committee shall review and scrutinise the content of the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the clarity of wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee is compliant with current disclosure requirements and is clear and understandable,
- changes in, and compliance with, the accounting Standards applicable to the NHS and with Trust policies and best practices
- unadjusted mis-statements in the financial statements
- major judgmental areas in the preparation of the accounts and the basis of the decisions made
- any significant adjustments resulting from the audit.
- that taken collectively the statements show a true and fair view
- the statements are in accordance with the monthly financial reports provided to the board and any variations are clearly explained

The Committee should also ensure that the systems for financial reporting to the Board and NHS Improvement, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided

The Audit Committee shall be informed of the work of the Finance and Investment Committee of the Board and receive a six monthly update report for this purpose.

3.8 Quality Reporting

The Audit Committee shall ensure the process undertaken to develop the Quality Report and Quality Accounts is appropriate prior to its submission to the Board for approval.

The Committee should also ensure that the systems for reporting to the Board and NHS Improvement are subject to review as to completeness and accuracy of the information provided to the Board and NHS Improvement.

3.9 Board Committees

In addition to the work of the Finance and Investment Committee and the Integrated Governance Committee, the Audit Committee shall review the work of any other committee set up by the Board as appropriate, the period and regularity of the reporting to be determined by the Audit Committee to reflect the nature and purpose of the committee.

4. Other Matters

The Committee shall be supported administratively by the Company Secretary, whose duties in this respect will include:

- agreement of agenda with the Chair and attendees and collation of papers
- taking the minutes & keeping a record of matters arising and issues to be carried forward
- advising the Committee on pertinent areas

5. Monitoring of Effectiveness

5.1 The group will review its own performance and terms of reference at least once a year to ensure it is operating at maximum effectiveness.

Terms of Reference ratified by: Audit Committee

Date recommended by the Audit Committee: **XX**

Date Approved by the Board: **xxx**

Date of Review: **XX**

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:** 20
Subject:	Trust Risk Register March 2022	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

To update the Trust Board of the revised risks on the Trust Risk Register.

Action required:

To receive the Trust Risk Register for discussion of the risks, their scores, ordering and mitigation.
To approve the updated risks

Summary and recommendations:

This paper sets out the Trust Risk Register following discussion at the Executive Team on 2 March 2022 and Integrated Governance Committee on 17 March 2022.
All the risks have been reviewed and updated.
In particular, there are new risks proposed relating to Cybersecurity, Quality of Care and Insufficient Beds.

Recommendation
The Trust Board are asked to review and approve the risks as outlined in the Trust Risk Register.

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

Relation to the BAF: (the following Strategic Objectives link to individual risks on the Trust Risk Register)
1. We will provide safe services, so that people feel safe and are protected from avoidable harm.
2. We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience
4. We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support, and treatment
5. We will improve, innovate, and transform our services to provide the most effective, productive, and high-quality care
6. We will deliver joined up care to meet the needs of our service users across mental, physical, and social care services in conjunction with our partners
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s).

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

There are no budgetary or financial implications in the Trust Risk Register report, however some actions taken linked to the risks may have budgetary or financial implications.

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

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

Health and Social Care Act 2008 (Regulated Activities) Regulations
Regulation 12: Safe care and treatment

- Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible. They should review methods and measures and amended them to address changing practice.

Regulation 17: Good Governance

- Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.
- Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.
- Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.
- Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate.
- Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.

Care Quality Commission Key Line of Enquiry; Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions

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

Executive Team 2 March 2022
Integrated Governance Committee 17 March 2022

Trust Risk Register Executive Summary March 2022

1. Introduction

1.1 The purpose of this Executive Summary is to present an overview of the recent updates to the Trust Risk Register (TRR), for discussion. Consideration should be given to the current situation and the mitigations that have been put in place. The TRR identifies the high-level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them.

1.2 Each Executive Director has reviewed the risks that they are Senior Responsible Officer (SRO) for, and the current position and mitigation has been updated.

1.3 The Trust Board is asked to:

- Consider the risks and whether they reflect the current risks for the Trust
- Consider the risk scoring and whether they are appropriate
- Consider whether the mitigation and actions are robust enough, offering constructive challenge to the team to ensure the risks are managed and mitigated.

2. Summary

2.1. The Trust currently has eight risks on the TRR.

2.2. Since the TRR was last presented to the Integrated Governance Committee (IGC) in November 2021, there has been a comprehensive review of the top risks for the Trust and this report sets them out.

2.3. The Trust Board are asked to review and approve the risks as outlined in the TRR.

Summary Trust Risk Register by Exec Lead and linked to Trust Strategic Objectives

Pos	Risk	Rating (Initial) LxC	Rating (Current) LxC	Rating (Target) LxC	Link with Strategic Objective	Key Mitigations	Executive Lead
1.	**People** We won't have sufficient number of staff with the right skills, due to high levels of turnover, insufficient recruitment, and limited supply of workforce. Which will impact on our ability to provide safe responsive care, avoid harm and unexpected deaths, which will also have an impact on staff's wellbeing.	12	4 x 5 **20**	2 x 4 **8**	We will attract, retain, and develop people with the right skills and values to deliver consistently great care, support and treatment	Recruitment and Retention action plan. Refreshed Engagement Strategy and staff engagement action plan. HPFT Workforce Plan 2021-2025. Together Strategy – MOSS together) to reduce Conflict (violence) and Containment (restrictive practices). Respect Training Recovery plan in plan with trajectory.	Janet Lynch (Interim Executive Director of People & Organisational Development
2.	**Demand and acuity.** Increase in demand for services and increase in complexity of needs of service users. Which will see a reduction in the quality of care, lengthening of waiting times and have an impact on our ability to provide safe responsive care, avoid harm and unexpected deaths.	16	4 x 5 **20**	2 x 4 **8**	We will provide safe services, so that people feel safe and are protected from avoidable harm	Increased staffing levels and revised establishments. Increased levels of safe and supportive and observations. Safety huddles for service users and for staff to work proactively identify/raise any concerns during a shift. Active monitoring through SafeCare and scrutiny of healthroster Securing additional funding for Transformation Transformation programmes for adult and CAMHS Increased system working through Mental Health, Learning Disability and Autism Collaborative	Jacky Vincent (Executive Director of Quality and Safety (Chief Nurse))
3.	**Insufficient beds** We don't have access to sufficient number of inpatient beds. Which sees an increases in use of out of area placements, an increased number of services users in the community waiting for admission and causes a financial pressure. Will also have an impact on quality of care and staff wellbeing	12	4 x 5 **20**	3 x 3 **9**	We will provide safe services, so that people feel safe and are protected from avoidable harm	Contract for additional acute inpatient beds at Kneesworth House. Re design of acute care pathways CAMHS wrap around care for young people in acute Trusts awaiting a bed. Development of step down facility CAMHS Eating Disorder waiting list system. CAMHS Eating Disorder review clinic to manage the waiting list and prioritisation. System wide work to reduce delayed transfer of care	Sandra Brookes (Executive Director of Service Delivery and Service Experience)

