Hertfordshire Partnership University NHS Foundation Trust
PUBLIC Board of Directors

The Colonnades

27 April 2022 10:30 - 27 April 2022 13:30

INDEX

NHS
Hertfordshire Partnership University
NHS Foundation Trust

PUBLIC Board of Directors Meeting
Date: Wednesday 27 April 2022

Venue: The Colonnades
Time: 10:30 – 13:30pm

AGENDA					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
1.	**Welcome and Apologies for Absence**	**Chair**			10:30
2.	**Declarations of Interest**	**Chair**	**Note**	**Attached**	
3.	**Shared Experience – Servcie User**				10:30
4.	**Minutes of the meeting held: 31 March 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.	**Chairs Report**	**Chair**	**Receive**	**Verbal**	11.25
QUALITY & PATIENT SAFETY					
8.	**COVID-19 Update**	**Sandra Brookes**	**Receive**	**Attached**	11.35
9.	**CQC Forest House Update Report**	**Jacky Vincent**	**Receive**	**Attached**	11.45
OPERATIONAL & PERFORMANCE					
10.	**Finance Report**	**Maria Wheeler**	**Receive**	**Attached**	12.00
11.	**People & OD Report**	**Janet Lynch**	**Receive**	**Attached**	12.10
GOVERNANCE AND REGULATORY					
12.	**Compliance with NHSI Licence**	**Helen Edmondson**	**Approve**	**Attached**	12:30
13.	**Audit Committee Report meeting held: 21/4/22**	**David Atkinson**	**Receive**	**Attached**	12:40
14.	**Audit Committee Annual Report**	**David Atkinson**	**Receive**	**Attached**	12:50
15.	**Integrated Governance committee Annual Report**	**Diane Herbert**	**Receive**	**Attached**	13.00
16.	**Finance & Investment Committee Annual Report**	**David Atkinson**	**Receive**	**Attached**	13.10
17.	**Matters Reserved to the Board & Scheme of Delegation**	**Maria Wheeler**	**Receive**	**Attached**	13.20
18.	**Any Other Business**	**Chair**			13.25
19.	**QUESTIONS FROM THE PUBLIC**	**Chair**			
Date and Time of Next PUBLIC Meeting: Thursday 26 May 2022 Thursday 9 June 2022 (Annual Accounts and Annual Report) Thursday 30 June 2022					

as One

Our Values
Welcoming Kind Positive Respectful Professional

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

April 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
Asif Zia	Director, Quality & Medical Leadership	Nil Return

Minutes of the PUBLIC Board of Directors Meeting
Thursday 31st March 2022
10:45 – 13:30
VIRTUAL and Face to Face

MINUTES	
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
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
Maria Wheeler | MW	Director of Finance, Performance & Improvement
Hakan Akozek	Director of Innovation & Digital Transformation
IN ATTENDANCE	
Allison Lerner | AL	Executive PA (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Barry Canterford | BC	Lead Governor & Engagement Champion – virtual
Ed Knowles EK	Development Director, Hertfordshire Mental Health, Learning Disabilities and Autism Collaborative (Item 17)
APOLOGIES	

Item	Subject	Action
022/22	**Welcome and Apologies for Absence** SBe welcomed all to the meeting. There were no apologies for absence received.	
023/22	**Declarations of Interest** The Declarations of Interest Register was noted. SBe informed the Board that Catherine Dugmore had been appointed as a Non-Executive Director of the Herts and West Essex ICS. Members offered their congratulations.	
024/22	**Shared Experience** AZ drew to the Board's attention that mental health is affecting younger people with more complex cases. All agreed that it was an inspiring story and considered the possibility to work with the service user to record or publish her story in order to utilise within a	

	learning environment. SBr agreed that this would be looked into and would work with her to ensure learning across the Trust.	
025/22	**Minutes of the Meeting held: 25 November 2021** The minutes were reviewed and approved as an accurate record of the meeting. **The Board APPROVED the minutes**	
026/22	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
027/22	**CEO Brief** KT presented the CEO Brief to the Board which was taken as read. Headline messages of note to the Board were: Nationally the NHS remains on alert level 4. Nationally there has been an increase in the number of reported cases of the COVID virus, with particular spikes in younger people. New guidance has been published on visiting in NHS facilities and guidance is awaited regarding access to LFDs which would remain available to NHS staff. Nationally health services have continued to experience unprecedented pressure, in particular emergency departments and ambulance services. In their national report the CQC has seen many examples of good practice and dedication of staff. Overall, the regulator found that services rose to the challenges presented and noted nationally the demand on mental health services. The increased level of regulatory activity in different part of the country was noted. Integrated Care Systems (ICS) 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 formal announcement of the outcome of the Director level appointments are anticipated shortly. KT noted a final response rate of 50% in the 2021 annual staff survey. The final results were published on 30 March 2022 and showed positive results for the Trust. The CQC report into Forest House was published on 30 March noting the Trust remains committed to making improvements. The Trust continues to robustly monitor the progress against the Service Improvement Action Plan which incorporates improvements to be made against the CQC Key Lines of Enquiry. It was noted that continued significant improvements are being made. And the Trust was in direct contact with young people's families. It was noted that	

	the CQC required a response to the Warning Notice withing 28 days of the publication. KT reported that the Trust is on plan to deliver a breakeven financial position at 31 March 2022, in line with the revised Financial Plan. Given the national regime and funding arrangements in 2022/23, the financial environment will become more challenging noting a draft submission to NHSE and will continue to work to close the draft. **RECEIVED** **The Board RECEIVED the CEO Update**	
028/22	**Chairs Report** SBe provided Board members with a verbal update on the work undertaken since the last Board meeting noting that a large number of events are taking place and local meetings that have been attended. She reported that the relationships and collaborative working is working well and a helpful platform to resolve issues. In relation to ICS, she advised that the recruitment process for the Board had taken place, including the appointments of CEO and four Non-Executive Directors. SBe noted that site visits were ongoing with a focus on acute sites and A&E. Reporting on her recent site visit to Little Plumstead with the Lead Governor she observed that joint working and sharing of work that was very encouraging. SBe reported that NHS Providers round table sessions are now being attended by Clare Murdoch and CQC and further noted there were two weekly briefing taking place for governors which would be interesting to understand their views and strategies. **RECEIVE** **The Board RECEIVED the verbal update**	
	QUALITY	
029/22	**COVID 19 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 the 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: SBr advised that there have been several COVID-19 outbreaks across Trust services and as of 17th March 2022, there are nine being actively managed. She assured the Board of continued focus on infection prevention and control to guard against outbreaks. It was noted that the numbers of cases are reducing. SBr pointed out that staffing continues to be challenging and is monitored on a daily basis. She noted that on 17 March, 86 staff were confirmed positive with COVID-19, including 25 within inpatient services. All absence is just	

	under 21% with high levels of annual leave in addition to COVID absence and high levels of other sickness absence. SBr informed the meeting that there has been recent response to international affairs and provided assurance robust plans were in place for services over Easter. **RECEIVE** **The Board RECEIVED the update**	
030/22	**Report of the Integrated Governance Committee: 17 March 2022** The Board congratulated DH on her PhD. DH thanks TB for chairing the March IGC meeting. DH presented the report and reported that the latest position on workforce planning would be considered at the May meeting. DH reported that she would be meeting with HE in April to considering findings of the Committee self-assessment. The Committee received a presentation on the updated Trust Risk Register (TRR). The Committee considered each of the updated risks, noting two new additions relating to Cybersecurity and Insufficient inpatient beds. DH noted that the action plans for Warren Court and Forest House were new actions within the BAF. Following a question from SBr in relation to the Quality Assessment and updates, and whether diversity would be added into the strategy, JV confirmed that diversity would be included. SBe raised the issue of Yusuf Aumeerally being appointed to the substantive, full-time post of Lead Freedom to Speak Up Guardian and progress with identifying a Freedom to Speak UP lead in each service. JV confirmed that expressions of interest had been received from over 30 people and would be looking to recruit more to ensure full coverage of services. **a) Q3, Integrated Safety Report** JV presented the quarter three Integrated Safety report. She reported that there had been an increase in the number of incidents reported in quarter 3 compared to the previous quarter but that there had been a reduction in incidents resulting in moderate or severe harm. There were no 'Never Events' and no 'Prevention of Future Death reports' issued by the coroner. JV advised that the Trust reported 35 Serious Incidents externally this quarter; a decrease of 3, when compared to the previous quarter. There was also a decrease in self-harm incidents, a decrease in unexpected deaths and an increase in violence and aggression incidents subject to investigations. JV advised that there were 389 Service User to staff assault incidents reported in the quarter, 13 of which were categorised as moderate harm. JV assured the members that these are being reviewed and actions are in place in relation to learning from previous quarters.	

	The Trust's Suicide Prevention group continues to work to reduce suicides and work will continue in the next quarter including learning from colleagues and other organisations who have made great strides in reducing deaths through suicide. There were two violence and aggression incidents reported as Serious Incidents and subject to investigations this quarter, we are working to ensure service users are supported. Following a question from AB regarding the reported ligature incidents and the increase in the number of medication incidents, JV advised that the reporting has increased is robust and following each incident there was a thorough review to identify learning. AZ emphasised that the pharmacy team visit every unit to monitor and audit regularly. AZ further noted that extra training is being offered when staff require. KK drew attention to the high mortality rate for LD patients and the level of learning that has been received. JV confirmed that the senior managers oversee the programme of learning that also covers cases nationally. Following discussion AZ indicated the number of deaths are reported to the national LeDeR programme and assured KK that learning is taking place in terms of physical health checks specific to LD service users as well as within the Collaborative. JV also advised that a Falls Group is in place that reviews all falls and that there is an increased training programme. Risk Assessments are reviewed and shared. In response to the Lexden discharge, JV advised of a comprehensive care plan which helps to support the individual. **b) Risk Management Strategy – Helen Edmondson** HE outlined that Risk Management Strategy is an integral part of the Trust's framework for directing, controlling risk to key functions. It is fundamental to delivering and embedding high quality, safe and sustainable services for the people we serve, to support good governance and is central to delivery of the Trust's Good to Great strategy as well as to strategic and operational management. HE informed the Board that the strategy had been considered by the Integrated Governance Committee in May was recommended to the Board. Board members welcome the Strategy noting it was supported by the detailed risk management policy. **APPROVED** **The Board Approved the Risk Management Strategy**	
OPERATIONAL AND PERFORMANCE		
031/22	**Report from Finance and Investment Committee: 22 March 2022** DA presented the report which was taken as read. DA advised that the report provides a summary of the items discussed at the Finance and Investment Committee meeting held on 22 March 2022. He	

	noted that the Committee had considered the draft Annual Plan for 22/23 and provided feedback. It had also considered the quarter three Performance Report noting it would be considered by the Board later on the agenda. DA highlighted that the draft Financial Plan for 22/23 had been considered noting that it set out a deficit position. It was noted that the Draft Financial Plan for 22/23 was due to be considered later on the agenda. DA updated that the Committee had considered and approved the draft capital plan for 2022/23 and were updated that all Capital projects had been delivered in 21/22. It was noted the capital plan for 22/23 was due to be considered later on the agenda. The performance of the Delivering Value Programme for 2021/22 was noted and the programme was forecast to deliver savings of £4.6m in line with the revised plan for the year. It was agreed that the Delivering Value Plan for 22/23 would be subject of a more detailed presentation to the Committee at a future meeting. It was noted that it had been agreed to delegate authority for the signing of contracts to Director Finance and CEO, as long as they were line with the Trust's overall financial plan. **a.) Quarter 3 Performance Report** HA advised that quarter three was more challenging than anticipated noting 42% of KPI's are underperforming and noted the key areas were an increase in unexpected deaths, 28 Day target demands and 48 Hour follow up. 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 we are keen to restore, recover and reshape our services. The benchmarking data reflects the position across the Trust of high bed occupancy in inpatient services, particularly adult services, with a below average number of beds and 100% occupancy. This correlates with the high number of out of area placements. Length of stay is below the national average, indicating a relatively efficient system of discharge for those who are admitted. There is a below average proportion of admissions under the mental health act, although this has increased by 31% over the last year. HA advised that quarter four forecast is that new referrals would exceed the range in planning guidance from NHSI/E, as they did for quarter four. It was further noted that challenges are expected to continue within CAMHS and LD&F services. Areas of strong improvement included Friends and Family Test; Service Users advised that they recommend our services to friends and family 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%). AB expressed concern over PDP and Appraisals rates. JL acknowledged the importance of staff appraisals indicating that in order to get these back on	

	track, it would be discussed in the next People and Organisational Development Group. SBe noted that the new traffic light system made the report easier to interpret and queried the trajectory for CPA's that are outstanding in the west. HA advised that the situation was being monitored and seeing some improvements. AZ felt confident that CPA trajectory is now on track. KT referred to the discussions noting that the focus is now on quarter four and that in terms of CPA's this is a national directive and part of transformation of community care. Challenges and back logs are recognised and are being reviewed on a weekly basis, with firm trajectories being identified and monitored. SBr stated that the community teams were under pressures and that it was key for services to transform to respond to the increase in demand. **RECEIVE** **The Board RECEIVED the report**	
032/22	**Finance Report** MW presented the report which was taken as read. MW updated the Board, as of 28 February, the Trust reported a break-even position in line with revised plan for the month and for the year to date. MW further noted the 21/22 year end position was on plan to break even. MW updated members that the Provider Collaborative was established in continues to forecast a break-even position in month and for the year to date. And that the Capital Plan remains on track to be delivered. **RECEIVE** **The Board RECEIVED the report**	
033/22	**Gender Pay Gap** JL presented the report which was taken as read. JLe advised the Board there has been a reduction in the pay gap in 2021. The gender pay gap across the Agenda for Change workforce is 1.25%, which is significantly reduced from 5.54% from 2020. The 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. Following a question from SBe regarding female staff applying for CEAs AZ outlined that the panel was changed to a ensure even female/male mix, and both part-time were encouraged to apply. **APPROVE** **The Board APPROVED for the data to be published on the Trust website.**	**JL**
034/22	**Community Survey Update** SBr updated the Board on the Community Survey report which was taken as	

	read. SBr advised that the Welcome App has been developed and is due for launch in April. The app provides service users with information that would 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. She further noted that work would commence in April to improve communications and learn from others. The development App was welcomed by the Board and noted as a positive development and they looked forward to seeing results. In response to DA's question SBr outlined that the Trust does have a team that offers support for services users to find employment. SBr confirmed that changes needed would take time to embed and may not see improvement in survey scores for a few years. **RECEIVE** **The Board RECEIVED the report**	
035/22	**Annual Staff Survey** JL provided a presentation to the Board which highlighted the Trust's performance in the national staff survey. She reported that the Trust is above average and that staff engagement had achieved a top score. She confirmed that overall, the Trust continues to have a hugely engaged and motivated workforce. Key points from the survey results highlight that the Trust have staff who are compassionate and inclusive and continue to be proud of the services provide. There are areas for improvement as staff do still consider leaving and that they work a high number of additional unpaid hours. SBe noted an excellent positive set of results for the last two years and staff are to be celebrated noting their daily challenges at work. It was noted that an update on the action plan would be considered by the IGC and Board. **RECEIVE** **The Board RECEIVED the report**	
036/22	**Draft Annual Plan 2022/23** PR presented the draft annual plan, which was taken as read. PR noted that the plan was not for approval today but is awaiting financial consideration following conversations with commissioners. The plan operates in the framework Restore, Reset and Reshape. The Board noted that the final draft would be presented at the April Board of Directors meeting. The Board were assured that the Plan had been considered by the Senior Leaders Team, had input from the Council of Governors. PR outlined that the good level of engagement across the organisation. Following a question from AB as to regarding CPA and personalised care, KT	**PR**

	advised that these are separate. KT set out that the draft Annual Plan outlines an ambitious but achievable plan for the year. SBe noted the metrics would be helpful in providing measurable targets. PR noted that the metrics would be measurable targets and that they are still being refined. The Chair concluded 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. **RECEIVE not for approval today** **The Board RECEIVED the report**	
037/22	**Draft Capital Plan 2022/23** MW presented the report which was taken as read. The capital plan has been designed with key priorities in mind and were aligned with the three key priorities: Operational Capital, Digital Capital and Capital Disposals. It was noted that nationally the Trust's capital allocations were set to reduce over the coming years. Capital allocations would be distributed to ICS's based on the recognised Kings Fund methodology and 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. MW advised that Digital Plan, CCTV, Safety Suites and Forest House maintenance are the main elements of the plan. Following a question from JW relating to planned new unit in East and North Herts, MW advised that there was a risk with the funding for this unit as was dependent on national funding. It was noted that draft plan includes an indicative plan for 23/24. **The Board RECEIVED and APPROVED the report**	
038/22	**Mental Health and Learning Disability and Autism Collaborative** EK presented the report which was taken as read. 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. EK advised that 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. SBe was encouraged by the role that the Collaborative is playing in driving the collaboration forward and noted that mental health and LD is high on the agenda and that there is a need to push the agenda forward. The Board observed that relationships with other agencies are improving as is the voluntary sector which will enhance positive relationships. **RECEIVE** **The Board RECEIVED the report**	
	GOVERNANCE AND REGULATORY	
039/22	**Audit Committee Report** CD introduced the report which was taken as read and asked the Board to formally note the appointment of RSM as internal auditors and counter fraud services. Also following support from the Council of Governors a one-year extension of KPMG's contract to provide external audit services had been agreed. She advised that the Trust will go out to tender for external audit in late summer. It was noted that the Committee had received a deep dive into year end 21/22 and received an update that the internal audit plan for 21/22 would be delivered. SBe thanked all involved noting a huge amount of work has been completed by the audit committee. **RECEIVE** **The Board RECEIVED the report**	
040/22	**Audit Committee Terms of Reference** CD presented the reviewed Terms of Reference and noted that the Audit Committee had reviewed these on 10 February 2022. One amendment has been made relating to the inclusion of the Committee's role with regard to losses and special payments following feedback from external audit. The proposed Terms of Reference are supported by the outcome of the Committee's self-assessment The committee approved the terms of reference. **RECEIVE** **The Board RECEIVED the report and APPROVED the Terms of Reference**	
041/22	**Trust Risk Register** JV presented the report which was taken as read and sets out the Trust Risk Register following discussion at the Executive Team on 2 March 2022 and Integrated Governance Committee on 17 March 2022 and confirmed that all the risks have been reviewed and updated. In particular there are new risks proposed relating to Cybersecurity, Quality of Care, and Insufficient Beds. CD believed it was important to note the situation in the Ukraine and requested if communications with staff updating on Cybersecurity were ongoing. HA advised that the potential issues are unknown and assured the	

	board that cascade alerts are sent out to staff and are working closely with NHS Digital. HA also gave assurance that HBLICT are fully licensed to respond to threats and retain copies of backups offline and had robust business continuity plans. HA added that HBLICT had also undertaken a table top exercise to test their business continuity plans. SBe suggested that the mitigations for some of the risks were updated. In response to AB's question SBr reported that the previous risk related to risk of legal action following long waits in section 136 suites, a risk that had reduced in likelihood and therefore had been de-escalated from the Trust risk register. **RECEIVE** **The Board RECEIVED the report**	**JV**
042/22	**Board Assurance Framework** HE presented the paper which was taken as read and presented the updated position, which had been updated following the last review November 2021.. Key headlines for the Board to note were that several actions have been added along with new sources of assurance. **RECEIVE** **The Board RECEIVED and APPROVED the report**	
043/22	**Report from Nominations and Remuneration Committee** The Chair presented the report on the work of the Committee over the past year. **RECEIVE** **The Board RECEIVED report.**	
044/22	**AOB** KK drew to The Board's attention to ceasing of NHS free parking and wondered what the Trusts position was. KT advised that all HPFT staff have free parking on site and provided further assurance that staff are reimbursed for parking on private sites, and that this would continue. BC thanked the Executive Team for their work during challenging times for the NHS. No further items of business were put forward.	
045/22	**Questions from the Public** No members of the Public were present.	
046/22	**Date of Next Meeting** The next public meeting is scheduled for Thursday 28th April 2022	