	Risk	Rating (Initial) LxC	Rating (Current) LxC	Rating (Target) LxC	Link with Strategic Objective	Key Mitigations	Executive Lead
4.	**Financial Sustainability** We won't have sufficient resources to deliver high quality care to service users due to over expenditure and reduction in income. All of which will have an impact on the quality and responsiveness of our services, which in turn will have an impact on the experience of our service users.	12	4 x 4 **16**	2 x 3 **6**	We will improve, innovate, and transform our services to provide the most effective, productive and high-quality care	Secure a fair share of the ICS revenue allocations including income allocated to MH Investment standard and LTP. Effective grip on resource use with appropriate cost controls Robust Delivering Value programme Effective Service Transformation programme Effective use of capital spending Supporting innovation	Maria Wheeler (Executive Director of Finance, Performance, and Improvement)
5.	**Quality of Care** We won't be able to provide high quality care at Forest House, Warren Court, SRS and northwest adult community services, due to a number of factors including workforce, significant increases in demand and availability of beds.	N/A	4 x 4 **16**	2 x 4 **8**	We will provide safe services, so that people feel safe and are protected from avoidable harm	Forest House Service Improvement Action Plan. Regular reporting on progress of actions in the Service Improvement Action Plan to Executive Team. Weekly oversight of Forest House Service Improvement plan by Executive Director lead. Warren Court Action Plan Northwest Herts Task and Finish Group Regular monitoring via performance report Increased visibility of senior nursing and other professional staff	Jacky Vincent (Executive Director of Quality and Safety (Chief Nurse))
6.	**External landscape:** Reduction in the influence of the Trust within the system, which could see a shift in influence and resources away from mental health, learning disabilities and autism and impact on Trust's ability to deliver high quality care to service users.	20	3 x 4 **12**	1 x 3 **3**	We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	Active Engagement and stakeholder management across the system Inc. ICS, Place based Partnerships & partner organisations, regional and national teams Development of Herts MH & LD Collaborative Development of EOE MH Collaborative Positive Relationship with Regional office and other regulators Secured MH Investment Standard and LTP plan requirements	Paul Wood (Interim Director of Strategy and Partnerships),
7.	**Cybersecurity** Trust's information and systems is at higher risk of being compromised by a cyberattack due to current international events. This is also because the attacks are getting increasingly sophisticated in identifying and exploiting known and unknown vulnerabilities which if successful, may result it loss and/or public disclosure information and loss of access to critical systems.	3 x 4 **12**	3 x 4 **12**	3 x 3 **9**	We will improve, innovate, and transform our services to provide the most effective, productive and high-quality care	Cyber security audits undertaken in HBL ICT IT Security Policy, Email and Internet Policy, Mobile Device Policy Intrusion Prevention Sensors on all 'internet' connections Regular/periodic messaging to staff regarding potential issues, vigilance, expected behaviours and appropriate responses. Information Governance mandatory training. Move to NHSmail	Hakan Akozek (Director of Innovation and Digital Transformation)

Trust Board PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:** 21
Subject:	Board Assurance Framework	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To provide assurance that the Trust's principal risks have been identified and are being appropriately managed.

Action required:

The Board is asked to:

- Review the Board Assurance Framework (BAF) noting it has already been considered and approved by the Integrated Governance Committee.
- Ensure the evidence in the BAF provides assurance that the principal risks have been identified and appropriate controls and assurance are in place.

Summary and recommendations to the Board:

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and also enable the board to gain assurance about the effectiveness of these controls. The Lead Director for each risk is responsible for assessing the risks assigned to them and providing assurance on the effectiveness of risk controls and updating the relevant actions.

This report provides an update on the latest iteration of the BAF. This version includes updated controls and lines of assurance together with the most recent dates for the assurance evidence

Appendix 1 details the significant changes to the BAF since it was reviewed at Board in November 2021.

Recommendation:

1. For the Board to review and approve latest iteration of the BAF.

Relationship with the Business Plan & Assurance Framework:

The BAF identifies the risks associated with the strategic objectives as set out in the Annual Plan.

Summary of Financial, IT, Staffing and Legal Implications:

None outlined in the summary report.

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

None.

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

Evidence of robust governance review process for the NHSI/CQC Well Led Standard.

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

Executive Team 9 March 2022 Integrated Governance Committee 17 March 2022

Please note the BAF has been updated to include most relevant dates for Board, Committees and other groups, these numerous updates are not included in the table below

Appendix 1

Principal Risks and Lead Director/s	BAF Risk No.	Risk Change in period
Strategic Objective 1: We will provide safe services, so that people feel safe and are protected from avoidable harm		
Risk that do not provide safe standards of care, meaning service users to not feel safe and are not protected from avoidable harm or deaths through suicide	1.1	**New Action** Deep Dive into unexpected deaths of Service Users in North West Community and Crisis services
Risk that do not deliver restrictive practice in line with best practice, therefore impacting on patient safety and experience	1.2	**New Action** Implement Forest House Assessment Unit Service Improvement Plan
Failure to provide safe working environment for staff, adversely impacting on staff wellbeing.	1.5	**New Action** Resetting of safety priorities

Principal Risks and Lead Director/s	BAF Risk No.	Risk Change in period
Strategic Objective 2: **We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience**		
Failure to engage effectively with service users and carers will impact on Trust's ability to transform services to best meet their needs	2.2	**New action** Implementation of the Warren Court Action Plan Implementation of the Forest House Assessment Unit Service Improvement Plan **Revised action** Implementation of digital technology to increase feedback e.g Friends and Family Test
Failure to invest to improve the standard of Trust's environments will impact on patient experience and quality of care.	2.3	**New Action** Delivery of capital plan for 2022/23