Close of Meeting

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Committee Meeting: PUBLIC Board of Directors
MATTERS ARISING SCHEDULE

April 2022

Matters Arising from meeting held on: 31 March 2022					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
03	**Service User Story**	**SBr**	Support service user to contribute to the Experience Shared Library	April 2022	**G**
12	**Gender Pay Gap**	**JL**	Publish information on Trust public website	March 2022	**G**
15	**Annual Plan**	**PR**	Final plan to be approved at April Public Board	April 2022	**G**
20	**Trust Risk Register**	**JV**	Update the mitigations for risks relating to people	April 22	**G**
Matters Arising from meeting held on: 25 November 2021					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
13	**System Update**	**DE**	Future Board to receive System Adult MH Strategy	TBC	**A**

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Our Values
Welcoming Kind Positive Respectful Professional

Board of Directors PUBLIC

Meeting Date:	27 April 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, although the NHS remains on alert level 4, the number of cases is reducing across the country. On the 14 April NHS England published revised Infection Prevention and Control (IPC) guidance with a further stepping down of COVID-19 precautions and sees a return to pre-pandemic physical distancing and cleaning protocols outside of COVID- 19 affected units/areas. Processes are in place to enable NHS staff to order Lateral Flow Devices free of charge and the guidance continues to require NHS staff to wear masks at work.

New Mental Health and Wellbeing 10 Year Plan

On 12 April 2022, the government published a discussion paper and launched its consultation to support the development of a new cross-government 10 year mental health plan. Responses to the consultation will also inform the development of a separate national suicide prevention plan, which will refresh the 2012 suicide prevention strategy. It will be published alongside, and complement, the 10-year mental health plan. The current understanding is that the next 10-year mental health plan will be published at the end of 2022 or early 2023.

The discussion paper outlines current work and evidence, key challenges that need to be addressed and questions for stakeholders to respond to in the following six key areas:

1. Promoting positive mental wellbeing
2. Preventing the onset of mental health conditions
3. Intervening earlier when people need support with their mental health
4. Improving the quality and effectiveness of treatment for mental health
5. Supporting people with mental health conditions to live well
6. Improving support for people in crisis

The government is asking for stakeholders to provide suggestions for tangible commitments and actions they think should be within the new plan. The Integrated Care System (ICS) will co-ordinate a response to this consultation, and for Hertfordshire this will be led by the Mental Health, Learning Disability and Autism (MHLDA) Collaborative. The Trust will also engage with stakeholders, service users, carers and staff to develop our response to the discussion paper.

Austerity
Nationally there are increasing reports of the impact on standards of living caused by the cost of living, significant increases in energy and fuel bills and changes to National Insurance. The resultant impacts on the health and wellbeing of the population are well documented and the Integrated Care System is working together to consider support for the local populations(s) served, and support to NHS and social care staff. As a Trust we are agreeing a number of support measures which seek to support our staff and service users. For example, nationally there has been a ceasing of the waivering of the charging of NHS staff for car parking, as a Trust we do not charge for car parking and any costs incurred providing care are reimbursed.

Ockenden Report
The Ockenden Report was published in April following a national enquiry into Maternity Services in the Shrewsbury and Telford Hospital Trust in which nearly 1,600 clinical incidents were reviewed, involving 1,486 families – the majority of which were between 2000 and 2019. In the final report, actions are identified for commissioners and providers of maternity and neonatal services who need to ensure that lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England are working with the Department of Health and Social Care to implement the 15 Immediate and Essential Actions. As a learning organisation, we are reviewing the report and will take the learning and actions on its findings to our Integrated Governance Committee, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families.

EPUT Inquiry
An independent inquiry, led by Dr Geraldine Strathdee, a leading psychiatrist and former national Clinical Director of mental health care at NHS England, is reviewing the care, treatment pathways, circumstances and practices surrounding the historic deaths of mental health inpatients, which took place in Essex between 1 January 2000 and 31 December 2020. The inquiry will draw conclusions in relation to the safety and quality of care, provided locally and nationally to mental health inpatients.

The report is expected to be published in spring 2023 and the inquiry is expected to provide regular updates on its progress and may highlight matters requiring urgent attention. The inquiry will consider key factors which led to the deaths, the role, involvement and communication with service users and their families/carers, the culture, leadership and governance. It will also consider previous investigations and will make recommendations to ensure action is taken to ensure appropriate and safe treatment and care is provided for current and future mental health inpatients. HPFT is continuing to monitor the progress of the inquiry and will report into the Integrated Governance Committee on any learning and actions to take.

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.

Hertfordshire & West Essex Integrated Care System (ICS)
The go live date for the Integrated Care Board (ICB) is still expected to be 1 July 2022, and Hertfordshire and West Essex has recently been assessed as 'green' in terms of readiness. The ICS continues to prepare to meet the requirements of the NHSE Gateway process and to prepare for the closure of the three CCGs. The appointment of Executive Directors to the ICB is completed and with the final team in place of:

- Accountable Officer – Jane Halpin
- Chief Finance Officer – Alan Pond
- Director of Nursing and Quality – Jane Kinniburgh
- Medical Director – Dr Rachel Joyce
- Director of Strategy – Beverley Flowers (holding the Mental Health & LD portfolio)
- Director of Performance – Frances Shattock
- Director of Operations – Elizabeth Disney
- Director of Primary Care Transformation – Avni Shah
- Chief People Officer – Tania Marcus

Michael Watson will be Chief of Staff working directly to the ICB Executive Team, Chief Executive and Chair.

The ICB has appointed four independent non-executive members, who are Thelma Stober, Ruth Bailey, Professor Gurch Randhawa, and Catherine Dugmore. The next stage of appointing for members of the ICB, which includes system partners, is due to start in May 2022.

As well as working to set up a new commissioning infrastructure the ICS is working to address elective backlogs and significant demands for urgent care, in particular, ambulance services and emergency departments.

Hertfordshire Mental Health, Learning Disability and Autism (MHLDA) Collaborative

At its meeting in March, the MHLDA Collaborative agreed its transformation priorities for the next 18 months. These priorities include Crisis Care and Suicide Prevention as well as investing additional resource to progress new strategic priorities, including a focus on Collaborative workforce planning, Preparing for Adulthood (including both SEND and CAMHS activity) and Dementia. The Collaborative also agreed three priorities addressing wider determinants of positive health and wellbeing for people with mental illness, learning disabilities and autism, specifically the impact of housing, employment and skills and improved physical health.

Since the meeting, it has been agreed that a new Task and Finish Group will be established to build on the work that has already taken place around ‘dual diagnosis’ between HPFT and the Change Grow Live (CGL), the Council’s commissioned Drug and Alcohol services provider. This group will develop clear pathways and the system-wide adoption of a true ‘no wrong door’ approach for people with who have both drug & alcohol and mental health, learning disabilities and/or autism. The group will be accountable to both the MHLDA Collaborative and the Hertfordshire Drug & Alcohol Strategic Board.

The Collaborative also agreed that it will develop a Physical Health Strategy for MH&LDA across Hertfordshire focussed on improving the overall health and wellbeing of people with mental illness, learning disabilities and autism by ensuring that all organisations recognise the part they can play in identifying and supporting better physical health. A scoping meeting is being scheduled for early May bringing together colleagues from across the Collaborative as well as people with lived experience.

Hertfordshire Health Care Partnerships

The HCPs are currently undertaking the final stage of their planning processes to identify priority transformation areas for 22/23 with HCP board sign off at the end of May. In the meantime, both HCPs are continuing to progress existing Transformation areas establishing clear work programme for Frailty, signing off the clinical model for the diabetes transformation work and working through the next phase of Virtual Ward Development. Existing Partnership documentation, including the Shadow Operating Model and Shadow Partnership Agreement is being reviewed and updated by the established workstreams.

East of England (EOE) Provider Collaborative

Progress continues to be made within the East of England Collaborative across the three care groups. The patient-flow hub is now well established and the prioritisation of Child and Adolescent

Mental Health Services(CAMHS) cases is working well although the waiting list fluctuates and the number of closed beds remains a challenge. All NHS organisations currently have some CAMHS beds closed, with workforce and complexity being the key issues. HPFT has successfully recruited to the intensive community support team in Norfolk secure services and the team is now being mobilised. Recruitment into the Adult Eating Disorder team is slowly progressing with some outreach work being provided by those who have been recruited.

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 the Trust continues to have incident command processes in place. Since the last report to Board the number of positive cases has stabilised with both the number of active outbreaks and levels of staff absence reducing. The Trust continues to operate according to the national Infection Prevention and Control (IPC) manual and following the publication of new guidance on 14 April 2022 Trust policy is being reviewed and updated. The Trust received a planned visit in March 2022 from the NHSE regional IPC lead who noted that *"Infection Prevention and Control standards have been well maintained despite the significantly challenges during the COVID 19 Pandemic*".

Operational update

Operational services remain under pressure with high levels of demand and acuity. The easter and bank holiday period was busy but the robust planning meant services coped well throughout. The local acute trusts and ambulance trust both also experienced high demand over the period and we are working closely with them on an ongoing basis to improve the care and experience for service users.

We have seen an increase in flow through adult acute inpatients with a correlating reduction in length of stay. We continue, however, to rely heavily on out of area placements to meet demand, and this remains a key focus for us as a Trust. Delayed discharges are an ongoing concern across all care groups, in particular learning disability services where the main challenge remains identifying suitable providers to support bespoke packages of care or appropriate accommodation. We are working closely with Hertfordshire County Council colleagues to improve this position.

We have seen a further increase in demand into adult community services and increased pressure in Child and Adolescent Mental Health Services (CAMHS) community services as we enter what is usually a very busy period. Community services are experiencing increased caseloads, longer lengths of stay and high levels of staff vacancies, which has resulted in a further decline in performance against the key access performance indicators. Additional resources have been approved to manage the backlog and to further extend the Flexible Assertive Community Treatment team to support assertive outreach to our service users.

As part of the Trust wide 'Restore, Reset, Reshape' programme we have been reviewing performance against all key targets and standards, and have been putting in place a clear plan and timetable for recovery. An update on this will be provided to Finance & Investment Committee and Integrated Governance Committee in May.

Safe and Wellbeing Reviews

Nationally, Safe and Wellbeing reviews have been carried out to check on the safety and wellbeing of people with a learning disability and autistic people who are being cared for in a mental health inpatient setting. For HPFT, this has included Aston Ward, Specialist Residential Services (SRS) and Dove ward. We have received feedback regarding SRS and have put in place an action plan in conjunction with Hertfordshire County Council to address the issues raised.

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 by the CQC in their inspection report. A report later on the agenda sets out further detail on the progress against the Service Improvement Plan and the further submission made to the CQC made in April.

Our People
Our vacancy rate and unplanned turnover has stabilised since December and we continue our active recruitment activity and campaigns, in particular for harder to recruit to areas and for nurses, healthcare support workers and allied health professionals. We also saw sickness absence reduce further in March.

Our appraisal rates have begun to recover, following the impact of pressures relating to the COVID-19 pandemic and Winter earlier in the year. We are focussing on appraisal as part of our retention plans to ensure our people are supported to thrive and further develop their careers with us. We are also concentrating on increasing mandatory training compliance.

As part of our retention work, we continue to provide a robust health and wellbeing offer to our staff, with wellbeing support to staff featuring as one of our highest scores in the annual staff survey and in our Quarter One pulse survey.

During April, we are talking to all our people about our annual staff survey results which show that our people are proud to work for the Trust, recommend us as a place to work, are proud of the standard of care we provide, and are clear that service users are our top priority. A report later on the agenda provides greater detail.

The survey results tell us that our people are highly engaged, motivated and emotionally invested in their work, that we have a strongly compassionate culture and that staff feel supported and looked after through the support for health and wellbeing, work-life balance and flexible working. This includes development and high-quality appraisals and people feel confident to raise concerns and know that if they do so, their concerns will be addressed.

The results indicate that the areas we should focus on to keep improving the experience of all our people include reducing violence and aggression, continuing to improve belonging and inclusion, helping our people to achieve better levels of self-care and embracing feedback as an opportunity to grow and improve. We are engaging with all our people to discuss our survey results and to co-produce an action plan to continue to make the Trust the best place to work.

Finance 2021/22 & End of Year Planning
The Trust has delivered a breakeven financial position at 31 March 2022, in line with the revised Financial Plan. Given the national regime and funding arrangements in 2022/23, the financial environment will become more challenging.

The draft accounts are due for submission on 26 April 2022. The external auditors completed their interim audit and will start the final audit after draft accounts have been submitted. The Audit Committee and Integrated Governance Committee will be considering the Annual Governance Statement and all Board members will be given an opportunity to review and feedback on the Annual Report. The Final Accounts and Annual Report will be considered for approval on 9 June 2022.

Planning 2022-23
We have been contributing to the ICS level planning process and have met all of the required deadlines. Internally the Trust Annual Plan is well developed and being mobilised however the final plan is dependent on completion of the financial negotiations. The Annual Plan has been informed by the national and local priorities in the different health and care systems that the Trust operates in.

The Annual Plan has also been developed following engagement with users and carers through the Service User Council and the Carers Council, and workshops with Experts by Experience. The final Annual Plan will be presented to the Trust Board in May.

In Hertfordshire the contract negotiations are almost complete, other than the financial negotiations. The overall approach has been to recognise that this is a variation to an existing contract, not a fundamental redesign of services. It has also been predicated on the recognition that we have been operating out of formal contract for the last two years during the COVID-19 pandemic and so there is a need for some updating to reflect the changes that have happened during this period. The proposed 2022/23 contract variation includes a number of Service Development and Improvement Plan items where we will work with commissioners to deliver service improvements over the year. The majority of Service Specifications will be reviewed during the year as the planned programme of reviews was put on hold over the past two years. Given the current demand levels and funding levels discussions are ongoing with commissioners prior to any final contract agreement being reached.

Mid Essex CCG have published a notice that they intend to directly award to the Trust a contract to deliver IAPT and Integrated Primary and Community Care (IPCC) for a period of five years (with the potential for a two-year expansion). Following the ten-day standstill period there were no challenges and the Trust has started formal contract negotiations.

Executive & Non-Executive Director update

The recruitment process for the Executive Director of People and OD (Chief People Officer) is underway with the search agency having been selected and the search started. The process will include shortlisting; stop go interviews; interview and stakeholder panels, with the aim for final interviews to take place towards the end of June 2022.

The recruitment process for Non-Executive Director posts has also commenced, under the oversight of the Appointments and Remuneration Committee. The aim is for final interviews to take place early July 2022.

April 2022 will be the last Board meeting for Paul Ronald, Director of Performance Improvement prior to his retirement. Paul was previously Director of Operational Finance and has been a senior member of HPFT for ten years. We wish Paul a very happy retirement and thank him for his commitment, hard work and contribution.

PUBLIC Board of Directors

Meeting Date:	27 April 2022	**Agenda Item:** 8
Subject:	Incident Command	**For Publication:** Yes
Author:	Sam Garrett, Financial Controller	**Approved by:** Sandra Brookes, Director for Service Delivery and Experience
Presented by:	Sandra Brookes, 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 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. Full tactical meetings take place 2 days per week Monday and Thursday (or Tuesday and Thursday in bank holiday weeks), 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
- 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 remain just 3 active COVID-19 outbreaks across Trust services: Oak Ward, Hampden House, and The Colonnades; this is a significant reduction on last month. Positive inpatient service user

numbers have reduced to 7 as at 14th April, also a reduction on last month. On 14th April 49 staff were confirmed positive with COVID-19, including 16 within inpatient services; reduced from a high of 86 overall during March. Although absence levels remain relatively high, it does appear that the latest peak has now passed for HPFT.

Nevertheless pressures do remain particularly around bed availability and service user acuity, in addition to the ongoing COVID-19 impact. These are mirrored by pressures in the wider system, with the Acute Trusts in particular reporting high levels of Covid-19 admissions, many with this as their primary reason for being in hospital, and despite cohorting a number of beds still having to remain 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 stays at current level for now. On 14th April a new National Infection Prevention and Control Manual for England was published in response to the UKHSA publishing their revised UK IPC Guidance. The main allowable changes are:

- Stepping down of Inpatient Covid-19 isolation precautions, reducing from 10 days to 7 with 2 negative LFD tests
- Stepping down of precautions for exposed patient contacts who are asymptomatic
- If local risk assessment indicates, and particularly where this is necessary for effective running of Urgent and Emergency Care, returning to pre-pandemic physical distancing in all areas and to pre-pandemic cleaning protocols outside of Covid-19 areas

The Manual is being reviewed by the HPFT IPC Team and any proposal for changes and revised procedures for HPFT will be taken to CPAC next week. Additionally the Manual will be discussed within the wider system and if possible a consistent approach will be taken.

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 20th April

Incident Command Update

As at 14th April 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. Focus in the country in general is now on "Living with Covid", however testing remains in place for staff, as does the current IPC guidance including mask-wearing on all sites. LFD tests remain free for NHS staff, available via the national portal on confirmation of being a staff member; they are also now being supplied for service user testing, in a change from PCR testing

2.2 Pressures do remain for HPFT, primarily due to unavailability of beds and service users acuity, as well as to staff absence (partially due to Covid). These pressures are mirrored in the wider system, reflected by the letter to all providers received on 7th April from Ann Radmore Regional Director for NHSEI East of England, to highlight concerns. In particular there are high numbers of acute inpatients with Covid; staff sickness remains high across all providers; there are high numbers of beds out of action due to IPC or occupied by Delayed Transfers of Care patients; and EEAST continue to experience pressures. The Executive Director for Service Delivery and Experience is leading HPFT's response and HPFT Operational Commanders have been focused this week on bed availability and staffing ahead of the Easter weekend.