Strategic Objective 3. **We will improve the health of our service users through the delivery of effective evidence based practice**		
Do not provide appropriate assessment and treatment of physical conditions which will impact on service user wellbeing and outcomes	3.1	**New Action** Implement training courses for simulation Hub

Strategic Objective 4. **We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment**		
Unable to recruit and retain the right numbers of people with the right skills, which will impact on quality of care for our service users and our staff satisfaction levels.	4.1	**New Action** Implement recruitment plan including new incentives
Failure to provide an inclusive and diverse workforce with equality of opportunity and experience	4.3	**New Assurance** Advisory Internal audit report on CEA
Failure to improve employment experience for all our staff, including health and wellbeing support which will mean staff do not feel valued or enabled to reach their potential	4.4	**New Action** Implement new agreed incentives Implement Staff Survey Action Plan

Strategic Objective 5 **We will improve, innovate and transform our services to provide the most effective, productive and high quality care**		
Failure to deliver a sustainable financial position and longer- term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements	5.1	**New Action** Implement Delivering Value Programme 2022/23
Staff do not have access to accurate and timely information to assist clinical and non-clinical decision making and planning, will impact on ability of Trust to innovate and transform.	5.2	**New Action** Implement findings from 21/22 internal audit report

Board Assurance Framework (BAF)

March 2022

Reviewed by:

- Integrated Governance Committee
- Audit Committee
- Trust Board (TB)

Introduction

This Board Assurance Framework brings together the principal risks potentially threatening the Trust's Strategic Objectives and outlines specific control measures that the Trust has put in place to manage the identified risks and the independent assurances relied upon by the Board to demonstrate that these are operating effectively.

Explanation of Assurance types and levels

Assurance Type - The identified source of assurance that the Trusts receives can be broken down into a three line model (1st, 2nd and 3rd line assurances)**. The assurance type column RAG rating records the highest level available for each control**

1st Line	2nd Line	3rd Line
Assurance from the service that performs the day to day activity E.g. Reports from the department that performs the day to day activity, Departmental Meetings, Departmental Performance Information	Assurance provided from within the Trust - Internal assurance E.g. Management Dashboards, Monthly monitoring	Assurance provided from outside the Trust - Independent assurance E.g. Internal Audit, External Audit, Peer Review, External Inspection, Independent Benchmarking

Assurance Level - For each source of assurance that is identified you can rate what it tells you about the effectiveness of the controls

High	Medium	Low
One or more of the listed assurance sources identify that effective controls are in place and the TB are satisfied that appropriate assurances are available Substantial assurance provided over the effectiveness of controls	One or more of the listed assurance sources identify that effective controls are in place but assurances are uncertain and/or possibly insufficient. Some assurances in place, or substantial assurance in place, but controls are still maturing so effectiveness cannot be fully assessed at this time.	The listed assurance sources identify that effective controls may not be in place and/or appropriate assurances are not available to the Board Assurance indicates poor effectiveness of controls.