2.3 On 14th April a new National Infection Prevention and Control Manual for England was published in response to the UKHSA publishing their revised UK IPC Guidance. The main allowable changes are:

- Stepping down of Inpatient Covid-19 isolation precautions, reducing from 10 days to 7 with 2 negative LFD tests
- Stepping down of precautions for exposed patient contacts who are asymptomatic
- If local risk assessment indicates, and particularly where this is necessary for effective running of Urgent and Emergency Care, returning to pre-pandemic physical distancing in all areas and to pre-pandemic cleaning protocols outside of Covid-19 areas

The Manual is being reviewed by the HPFT IPC Team and any proposal for changes and revised procedures for HPFT will be taken to CPAC next week.

Additionally the Manual will be discussed within the wider system and if possible a consistent approach will be taken.

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, 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.

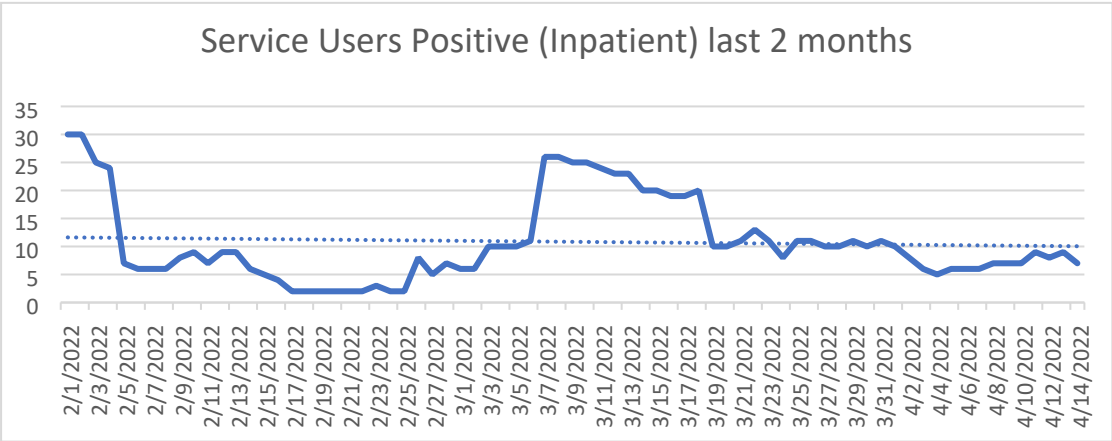
3.3 The Trust Incident Command framework and agenda has continued to focus on:

- 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 14th April there were 7 Covid-19 positive service users in inpatient settings.

Figure 1 Positive service user inpatient cases



4.2 On 14th April there were just 3 active outbreaks being managed at Oak Ward, Hampden House, and The Colonnades, with all others now moved to "Watch

and Wait". They 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.

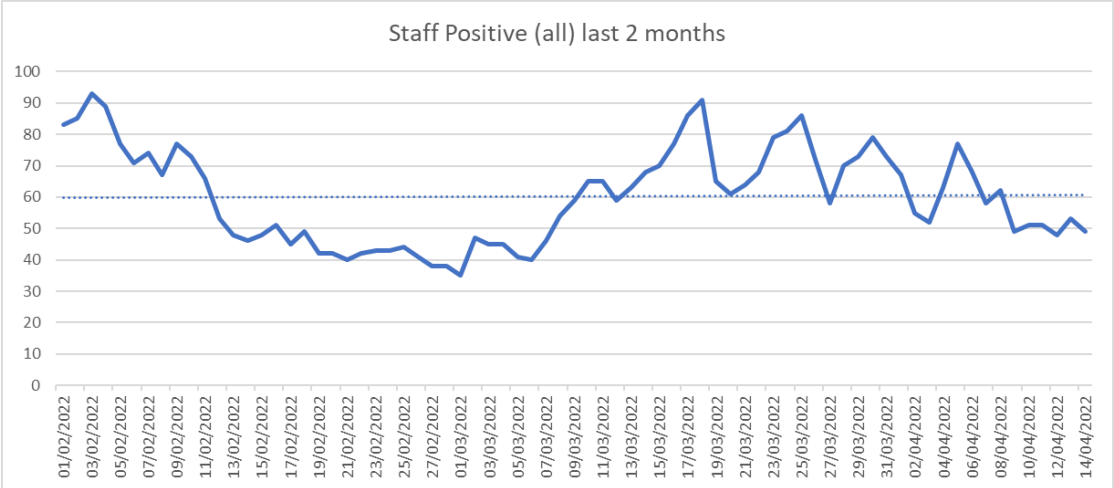
4.4 Service user testing moved to LFD from PCR with effect from 1st April and additional stock of LFD kits has been received to facilitate this, which can be reordered once a month. These stocks have been distributed to all inpatient areas and can now be replenished via the PPE stocking process based on number of kits remaining.

4.5 There have been no further Covid-19 related service user deaths in the last week, and the total to date remains at 226.

5. Safe and Effective and Timely Care Delivery

5.1 Staff positive cases have decreased further this week to 49 as at 14th April (58 last week).

Figure 2 staff positive cases

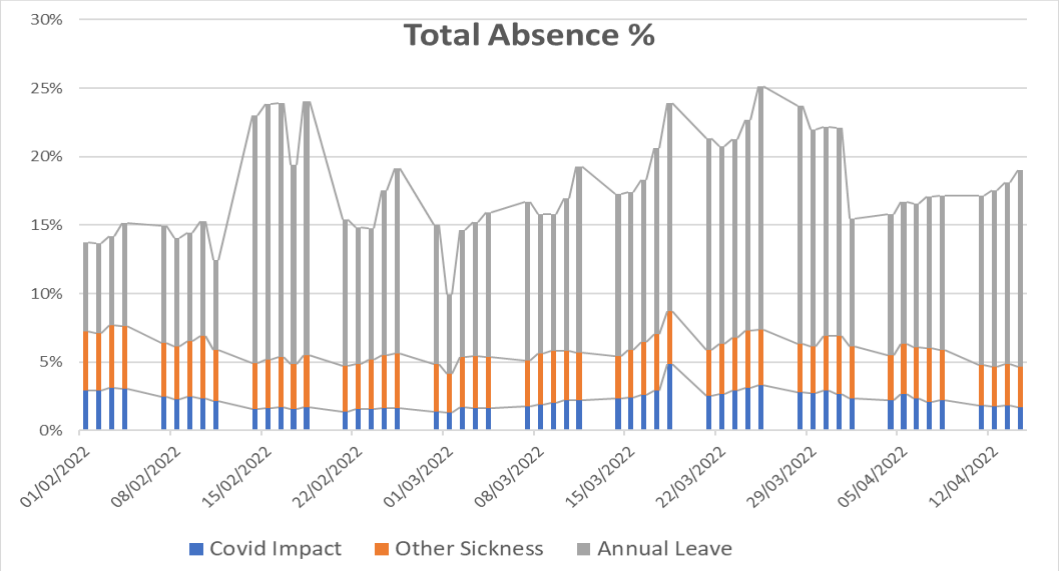


5.2 Staffing levels have remained challenging and daily operational intervention continues to be required to ensure safe staffing and each clinical area has a clear plan for deployment of staff, including contact details, registration, and training details, should this be necessary.

5.4 All absence including annual leave all sickness & non-working isolation at 17% has remained fairly static with,Covid absence is just under 3%.

5.5 The impact of all absence tracked over the last 2 months is shown in the graph below split by Annual Leave, non-Covid sickness, and Covid impact (including confirmed and suspected Covid, Long Covid, and self-isolation).

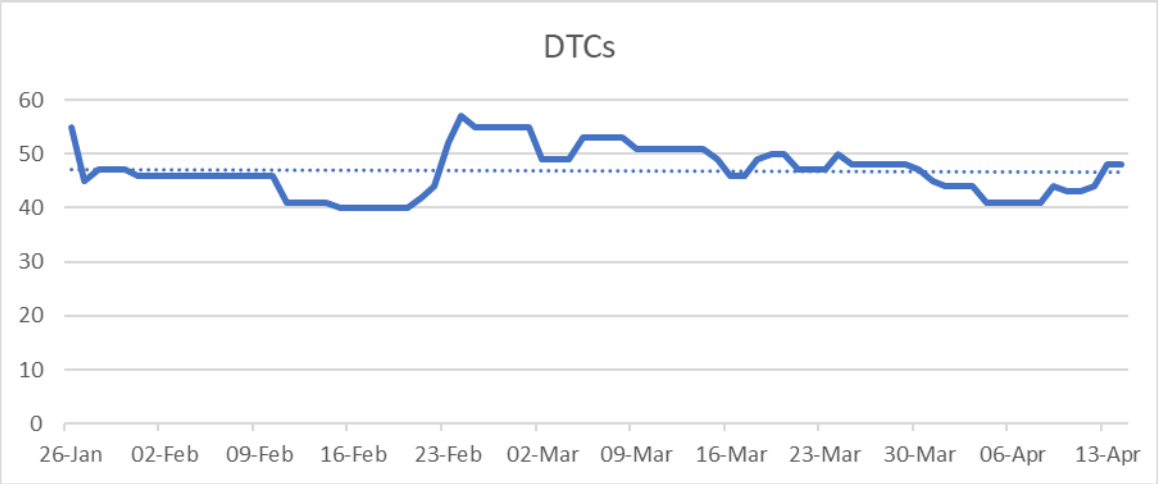
Figure 3 Absence



5.6 The Easter holiday plan included provision to increase staffing levels as required, including over-booking of bank shifts where this is likely to be necessary to manage wards safe staffing levels. Clear escalation processes were within the plan to support resourcing additional staffing

5.7 Delayed Transfers of care are being tracked daily to ensure timely escalations are actioned, on 14th April these were recorded at 49, an increase on last week.