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	1.1 Risk that do not provide safe standards of care, meaning service users to not feel safe and are not protected from avoidable harm or deaths through suicide.	Briefing of all Serious and potential serious Incidents Moderate Harm Panel	Executive Committee Board CCGs QRMs Safety committee reporting into QRMC	Moderate harm panel/ datix notes Internal review of incidents during Covid19	Serious Incident Briefing Report. Weekly to exec and Board Exec and Board reports and minutes of meetings	CCG SI reviews Independent Authors from selected SI investigations CQC Whistleblowing	High	Weekly SI report to Exec and monthly report to TB Weekly moderate harm panel	**Action** **Reset approach to risk assessment and formulation.** **Deep Dive into unexpected deaths of Service Users in North West Community and Crisis services** **Implement Warren Court Forest House Action Plans**	Director of Quality and Safety [IGC]
		Mortality Governance processes (including LEDER)	IGC TB		Mortality Governance Reporting Quarterly Integrated Safety Report	Externally Reporting	High	IGC 8.3.21 13.5.21 15.7.21 16.7.21 16.9.21 11.11.21 20.1.22 TB 24.6.21 29.7.21 30.9.21 25.11.21	**Action** **Risk Formulation Training**	
		Quality Report Processes (including Annual Report)	Executive Committee IGC TB Commissioner's Eternal Audit	Service reports on Quality priorities Covid 19 Update reports Clinical and Professional Advisory Committee	SBU, ICG and Board reports on Quality priorities and Quality Account	Quality Account 20/21 (published) Annual Report 20/21 (externally audited) External audit advisory report	High	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 Audit Committee 27.4.21 10.6.21 19.7.21 9.9.21 2.12.21 10.2.22 TB 24.6.21 29.7.21 30.9.21 25.11.21	**Action** **Implement of Quality framework to triangulate information from visits.**	
		CQUIN Processes	TMG Executive Committee IGC TB CCG QRM	Trust Management Group update reports	CQUIN Reports – Part of quarterly Performance Report	CCG CQUIN reports as part of the Quality report	High	IGC 15.7.21 11.11.21 qrm 25.5.21		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
				Service and SBU reports on CQUIN				2.7.21 3.9.21 TB 30.7.21		
1. We will provide safe services, so that people feel safe and are protected from avoidable harm		Training Recruitment process Professional standards adhered to Clinical Outcomes	Executive Committee IGC TB QRM	Quarterly Safe Staffing Levels report CCG Contract reporting (quarterly) Supervision Appraisals			High	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 QRMC 30.4.21 25.5.21 2.7.21 3.9.21 29.10.21 7.1.22 4.3.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21		
	1.2 Risk that do not deliver restrictive practice in line with best practice, therefore impacting on patient safety and experience	Freedom to Speak Up Practice and Processes	Integrated Governance Committee Quality and Risk Management Committee CCG QRM	Service audits Service feedback from FSUG	Freedom to Speak up – 6 monthly review & Annual Report	CQC MHA Inspections Freedom to speak up Guardian Concerns raised with the Trust via the CQC (CQC Concerns) Duty of Candour Audit	High	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 QRMC 30.4.21 25.5.21 2.7.21 3.9.21 29.10.21 7.1.22 4.3.22	**Action** **Recruitment of full time Guardian and service-based advocates** **Implement Warren Court Action plan** **Implement Forest House Assessment Unit Service Improvement Plan**	
		Making Our Services: MOSStogether Strategy	QRMC Executive Committee	Peer review (SBU to SBU) of	Quarterly & Annual Integrated Safety Reports	Independent reviews of	High	IGC 8.3.21 13.5.21	**Action** **Implementation of Strategy**	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
			IGC TB CCG QRM	seclusion practice.	MOSS Together strategy Use of Force Act and Restrictive Practice Committee Clinical and Professional Advisory Committee	Respect Seclusion) Assurance visits from CQC & CQC, MHA team. Ongoing involvement in Restrictive Practice Peer Review Collaborative.		15.7.21 16.9.21 11.11.21 20.1.22 TB TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 Ongoing. unannounced & announced visits QRMC 30.4.21 25.5.21 2.7.21 3.9.21 29.10.21 7.1.22 4.3.22	**Action** **Warren Court Action Plan** **Implementation for HOPE model and local trainers for Respect** **Implement Forest House Assessment Unit Service Improvement Plan**	
	1.3 Failure to implement Infection Prevention and Control policies and behaviours.	Infection Prevention and Control Board Assurance Framework	Infection Prevention & Control Committee IGC	Reports to IGC IPC audits Outbreak management	Annual Infection Prevention & Control Report Reports on emerging issues	CQC external review of IPC Externally commissioned review of IPC BAF Internal Audit report 2021	High	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22	**Action: Implement internal audit management actions**	DIPC [IGC]
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	1.4 Failure to comply with the legislative framework for the care and treatment of individuals with mental health problems, will impact on quality of care and could lead to regulatory sanctions.	Mental Health Act & DoLs Act Guidance is updated and followed.	CCG QRM IGC TB QRMC Safeguarding Strategic Committee		HPFT Quality Visits & CCG Quality Visit reports. CCG Adult and children's safeguarding reviews Deprivation of Liberty using MHA & DoLS Quarterly Report	Assurance visits from CQC and CQC MHA team – Provider Action Statements Herts-wide assurance group	High	QRMC 30.4.21 25.5.21 2.7.21 3.9.21 29.10.21 7.1.22 4.3.22 IGC 8.3.21 13.5.21 15.7.21		Director of Quality and Safety [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
				MHA Quarterly Newsletter (themes & actions)	Mental Health Legislation Quarterly Update from MH Legislation Quality and Policy Group (attended by CCGs) Mental Health Act Managers Annual Report 2020/21			16.9.21 11.11.21 20.1.22 TB 30.9.21		
		Major Incident Policy Business Continuity Plan	Executive Committee IGC TB	Service Business Continuity plans Core standards compliance Implementation of Business Continuity Plan during Covid 19	Emergency preparedness, Resilience and Response Annual Report 2019 reported to TB Table top exercises	Emergency Planning and Business Continuity EPRR Core Standards compliance – CCG & NHSE approval Quarterly meetings and reports from Herts wide Local Resilience Partnership	High	TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22		Director of Service Delivery and Experience [IGC]
		Safeguarding processes and monitoring	Safeguarding Strategic Committee		Safeguarding Reports (Annual and quarterly)	Section 11 safeguarding assessment Annual CCG safeguarding assurance assessment Adults and Children's Quality Assurance Visit Internal Audit report	High	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22	**Action** **Implement recommendations from internal audit report**	Director of Quality and Safety [IGC]
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	1.5 Failure to provide safe working environment for staff, adversely impacting on staff wellbeing.	Safe Care Standards processes and policies	CCG QRM		Quality Assurance Visit Programme Quarterly & Annual Integrated Safety Reports	Integrated Health and Care Commissioning Team (IHCCT) Volvina annual audit programme (ligatures)	High	QRM 24.8.21 29.10.21 22.2.22	**Action** **Implement Warren Court Action Plan**	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
			Health Safety and Security Committee Audit Committee		Health, Safety and Security Report (Annual / Quarterly Report) Health & Safety Annual Report			TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22		
			Quality and Risk Management Committee		Quarterly Safety Reports Policy Compliance Report CQC Action Plan	CQC Insight Reports CQC TMA		QRMC 30.4.21 25.5.21 2.7.21 3.9.21 29.10.21 7.1.22 4.3.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22		
			IGC	Clinical and Professional Advisory Committee	Reporting Quarterly Integrated Safety Report	Internal Audit Reports - CQC Action Plan		IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22		
		Quality Strategy	QRMC IGC Board	Service and SBU objectives related to the Quality Objectives as defined in the Strategy Covid19 Risk Register	HSCC QRMC IGC Quality Improvement reports Quality Strategy launched	CCG performance reports related to Quality Objectives	High	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22	**Action** **Quality strategy being roll out. Leads identified for four domains and reporting back to IGC.**	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
		Quality Measures including Quality Strategy	IGC TB CCG QRM		Trust performance KPI report on Workforce Quality Strategy review & approval Quarterly Claims Reports Briefing & Annual Claim Report	POM UK Accreditation Quarterly CCG Quality Review Meeting/Reports	High	QRMC 30.4.21 25.5.21 2.7.21 3.9.21 29.10.21 7.1.22 4.3.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 QRM 24.8.21 29.10.21 22.2.22	**Action** **Resetting of safety priorities**	
2. We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	2.1 Service Users unable to access the right services in a timely way, meaning a poor experience and or outcomes for service users.	Performance Monitoring Processes - Implementation of Accurate Clinical Information Strategy - SPIKE	Service Line Leads & Modern Matrons Executive Committee TMG TB SBU Core Management PRM Contract review meetings Internal & External Audit FIC	Spike Performance Reports Service Experience team reports Complaints seen in real-time Datix and local reporting of incidents SBU performance reporting and local PRM service line reporting structures Agreed service changes to meet Covid 19 pandemic	Trust Performance KPI report – Access Times. Re-admission rates. SBU Quarterly Performance Reviews Live Data Performance Dashboards Performance Audit Performance against Annual Plan Internal & External Audit SPIKE live data Spike data quality reports QIAs of service changes to respond to Covid19	Internal Audit Data accuracy and data quality report to Audit Committee Quality Account 20/21 externally published Audited Annual Report 2020/21		FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 Audit Cttee 27.4.21 10.6.21 19.7.21 9.9.21 2.12.21 10.2.22 AGM 21.7.21		Director of Service Delivery and Customer Experience / Director of Finance [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
		Quality Impact Assessments	QRM – reports to Commissioners IGC	Datix Complaints in real-time Experience reports Friends and Family results Having Your Say	Individual Quality Impact Assessments External Commissioner scrutiny Quality Impact Assessment reports to IGC		High	QRMC 30.4.21 25.5.21 2.7.21 3.9.21 29.10.21 7.1.22 4.3.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22		
	2.2 Failure to engage effectively with service users and carers will impact on Trust's ability to transform services to best meet their needs	Service User Feedback	QRMC Executive Committee IGC TB	Complaints in real-time Experience reports Friends and Family results Having Your Say	Peer listening reports and feedback Friends and Family Test data Feeling Safe data	Community Mental Health Annual Survey Commissioner reviews by carers in Herts and View Point	High	TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22	**Action** **Community Survey action plan and task and finish Group** **Implementation of digital technology to increase feedback e.g Friends and Family Test** **Programme of mutual help meetings**	
		Outcomes Framework for Carers Pathway Development	QRMC TMG	Reporting via Experience Team Feedback from the Council of Carers	Carer Pathway report	CQC inspection CCG reports TMA process	High	May 2019 December 2020 January 2022	**Action** **Implementation of the Warren Court Action Plan** **Implementation of the Forest House Assessment Unit Service Improvement Plan**	
	2.3 Failure to invest to improve the standard of Trust's environments will impact on patient experience and quality of care.	Capital Plan	FIC TB	Quarterly reports to FIC and TB			High	Exec Qly reports on capital plan FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21	**Action** **Completion of additional safety suites** **Delivery of capital plan for 2022/23**	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								25.11.21 27.1.22		
3. We will improve the health of our service users through the delivery of effective evidence based practice	3.1 Do not provide appropriate assessment and treatment of physical conditions which will impact on service user wellbeing and outcomes.	Physical Health Strategy CQUIN IAPT Adult Community FEP Dedicated consultant for physical health Tool kit to support the physical health and wellbeing of people with severe mental illness	TMG TB Physical Health Committee IGC QRM QRMC	Structured Judgement reviews Clinical and Professional Advisory Committee	CQUIN achieved and agreed with commissioners quarterly SBU Physical Health Leads Annual Physical Health Strategy Report Mortality Harm Panel FIC deep dive	CQC inspection CCG reports on CQUIN ICS Ethics Committee	Medium	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22	**Action** **Implement training courses for simulation Hub**	Director of Quality and Medical Leadership [IGC]
	3.2 Do not provide appropriate psychological intervention and treatment, leading to poorer outcomes.	Psychology Services Development Strategy Implementation Plan Clinical outcome measures Transformation Programme	TMG Transformation Board Exec	Implementation Plan Departmental review of clinical outcomes	Transformation Board TMG Performance monitoring and KPIs	Internal Audit programme	Medium	Monthly and quarterly perf reports Monthly transformation updates to Exec	**Action** **Roll out of additional psychology resource to target areas** **Development organisation wide performance metrics**	
	3.3 Do not use latest research or evidence to inform clinical practice which means we don't deliver the optimum outcomes for service users.	Annual Programme of Clinical Audit (Practice Audit and Clinical Effectiveness) inc NICE Guidance Policy	Executive Committee QRMC IGC Audit Committee TB CCG QRM	Individual Clinical Audits	Annual Audit Programme Practice Audit Clinical Effectiveness Progress Reports (PACE) PACE Annual Report	NICE Progress Reports	High	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 Audit Cttee 27.4.21 10.6.21 19.7.21 9.9.21 2.12.21 10.2.22		
		Medicines Management	QRMC Executive Committee IGC	Service level feedback Datix reports	DTC Annual Report 6 monthly committee update	CCG Quality report	High	IGC 8.3.21 13.5.21 15.7.21		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
			TB		Pharmacy & Medicines Optimisation Annual Report Medicines Management Strategy			16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22		
4. We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment	4.1 Unable to recruit and retain the right numbers of people with the right skills, which will impact on quality of care for our service users and our staff satisfaction levels.	People and OD performance metrics Safe Staffing levels People and OD strategy – implementation programme	TMG Executive Committee PODG TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB	Internal Audits	Medium	PODG 16.4.21 28.5.21 1.7.21 6.8.21 2.9.21 5.10.21 2.11.21 2.12.21 5.1.22 10.2.22 2.3.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22	**Action** **Implement recruitment plan including new incentives**	Director of People and OD [IGC]
		Organisational Development Strategy	Executive Committee PODG IGC TB	Supervision Appraisal	People and OD Reports Pulse Survey Good to Great Road Shows Big Listen and Local Listen.	CQC inspection Internal audits External Well Led Review	High	TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22	**Action** **Well Led Review action plan**	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
		Appraisal / PDP Reward and Recognition Processes	TMG SBU Core management SLL's Executive Committee PODG Workforce Board IGC TB	Performance by team/service reported monthly from Discovery system	Quarterly PODG reports to IGC Monthly Inspire and annual awards Staff awards Long Service Recognition Awards	External award nominations and awards	High	PODG 16.4.21 28.5.21 1.7.21 6.8.21 2.9.21 5.10.21 2.11.21 2.12.21 5.1.22 10.2.22 2.3.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22		
	4.2 Failure to develop a sustainable, adaptive and resilient workforce model that will impact on Trust's ability to deliver safe and effective care.	Revalidation and appraisal of medical staff	IGC TB		Annual Report on Revalidation and Appraisal of Doctors	Internal Audit – Doctor Revalidation	High	TB 29.7.21		
	4.3 Failure to provide an inclusive and diverse workforce with equality of opportunity and experience	People's Plan Implementation Plan	Executive Committee PODG IGC TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB Pulse Survey	Internal Audits	Medium	TB 25.2.21 and 25.3.21 (National Staff Survey) TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 8.3.22		