Figure 4 Delayed Transfers of Care



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.

6.2 A spring vaccination booster programme has been launched this week for vulnerable groups including: those aged 75 and over; adult care home residents; and people aged 12 and over who are immunosuppressed. This will be offered via HPFT for all inpatient service users due to their vulnerability.

7. Winter planning

7.1 A review and debrief of winter incident command will take place during the 1st week of May, with a dedicated session for admin support.

8. People

8.1 LFD Testing continues to fluctuate with latest frontline staff averaging under 30% reported compliance. It is likely that the uncertainty around having to pay for testing (even though this will not apply to NHS staff) has impacted this.

8.2 The issue of free testing continuing for NHS staff has been clarified for all staff this week with additional supplies being received and sent out to outbreak wards for any staff who attend work untested. The portal is now only open to priority groups and anecdotally this has improved availability of test kits for staff.

Figure 5 staff tested twice SBU percentage

SBU	% Compliance
367 Corporate Support Services	**27.55%**
367 SBU Essex and IAPTS	**46.73%**
367 SBU Learning Disability and Forensic	**34.98%**
367 SBU MH East and North Herts	**28.03%**
367 SBU MH West Herts	**12.36%**
Trust Total – 26.17%	

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 The Trust has confirmed that it has no contracts with either Russia or Belarus nor any exposure to products from those countries.

10. System and Partnership

10.1 HETCG met this week as noted above, pressures have continued for all providers.

10.2 Referrals have started to come through for Ukraine refugees entering the UK with an expectation that these will increase.

11. Communications

11.1 Communication this week has continued to focus on ensuring the process for LFD testing is understood, and on the spring booster vaccination programme for vulnerable people.

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 Though numbers of positive staff and service users have decreased, overall unavailability remains fairly high and annual leave is likely to increase in the next week; progress will continue to be monitored closely with detailed planning for the Easter holidays to ensure sufficient staff remain available.

13. Recommendation

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

Board of Directors PUBLIC

Meeting Date:	27 April 2022	**Agenda Item:** 9
Subject:	Forest House Adolescent Unit – Care Quality Commission focused inspection	**For Publication:** Yes
Author:	Jacky Vincent: Executive Director Quality and Safety (Chief Nurse)	**Approved by:** Jacky Vincent: Executive Director Quality and Safety (Chief Nurse)
Presented by:	Jacky Vincent: Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

This paper provides an update on the outcome of the CQC's focussed inspection of Forest House Adolescent Unit. It also provides details of the action the Trust has taken and improvements made in the areas identified by the CQC.

Action required:

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

Summary and recommendations:

Summary

In November and December 2021, the Care Quality Commission (CQC) carried out a focused inspection process at Forest House Adolescent Unit (FHAU). During the inspection process, the CQC completed two unannounced visits to FHAU, met with young people and their families/carers receiving care and treatment at the unit and also met with staff members, including bank and agency staff.

On 30 March 2022, the final inspection process report was published by the CQC. Within the report, the CQC have identified actions which the Trust *must* take to comply with its legal obligations and actions which the Trust *should* take to improve the services. As a consequence of their findings the service line (Child and Adolescent Mental Health Wards - CAMHS) was rated at the inspection as *Inadequate*.

Although disappointed, the Trust fully accepts the findings of the CQC and has taken immediate action to address the quality of the service provided and is committed to getting this right for young people and their families/carers for the future.

The Trust has a detailed Service Improvement Action Plan (which builds on a plan implemented in September 2021, prior to the inspection for FHAU) the plan includes the key areas of improvements identified by the CQC as identified in their inspection process report. The Trust can evidence that progress is being made against the plan, led by the leadership team responsible for FHAU. There is a robust process in place to both monitor and track progress, and to ensure the progress is sustained, reporting weekly to the Trust's Executive Director, Quality and Safety with a weekly report provided to the Executive team.

In line with CQC process, the Trust is required to submit the actions it has taken by 26 April 2022.

The Trust Board is asked to note the content and the key findings of the CQC report, which has already been circulated to Board members and can be found here. www.cqc.org.uk/provider/RWR/inspection-summary#mhadolescent

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

Strategic Objective One – safety

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

There are no financial implications

Equality & Diversity /Service User & Carer Involvement implications:

N/A.

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

CQC Essential Standards and the Safe KLOE.

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

The IGC have been regularly updated with regard to the focused inspection and CAMHS services.

1. Introduction

1.1 This paper provides an update on the outcome of the Care Quality Commission's (CQC) focussed inspection of Forest House Adolescent Unit (FHAU).

1.2 The paper also provides details of the action the Trust has taken and improvements that have been made in the areas identified by the CQC.

2 Inspection Process

2.1 In November and December 2021, the CQC carried out a focused inspection process at FHAU, following a number of whistleblows raising concerns about the safety and quality of the services provided. The process included two unannounced visits carried out by two CQC Inspectors, meetings with young people and their families/carers receiving care and treatment at FHAU at the time and also meetings with staff members, including bank and agency staff.

2.2 The Trust provided the CQC with information as part of the inspection process, which included (but not limited to) 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 a Service Improvement Action Plan (the Plan) which commenced in September, detailing key actions to improve the service.

2.3 The inspection focused particularly on the Safety and the Well-led Key Lines of Enquiry (KLOE). The other KLOEs were also looked at with key regard to the process.

2.4 On 18 January 2022, the Trust was issued with a Section 29A Warning Notice notifying the Trust that the CQC *"has formed the view that the quality of health care provided by HPFT for the regulated activities [in relation to FHAU] requires significant improvement".*

2.5 The Warning Notice identified five areas that require significant improvement:

a) Psychological input into care and treatment
b) Systems for administration and recording of medication
c) Completion of physical healthcare checks for young people following administration of medication administered for the purpose of rapid tranquilisation
d) Management and oversight of the running of the service to ensure all policies, procedures and local governance arrangements were maintained, monitored, accurately documented and effective
e) Ensuring suitably trained, competent, skilled, and experienced staff to deliver safe care and treatment to the young people.

2.6 The areas identified in the Warning Notice are detailed in the Plan, which is monitored and reviewed three times a week by the East and North Strategic Business Unit's (SBU) leadership team. The leadership team report weekly to the Executive Director, Quality and Safety; progress of the Plan is reported to and reviewed by the Executive Team, with assurance on progress provided to the Integrated Governance Committee.

2.7 Progress against each of the five areas has been made and is included in the Plan. These areas are included in section 4.4, having been detailed in the inspection report.

2.8 On 11 February 2022, the Trust received the draft Inspection Report and, following completion of the standard CQC Factual Accuracy process, the final report was published on 30 March 2022. Consequently, the service line (Child and Adolescent Mental Health Wards - CAMHS) was rated at the inspection as *Inadequate*.

3 CQC Findings and Actions

3.1 The full findings of the CQC's inspection can be read in their report www.cqc.org.uk/provider/RWR/inspection-summary#mhadolescent. In their summary, the CQC said that *"most regular staff worked hard and showed compassion and kindness to the young people"* and that overall, they found *"the risk assessment and care plans to be holistic and person centred".*

3.2 The CQC in their findings recognised the context in which the Trust was operating and the significant context of the pandemic, the regional pressures and demands of young people requiring services. In their report, they said *"the service encountered a significant increase in the acuity of the presentations of the young people who were admitted to it. This was in part as a consequence of the pandemic, and the well-publicised deterioration in the mental health of some individuals. At the same time, half of the General Assessment Unit beds in the East of England were closed to new admissions, which meant more reliance on Forest House".*

3.3 In its report, the CQC identified four Requirement Notices and five Enforcement Actions the Trust *must* take, which are necessary to comply with its obligations. The CQC has also identified two actions that *should* be taken, as detailed below. Appendix 1 provides a status report against the requirements.

3.4 Requirement Notices.

- *The Trust must ensure that young people's risk management plans are updated in a timely manner and mitigations to manage risks are clearly documented to ensure young person safety*
- *The Trust must ensure that staff consistently enforce the unit's mobile 'phone policy to ensure the safety and wellbeing of all young people on the unit*
- *The Trust must ensure that formal complaints are investigated in accordance with timeframes indicated within the Trust's policy*
- *The Trust must ensure that staff fully complete young people's observation allocation sheets*.

3.5 Enforcement Actions:

- *The Trust must ensure that sufficient psychological interventions are part of the care and treatment for young people to assist them in their recovery*
- *The Trust must ensure that effective systems are in place to ensure staff administer and record medicines given to young people in accordance with their prescription charts*
- *The Trust must ensure that staff complete physical health checks for young people following administration of medication administered for the purpose of rapid tranquilisation*
- *The Trust must implement robust systems and sufficient management oversight of the running of the service to ensure all policies, procedures and local governance arrangements are maintained, monitored, accurately documented and effective*
- *The Trust must ensure that there are suitably trained, competent, skilled and experience staff to deliver safe care and treatment to young people and that all staff receive a full induction.*

3.6 Actions the Trust *should* take to improve:

- *The Trust should ensure that risk assessments are updated in a timely manner to reflect current risks posed by young people*
- *The Trust should ensure that young people and their parents and carers are fully involved in care planning and decision making.*

4 Trust Response, Action and Oversight

4.1 The Trust had identified a number of issues at FHAU and developed a plan to address these, which was in place from September 2021. This was submitted to the CQC as part of the data request during the inspection process. This Plan, which evolved further during the focussed inspection in November and December and the subsequent feedback received, provides detailed information of actions taken to date, including those currently being implemented.