		External Systems for Staff Feedback	Executive Committee PODG IGC TB	FSUG report	PULSE quarterly report	National Staff Survey	High	TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22	**Action** **Implement Staff Survey Action plan**	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								Qly reports to Exec Team		
		People and OD performance metrics, including Gender Pay Analysis, WRES and WDES and Clinical Excellence Awards Inclusion Strategy	Executive Committee PODG IGC TB		CEA awards	WRES and WDES Gender Pay Analysis Advisory Audit on CEA process	Medium	PODG 16.4.21 28.5.21 1.7.21 6.8.21 2.9.21 5.10.21 2.11.21 2.12.21 5.1.22 10.2.22 2.3.22 Exec June 2021 TB 29.7.21 20.10.21	**Action** **Action plan to support Inclusion strategy**	
	4.4 Failure to improve employment experience for all our staff, including health and wellbeing support which will mean staff do not feel valued or enabled to reach their potential	Appraisal / PDP Reward and Recognition Processes	TMG SBU Core management SLL's Executive Committee PODG Workforce Board IGC TB	Performance by team/service reported monthly from Discovery system	PODG reports to IGC Monthly Inspire and annual awards Staff awards Long Service Recognition Awards		High	PODG 16.4.21 28.5.21 1.7.21 6.8.21 2.9.21 5.10.21 2.11.21 2.12.21 5.1.22 10.2.22 2.3.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22	**Action** **Implement new agreed incentives**	
		Workforce Health and Wellbeing Strategy Action Plan	Executive Committee PODG IGC TB	Service and SBU objectives related to Strategy Wellbeing offer for staff	People and OD Report 24/7 staff helpline Interactive Q&A sessions for staff	CQC inspection Well Led Review	High	PODG 16.4.21 28.5.21 1.7.21 6.8.21 2.9.21 5.10.21	**Action** **Implement Well Led Review Action plan**	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
		New Occupational Health provider		Well being bulletins				2.11.21 2.12.21 5.1.22 10.2.22 2.3.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22		
		External Systems for Staff Feedback	TMG Executive Committee PODG IGC TB	OD activity plan for bullying and harassment	Equality review meetings with commissioners (annually)	National Staff Survey 2018 Report on Key Findings and action plan in place	High	Staff Survey TB 27.1.22 Exec Feb and March 2022	**Action** **Implement Staff Survey Action Plan**	
		People and OD strategy – implementation programme	TMG Executive Committee PODG TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB	Internal Audits CQC visit	High	TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22		
		Staff Feedback systems		Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Well Led Review Report	High	PODG 16.4.21 28.5.21 1.7.21 6.8.21 2.9.21 5.10.21 2.11.21 2.12.21 5.1.22 10.2.22		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
				Q&A Interactive Sessions				2.3.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22		
	4.5 Unable to provide appropriate learning, development and training opportunities to enable staff to be skilled to the right levels, both clinically and managerially	Discovery Learning Management System (easier access to e-learning and training compliance)	PODG IGC FIC	Training Compliance to PODG Training Compliance to IGC		Internal Audits	High	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 FIC 16.3.21 10.5.21 21.7.21 22.9.21 17.11.21 18.1.22		
		Organisational Development Plan Continuous Quality Improvement Implementation	Executive Committee PODG IGC TB FIC	Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum Team Leaders Development Programme Exec. Committee Update	People and OD Reports	Internal Audit	High	PODG 16.4.21 28.5.21 1.7.21 6.8.21 2.9.21 5.10.21 2.11.21 2.12.21 5.1.22 10.2.22 2.3.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 FIC 16.3.21 10.5.21 21.7.21 22.9.21 17.11.21 18.1.22		
		Clinical leadership within teams – clinical &	Trust Management Group	SPIKE Audits Supervision	Guardian of safe working report	Focus Group feedback to CQC	High	IGC 8.3.21		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
		management leadership aligned in teams including nurse leadership & modern matrons.	Senior Leadership Team Senior Leadership Forum	Appraisal	QRMC PACE report IGC Quality report Audits			13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22		
		Mandatory Training Programme Statutory & Essential Training Policy	IGC Executive Committee TMG SBU Core management SLL's	Performance by team/service reported monthly from Discovery system	Quarterly Workforce and Organisational Development KPI Report (to services monthly) Bi-annual statutory & mandatory training report Quarterly report to WODG & TB Statutory & Essential Training Policy Ratification	Internal Audits	High	PODG 16.4.21 28.5.21 1.7.21 6.8.21 2.9.21 5.10.21 2.11.21 2.12.21 5.1.22 10.2.22 2.3.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 Monthly flash reports to Exec		
	4.6 Fail to deliver the promises within the NHS People Plan ('we are the NHS') resulting in increased regretted attrition	People and OD strategy – implementation programme	TMG Executive Committee PODG TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB	Internal Audits CQC visit	Medium	TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 IGC 8.3.21 13.5.21		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								15.7.21 16.9.21 11.11.21 20.1.22 Audit Cttee 27.4.21 19.7.21 9.9.21 2.12.21 10.2.22		
		Staff Feedback systems		Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum Q&A Interactive Sessions	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Well Led Review	High	PODG 16.4.21 28.5.21 1.7.21 6.8.21 2.9.21 5.10.21 2.11.21 2.12.21 5.1.22 10.2.22 2.3.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 Exec Cttee Monthly reports		
		External Systems for Staff Feedback	TMG Executive Committee WODG IGC TB	OD activity plan for year 2, bullying and harassment	Equality review meetings with commissioners (annually)	National Staff Survey 2021 Report on Key Findings and action plan in place	High	Staff Survey TB 24.2.22 Exec Feb and March 2022		
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care	5.1 Failure to deliver a sustainable financial position and longerterm financial plan, will impact on Trust's sustainability and ability to deliver quality improvements.	Annual Operational & Financial Plan Strategic Investment Programme NHSI Control Total NHSI Agency Cap Delivering Value Programme	Executive Committee TB FIC Trust Management Group Modernising our Estate Board Executive Committee FIC Audit Committee	Monthly 'flash' reports from finance dept Weekly monitoring of key financial indicators Departmental Budget Reports (monthly)	Financial summary report monitoring performance against plan including the NHSI Use of Resources Risk Rating and the Agency Cap Progress report on Delivery of Strategic	CQC reports Internal Audit Reports – CRES Planning & Delivery Internal Audits External Audit Proactive Counter Fraud work	High	FIC 16.3.21 10.5.21 21.7.21 22.9.21 17.11.21 18.1.22 Exec Team Monthly reports TB 25.3.21	**Action** **Implement Delivering Value Programme 2022/23**	Director Finance and Performance [FIC and Audit]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
				Bi-monthly FIC reports. Board Finance Reports	Investment Programme			20.5.21 29.7.21 30.9.21 25.11.21 27.1.22		
			TB Audit Committee			Annual Governance Statement Annual Financial Statements & Audit Report Head of Internal Audit Opinion External Audit	High	Audit Cttee 27.4.21 10.6.21 19.7.21 9.9.21 2.12.21 10.2.22 TB 10.6.21 AGM 21.7.21		
		Productivity Monitoring Processes	Executive Committee FIC IGC IM&T Programme Board TB	Monthly 'flash' reports from finance dept Weekly monitoring of key financial indicators ICT Service Improvement Update	Financial summary report Annual Accounts Finance Reports CRES Programme Assurance Board Trust Performance KPI report	Internal and External Audit Benchmarking	High	FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22 Exec team monthly flash reports		Director Finance [FIC and TB]
		Trust Contracts with Commissioners	TB FIC		Contract Update Reports	5 Year contract signed with commissioners	High	FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22		
		Cash Releasing Efficiency Programme Delivering Value Programme	Executive Committee FIC TB Trust Management Group	Delivering Value Group Monthly updates to TMG	Part of Financial Summary Report Updates to CRES Assurance Board		High	FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22		