4.2 The Plan sets out the areas of development identified by the Trust against the five KLOES, the specific actions required, including relevant leads, and actions to date with clear timescales. Appendix 1 has an assessment of the status of the improvements that have been taken overall against the actions, noting that the majority of the action have now been completed.

4.3 Implementation of the Plan is led by the CAMHS leadership team, which sits in the East and North Strategic Business Unit (SBU). The leadership team hold the governance and oversight of the Plan, ensuring that actions are completed, and any risk is managed and mitigated, and ongoing monitoring is maintained.

4.4 Following the inspection process report, we met with young people and their families/carers to talk through any remaining concerns they may have, the actions the Trust has taken and any further action the Trust needs to take.

4.5 We have further strengthened leadership on FHAU and have been robustly recruiting into the multi-professional team providing care and treatment to the young people.

4.6 FHAU has remained open to admissions throughout this period and the CQC have not placed any restrictions on admission. The Trust reduced the bed capacity at FHAU from 16 beds to 14 beds, outside of the inspection process, in order to safely manage the building refurbishment taking place. Subsequently, the Trust further reduced the bed capacity to ten beds in December, reflecting the ongoing challenges with the building work and the staffing establishment at that time.

4.7 FHAU currently has six young people admitted for care and treatment. The Executive Team have agreed the principles for safely increasing the number of young people cared for on the unit, with a trajectory agreed for the next three months and this is overseen by the Trust's Executive Director, Quality and Safety, and reported to the Executive Team.

5. Next Steps

5.1 The oversight, monitoring and support for FHAU will continue by the CAMHS leadership team and Service Line Leads, overseen by the Trust's Executive Director, Quality and Safety. We are auditing practice to ensure changes made are sustained and will remain a key priority.

5.2 We anticipate that the CQC, as part of their inspection process, will reinspect FHAU.

5.3 As a result of the judgements made in their inspection, the CQC set actions the Trust are required to take. The Trust is required, under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 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. This is to be submitted to the CQC by 26 April 2022.

6. Conclusion

6.1 This paper has provided an update on the outcome of the CQC's focused inspection of FHAU and details of the action the Trust has taken and improvements that have been made in the areas identified by the CQC.

6.2 The Trust, although disappointed, fully accepts the findings of the CQC. The Trust has taken the findings seriously and is taking action to address the quality of the service provided and is committed for getting this right for young people and their families/carers for the future.

6.3 The Board is asked to note the progress made and the content of the report.

Appendix 1

The following actions have been addressed, with ongoing monitoring:

- The Trust must ensure that young people's risk management plans are updated in a timely manner and mitigations to manage risks are clearly documented, to ensure young person safety
- The Trust must ensure that staff consistently enforce the unit's mobile 'phone policy to ensure the safety and wellbeing of all young people on the unit
- The Trust must ensure that formal complaints are investigated in accordance with timeframes indicated within the Trust's policy
- The Trust must ensure that staff fully complete young people's observation allocation sheets
- The Trust must ensure that effective systems are in place to ensure staff administer and record medicines given to young people in accordance with their prescription charts
- The Trust must ensure that staff complete physical health checks for young people following administration of medication administered for the purpose of rapid tranquilisation
- The Trust should ensure that risk assessments are updated in a timely manner to reflect current risks posed by young people
- The Trust should ensure that young people, and their parents and carers, are fully involved in care planning and decision making.

The following actions have progressed, with a clear timeline in place to fully address, supported with further recruitment:

- The Trust must ensure that sufficient psychological interventions are part of the care and treatment for young people to assist in them in their recovery
- The Trust must implement robust systems and sufficient management oversight of the running of the service to ensure all policies, procedures and local governance arrangements are maintained, monitored, accurately documented and effective
- The Trust must ensure there are suitably trained, competent, skilled, and experienced staff to deliver safe care and treatment to young people and that all staff receive a full induction.

PUBLIC Board of Directors

Meeting Date:	27 April 2022	**Agenda Item:** 10
Subject:	Financial Position – Month 12	**For Publication:** Yes
Author:	David Flint, Head of Financial Performance & 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 a summary of financial performance for the year-ended 2021/22.

Action required:

To note the draft financial position for Month 12 and the full year 2021/22.

Summary and recommendations

Headlines

Subject to audit, the Trust has delivered the following financial performance in 2021/22:

Headline		Comment
Delivered break-even control total	Y	Break-even control total met in line with revised Financial Plan, (£84k surplus)
Delivering Value programme	Y	£4.6m efficiencies delivered and reinvested in services – in line with plan requirement.
£17.1m Capital investment	Y	Fully invested capital funding with small (£9k) underspend on CDEL limit.

In addition to the above, in July 2021 the Trust took on the role of Lead Provider for CAMHS Tier 4 services in the East of England (EoE) Provider Collaborative, with a Commissioning budget of £34m, (part year effect).

The Trust Audit Committee has received a summary presentation of the Trust's Draft Accounts for 2021/22 at its meeting on 21 April and will scrutinise the full accounts in due course.

The Trust will be submitting its draft, unaudited accounts to NHSE by 26 April 2022 with final audited accounts to be submitted to the Department of Health & Social Care on 22 June 2022.

Financial Position

Subject to audit, the Trust has delivered a small surplus position of £84k against a break-even plan. This has been delivered against a backdrop of significant increases in demand and acuity, especially in Half 2 of the financial year.

The Trust continued to receive Covid income throughout 21/22 totalling £10.4m to support Covid related costs.

Secondary Commissioning related spend has continued to exceed plan in month 12 and for the full year.

In month 12 the Trust – in line with previous years and in common with all NHS bodies - has accounted for £7.897m of both income and expenditure relating to the centralised payment of the 6.3% pension contributions made directly by NHSE to the Pensions agency on behalf of HPFT staff. This accounts for a significant proportion of the pay and income variance detailed below.

	Month 12			Year to Date		
Financial Position to 31 March 2022 £000	**Plan**	**Actuals**	**Variance**	**Plan**	**Actual**	**Variance**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Income incl. COVID-19	24,753	39,164	14,411	293,229	310,008	16,779
Income - Provider Collaborative	3,294	3,797	503	34,032	34,032	0
Pay	16,740	28,155	-11,415	196,250	206,267	-10,017
Secondary Commissioning	3,113	3,800	-687	36,873	39,175	-2,302
Provider Collaborative	3,294	3,797	-503	34,032	34,032	0
Non Pay	1,867	2,598	-731	22,487	22,725	-238
Overheads	3,033	4,527	-1,494	37,619	41,758	-4,139
Surplus / (Deficit)	**-**	**84**	**84**	**-**	**84**	**84**

Capital Departmental Expenditure Limit (CDEL)

At the start of 2021/22 the Trust was allocated a £16.1m Capital spending limit by the ICS. During the year an additional amount of just under £1m was awarded for capital investment in IT/digitisation, giving a total of £17.1m.

The Trust has fully applied these capital allocations in 2021/22, recording a small underspend of 9k against its capital expenditure limit. The £17.1m investment has contributed to significantly improved environments for both service users and staff across a range of sites and services. Most notably £11m was spent on major projects including the completion of 4 new safety suites, a new therapy garden at Oak Ward, refurbishment of Forest House and Albany lodge.

Remaining Year End Timeline

- 26th April 2022 - Draft, unaudited financial accounts submitted to NHSEI
- 26th April 2022 – KPMG commence audit of financial accounts over expected 4-week period
- 9th June 2022 – Audited accounts presented to Audit Committee for approval and sign off
- 22nd June – Audited accounts submitted to NHSEI

Forward Look

The Trust enters 2022/23 against a backdrop of a continuing demand for MH & LD services, specifically – in financial terms – in the need for Out of Area/Private Sector placements. This is further exacerbated by a 57% reduction in Covid income.

At the time of writing, the Trust has an £8.5m deficit on its Plan for 22/23 but discussions with Commissioners continue in advance of the final Plan submission on 28th April.

In parallel with the development of the Financial Plan, budgets are being finalised and agreed with Budget holders.

It is expected that 2022/23 will represent a significantly more challenging financial environment than in the past two years with a continued focus on Delivering Value to mitigate the risk of continued high demand for the Trust's services.

Going Concern

The Government Accounting Manual (GAM) requires all NHS Organisations to formally consider the application of a Going Concern basis for the production of Annual Accounts. In recent years guidance has been updated to suggest that a Going Concern basis should be applied, unless there are exceptional circumstances which would suggest otherwise. This has been considered by the Audit Committee at its meeting on 21 April and no such exceptional circumstances were identified.

Conclusion

In planning terms, 2021/22 was split in to two half years with the Trust's original deficit Financial Plan of a £1m deficit, revised to reflect a Break-even position during the year.

The Trust pro-actively invested in services during 2021/22 so as to add resilience to its services during a period of ongoing high demand for its services.

Subject to audit, the Trust has delivered against its key financial targets for 2021/22.

Recommendations

Members are asked to APPROVE the application of the Going Concern basis in the production of the 2021/22 Annual Accounts and to NOTE the summary financial outturn position presented in this paper.