	5.2 Staff do not have access to accurate and timely information to assist clinical and non-clinical decision making and planning, will impact on ability of Trust to innovate and transform.	Monitor, validate and audit data quality against standards	TMG Digital Strategy Board IM&T Programme Board MSC Executive Committee	Progress reports against project plan Accurate Information Group		Internal Audit Data accuracy and data quality report to Audit Committee	High	Audit Cttee 27.4.21 10.6.21 19.7.21 9.9.21 2.12.21 10.2.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22	**Action** **Implement findings from 21/22 internal audit report**	Director Innovation and Digital Transformation [FIC & TB]
		Performance Monitoring Processes	Executive Committee FIC TB	Weekly and Monthly 'flash' performance KPIs	Quality Dashboard Performance Review Process Operational Services Report Quarterly Performance Report Trust Performance KPI report	CCG Quality reports CQC inspection CQC TMA	High	Exec: Monthly and quarterly FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22		
	5.3 Failure to implement and embed digital technology will impact on service user and carer experience and our ability to transform services and support staff to respond to changing needs.	Opportunities for staff to develop ideas and implement through and innovation fund. Implementation of Digital Strategy	IM&T Programme Board Executive Committee IGC TB	Service level reports	Pulse Survey Report– Part of the Workforce & Organisational Development Report PARIS/BI Development Group – progress	Benchmarking with like organisations	High	IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 TB 25.3.21 20.5.21		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
					reports IM&T Strategy External review			29.7.21 30.9.21 25.11.21 27.1.22		
	5.4 Do not enable or encourage people to continuously improve care provided	Continuous Quality Improvement	Executive Committee PODG IGC FIC TB	Improvement & Innovation Fund Updates Transformation Update	CQI Update Reports		High	Weekly to Exec IGC 8.3.21 13.5.21 15.7.21 16.9.21 11.11.21 20.1.22 FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22		Director Innovation and Digital Transformation [IGC]
6. We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	6.1 Failure to develop and sustain partnerships with other organisations which will improve access to joined up services and outcomes.	Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans in year as necessary	CCG QRM Strategy Group Exec FIC TB	Stakeholder bulletins		Bi-monthly Joint Delivery Boards (Hertfordshire) Feedback from Clinical Commissioning Group Minutes (Reviews)	High	At least monthly QRM 24.8.21 29.10.21 22.2.22		Director of Strategy and Integration [FIC or IGC]
		Stakeholder Map and plans	Exec Committee	Intelligence sharing via EC	Exec Buddies for Collaboratives	Feedback from Commissioners	Medium	Trust Board 24.6.21 Workshop 21.10.21	**Action** **Stakeholder plans to be updated to reflect changing external landscape**	
	6.2 Fail to develop relationships with Primary Care Networks which means primary mental health services are fragmented and disjointed for service users	Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans in year as necessary	CCG QRM Exec TB	Stakeholder bulletins	Aligned NEDs and EDs to emerging system infrastructure	Bi-monthly Joint Delivery Boards (Hertfordshire) Feedback from Clinical Commissioning Group Minutes (Reviews)	High	At least monthly Weekly to Executive Committee SLT QRM 24.8.21 29.10.21 22.2.22		
	6.3 Fail to deliver integrated mental health services for older people which detrimentally impacts on their recovery and wellbeing	Integrated Care projects and plans (e.g. primary mental health, LTC, older peoples, frailty)	Executive Committee FIC TB	Complaints seen in real-time Performance data via SPIKE	ICS Participation Project reports Aligned NEDs and EDs to emerging	ICS Updates to Trust Board	High	TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22	**Action** **Ensure appropriate representation and engagement at system meetings**	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
				GP feedback Contract hotline via CCG Integrated care Systems Board Workshop Service Changes in response to Covid19	system infrastructure			Board workshop 21.10.21 FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22		
	6.4 Fail to develop and deliver integrated services for CYP across partners, which would provide earlier intervention and suitable treatment options for young people	CAMHS transformation CYP Emotional Wellbeing work stream MH & LD Collaborative	TMG Exec TB	PRM SBU reporting	Executive reports Monthly TMG reports	EoE Collaborative ICS reporting OSM with NHSI/E Scrutiny	Medium	Weekly to Executive Committee FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22 PRMs	**Action** **Lead System actions in relation to pathways and capacity for Children and Young People services** **Delivery of relevant MH & LD Collaborative work streams**	
	6.5 Fail to work with the third sector and other organisations such as the police which would lead to poor crisis response and services being available when they are at their most unwell.	Crisis concordant MH &LD Collaborative work stream Transformation programme	TMG Exec FIC TB	PRM Transformation programme	TB reports	Scrutiny	Medium	Weekly to Executive Committee FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22 Scrutiny 7.7.21 PRMs	**Action** **Continued active involvement in system wide work for Crisis services, and external partners e.g. police** **Delivery of relevant MH & LD Collaborative work streams**	
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)	7.1 Fail to develop the Hertfordshire MH and LD Collaborative, which may mean voice of service users not represented and has adverse impact on resources available and care provided in the future	MH & LD Collaborative Board Collaborative Development Group Co Chair of MH & LD Collaborative	Exec FIC TB		Exec monthly updates Board updates	ICS CEO Board ICS Partnership Board E&N and South West Partnership Boards	High	Weekly to Executive Committee TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22		Director of Strategy and Integration [FIC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22		
	7.2 Changing external landscape regionally and nationally leads to a shift of influence and resources away from MH and LD, the services users and communities served by HPFT	Visibility and leadership by HPFT across the Place Based Partnerships Leadership of MH and LD Collaborative streams Place Based Partnership Board East of England Provider Collaborative Locality Board membership across Herts	Executive Committee FIC TB	Clinical staff involved in system meetings Executive Committee Minutes	Updates to TB Board workshop to agree approach to emerging system architecture	Place Based Partnership delivery group East of England collaborative Board	High	Weekly to Executive Committee TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21 27.1.22 FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22	**Action** **Update stakeholder map and plan.**	
	7.3 Fail to develop relationships with the Place Based Partnerships to ensure the needs of those with LD and/or SMI, services users and communities served by HPFT are appropriately addressed	Relationships with all Key Stakeholders to drive and deliver key priorities	Executive Committee	Update to Executive Team	Weekly reports Stakeholder map and plan Aligned NEDs and EDs to emerging system infrastructure		Medium	Weekly to Executive Committee Trust Board 24.6.21 Board workshop 21.10.21	**Action** **Stakeholder plans to be updated given changing external landscape** **Develop relationships with emerging PCNs**	
	7.4 Fail to develop the required relationships with the developing ICS to ensure there is not a shift of influence /resources away from MH & LD	Annual Plan Emerging system strategy for MH and LD East of England Collaborative (leadership role for CAMHS)	Executive FIC TB Executive Committee FIC TB	Partnership Advisory Board for MH and LD Collaborative	Annual plan Quarterly reports CCG Commissioning Intentions. Aligned NEDs and EDs to emerging system infrastructure East of England Collaborative Directors Group	ICS CEO Board EoE Provider Collaborative CEO Group	High	Exec Quarterly reports on Annual Plan FIC 16.3.21 10.5.21 21.7.21 16.8.21 22.9.21 17.11.21 18.1.22 TB 25.3.21 20.5.21 29.7.21 30.9.21 25.11.21		

HPFT BAF March 2022

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								27.1.22 Board workshop 24.6.21 21.10.21		

Board of Directors PUBLIC

Meeting Date:	31 March 2022	**Agenda Item:** 22
Subject:	Annual Report from Nominations & Remuneration Committee	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Sarah Betteley, Chair
Presented by:	Sarah Betteley, Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Nominations and Remuneration Committee over the past year. The Committee's Terms of Reference required the Board to consider a report from the Committee.

Action required:

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

Summary and recommendations to the Board/Committee [to be amended]:

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

Recommendation
The Board are asked to note the report.

Relationship with the Annual Plan & Assurance Framework:

Summary of Implications for:

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

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

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

Not applicable.

Annual Report from the Nominations & Remuneration Committee

31 March 2022

1. Introduction

1.1 The Nominations and Remuneration Committee is a Committee of the Trust Board of Directors and is responsible for:

- Reviewing and making recommendations to the Board of Directors on the composition, balance, skill mix and succession planning of the Board. It recommends to the Board of Directors the appointment of Executive Directors.

- Setting the remuneration policy for the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

- Approving contracts of employment for the Chief Executive, Executive Directors, and non-voting Directors and other senior managers reporting directly to the Chief Executive.

- Agreeing arrangements for termination of contracts, including severance payments paid to the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2. Meetings from March 2021 – February 2022

2.1 Since March 2021 the Committee had met ten times:

25 March 2021	22 September 2021
4 May 2021	22 October 2021
1 June 2021	16 December 2021
29 June 2021	31 January 2022
20 July 2021	

2.2 Each meeting was quorate as outlined in the Committee's Terms of Reference. Please note that the Trust's Annual Report will detail the attendance for each Committee member for 2021/22.

2.3 At the beginning of each meeting any conflicts of interests were reviewed and mitigating action taken as appropriate.

2.4 The Committee forms part of the overall governance framework for the Trust which supports the assurances and controls detailed in the Board Assurance Framework.

2.5 During the past year a range of topics were discussed in line with the Committee's responsibilities, namely:

a) Changes to the Executive Team and Structure
b) Succession Planning
c) Approach to equality
d) Recruitment to the Executive Team, including skills required, remuneration and terms and conditions for the posts of:
    - Executive Director of Finance
    - Executive Director of Quality & Safety (Chief Nurse)
    - Interim Executive Director People & OD
    - Chief Executive Officer
    - Interim Executive Director Strategy & Partnerships
    - Executive Director Innovation & Digital Transformation
    - Executive Director Strategy & Partnerships
e) Updates on relevant employee relations cases

3. Committee Effectiveness

3.1 Each meeting in the past year has been minuted and matters arising logged and followed up.

3.2 The Committee's agendas have been in line with the Terms of reference and papers distributed in advance of the meeting.

3.3 The Terms of Reference for the Committee were reviewed in July 2021 which included recommendation for two amendments, which were agreed by the Board. The Terms of Reference are next due to be reviewed in July 2022.

3.4 Committee members and attendees undertook an effectiveness self-assessment questionnaire in July 2021 which was positive and was an improvement on the previous year. The Committee discussed and agreed identified areas for improvement. The committee effectiveness self-assessment for 2022 is currently underway, the results of which will be reported to a future Committee.

3.5 During the year the Committee has implemented an business planner.

4. Next Steps

4.1 The Committee will review the outcome of the 2022 self- assessment, identifying and agreeing any actions as required.

4.2 The Committee will review and recommend their Terms of Reference for approval by the Trust Board in July 2022.

5. Recommendations

The Board of Directors are asked to receive the report.