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

Delivery of Financial Plan

Summary of Financial, IT, Staffing & Legal Implications:

Delivery in excess of Financial Control Total

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

PUBLIC Board of Directors

Meeting Date:	27 April 2022	**Agenda Item:** 11
Subject:	People and OD Report	**For Publication:** Yes
Author:	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:

This report covers two areas of update since the last Board meeting.

Firstly, there is a short general People and OD update including a summary of quarter 4 workforce indicators (a more detailed report will be available next month) and secondly, more details on the results of the national Staff Survey. The Board received a short presentation on the results in March, although the embargo on publication had meant that the full results could not be shared in advance of the meeting. This report therefore provides more details on the survey outcomes and outlines the steps in place to address issues raised.

Action required:

The Board are asked to receive this report.

Summary and recommendations to the Board:

People and OD Update

At the end of Q4, vacancy rates had fallen slightly to 14.14%, having stabilised since December. Levels of recruitment activity continue to be high, with ongoing campaigns, in particular for harder to recruit to areas and for nurses, healthcare support workers and allied health professionals. The recruitment pipeline has consistently been over 600 WTE, with an average of 59 staff joining each month and an average time to hire of 45 days. Unplanned turnover at 12.82% has also remained the same for the fourth month in succession.

Sickness absence reduced to 5.08% in March despite increased levels of Covid19 absence. There has also been a continued reduction in mental ill health related absence during Q4 and reduced levels of absence related to colds and flu. A significant amount of wellbeing support continues to be provided, with wellbeing support to staff featuring as one the highest scores in HPFT surveys.

Appraisal rates were at 72%. Improving these rates is a focus for Q1 as part of retention plans. There is also some focussed work to increase mandatory training compliance, which was at 89.4% at the end of the quarter.

Annual Staff Survey

The results of the 2021 annual staff survey were released on 30th March 2022 and the Board received a presentation on the headlines at its meeting on 31st March 2022.

Our results are compared to our 2020 results and the 51 Mental Health and Learning Disability

Trusts nationally. The results are overwhelmingly positive. The key headlines are as follows:

- We achieved a 50% response rate compared to the 52% median response rate across all 51 trusts nationally and our 2020 response rate of 52%.

- Questions were collated into nine themes, seven of which map to the NHS People Promises. We scored better than the national average in eight of the nine themes and the same as the average for the remaining theme.

- We achieved a national best score for "Motivation" and scored close to the national best score for the overall theme of staff engagement.

- Of the 104 questions, 26 questions scored significantly better that the national average (by 3% or more), whilst only three scored worse than the national average (by 3% or more), as follows:
    - Experience of violence and aggression from service users
    - Having received an appraisal in the last 12 months
    - Working additional unpaid hours

- Our Workforce Race Equality Standard and Workforce Disability Equality Standard scores remain very similar to 2020. There remains a difference in staff experience according to long term health condition status and ethnicity.

- Overall, our results create a strong narrative of a staff team who are:
    - Proud to work for HPFT and would recommend us as place to work;
    - Proud of the standard of care we provide
    - Confident that service users are our top priority
    - Highly engaged, motivated and emotionally invested in providing great care to our service users
    - Reporting a strong compassionate culture
    - Supported and looked after through:
        - Health and wellbeing support
        - Work-life balance and flexible working support
        - Support with their development, including high quality appraisals
        - Feeling confident to raise concerns and have these be heard and addressed

- The unintended negative consequence of having such a highly motivated, passionate and compassionate team of people is that this may be having an adverse impact on their own wellbeing. This may be being compounded by our collective experience of being two years into the Covid-19 pandemic and our high vacancy rate levels. This context means that people reported:
    - Working additional unpaid hours
    - Feeling exhausted or burnt out
    - That there are not enough staff to do their jobs properly
    - That they are unable to meet the conflicting demands of their roles
    - They are attending work even when not well enough
    - They are more likely to be thinking of leaving than in 2020

During April, we are talking to all our people about our annual staff survey results which show that our people are proud to work for the Trust, recommend us as a place to work, are proud of the standard of care we provide, are clear that service users are our top priority. The survey results tell us that our people are highly engaged, motivated and emotionally invested in their work, that

we have a strongly compassionate culture and that staff feel supported and looked after through the support for health and wellbeing, work-life balance and flexible working, development and high-quality appraisals and that people feel confident to raise concerns and know that if they do so, their concerns will be addressed. The results indicate that the areas we should focus on to keep improving the experience of all our people include reducing violence and aggression, continuing to improve belonging and inclusion, helping our people to achieve better levels of self-care and embracing feedback as an opportunity to grow and improve. We are engaging with all our people to discuss our survey results and to co-produce an action plan to continue to make the Trust the best place to work.

The Senior Leadership Team are working with People and OD and all of our staff to co-produce a meaningful Trust staff survey action plan. The following are the key areas for us to focus on in relation to the conversations with our people:

- Taking pride in our culture and achievements together
- Reducing violence and aggression
- Inclusion and belonging
- Self-care whilst maintaining passion and compassion for our service users
- Embracing feedback - skilfully giving, receiving and valuing feedback in the context of our values

The Board is asked to receive this report.

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.

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

The staff survey questions map to each element of the NHS People Promise, including “we are compassionate and inclusive”. In addition, key survey questions form part of the Workforce Race Equality Standard and Workforce Disability Equality Standard. The survey therefore enables us to assess staff experience as it relates to equality and inclusion and to assess differences between people with different protected characteristics, enabling us to work with our people to co-produce action plans to address difference in experience.

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

Staff survey preliminary results received by the Executive Team on 19.01.22 and PODG 03.03.22; final results received by Executive Team 09.03.22; IGC – 17.03.22; Board 30.03.22

People and OD Report April 2022

1. Introduction

1.1 This report covers two areas of update since the last Board meeting.

1.2 Firstly, there is a short summary of quarter 4 workforce indicators (a more detailed report will be available next month) and secondly, more details on the results of the national Staff Survey. The Board received a short presentation on this at its meeting on 31st March, the results having been under embargo until 30th March. This report provides full details on the survey and outlines the steps in place to address issues raised.

1.3 The results should also be considered in the context of the Q4 workforce indicators to ensure action planning is comprehensive and consistent.

Part 1 – People and OD Update

2. Q4 Workforce Indicators

2.1 At the end of Q4, the Trust's vacancy rate was slightly reduced at 14.14%, having stabilised since December. Funded establishments had increased to 3955.74 fte with 559 posts vacant. We consistently have a recruitment pipeline of over 600 WTE, with an average of 59 staff joining each month and an average time to hire of 45 days. Within the pipeline currently, there are 60 new staff with start dates and a further 133 at offer stage. We continue our high levels of recruitment activity and campaigns, in particular for harder to recruit to areas and for nurses, healthcare support workers and allied health professionals.

2.2 Our unplanned turnover remained the same for the fourth month in a row at 12.82% in March. Current work to support retention and reduce turnover includes a refresh of staff benefits; an action plan developed using feedback from staff networks to support flexible working, following participation in a national "flex for the future" programme; and ongoing work to support wellbeing including additional information for staff covering financial wellbeing.

2.3 We are also focussing on how we can further support staff with regards promotion and career development within the Trust. Actions to note include:

- Establishing all Band 2 HCSW posts as Band 3 posts to enable career progression upon demonstration of core competencies, with a supportive development framework in place. This is to tackle our 20% turnover rate amongst Band 2 HCSWs, almost half of whom have been employed with us for over four years. There is also a disproportionate over-representation of BAME staff in this group.
- Exploring the development of talent pools for Band 5 nursing staff to develop into Band 6 roles, with a similar scheme for some AHP roles.
- Finalising a career map for nursing staff from non-registered through to Executive Director level to use as part of our attraction campaigns, and to

promote the options available to existing staff in order to retain them and develop their careers within HPFT.

- Focusing on equality and inclusion in recruitment and promotion practices, making this an integral part of our planned talent pools and introducing our new Inclusion Ambassador programme in Q1 of 2022/3, now that we have 21 people from across our BAME Staff Network who are participating in the scheme and are currently being trained.

2.4 Sickness absence was at 5.08% for March, despite increased levels of Covid19 absence, with continuing reduction in mental ill health related absence and reduced levels of absence related to colds and flu. Our Here for You service and Employee Assistance Programme continue to provide a comprehensive wellbeing offer. We also offer a fast-track physio service for people suffering MSK issues.

2.5 Our appraisal rates were at 72%; improving these rates will be a focus during Q1 to ensure our people are supported to thrive and further develop their careers with us. We are also concentrating on increasing mandatory training compliance, which is 89.4% (just below our target of 92%).

Part Two – Annual Staff Survey

3. Introduction

3.1 The results of the 2021 national staff survey were published on 30th March 2022, and although the Board received a summary presentation at its last meeting, more comprehensive analysis now follows.

3.2 The results are overwhelmingly positive. The areas of strength, where we achieved better results than our comparator group or our 2020 results are detailed in this report, together with detail of the areas we will focus on in order to continue to improve staff experience.

3.3 Finally, our next steps for engaging with staff to share our results and co-design action plans are set out.

4. Participation and Methodology

4.1 There are two staff survey providers which NHS trusts can commission to carry out the NHS annual staff survey so that individual responses are anonymous and confidential. The Trust opted to engage Picker, as we have in previous years. Picker surveyed 24 of the 51 Mental Health and Learning Disability trusts this year.

4.2 The annual staff survey launched on 22 September and closed on 26 November 2021. The survey was sent to staff via email, however, staff without easy access to IT equipment were also sent paper surveys.

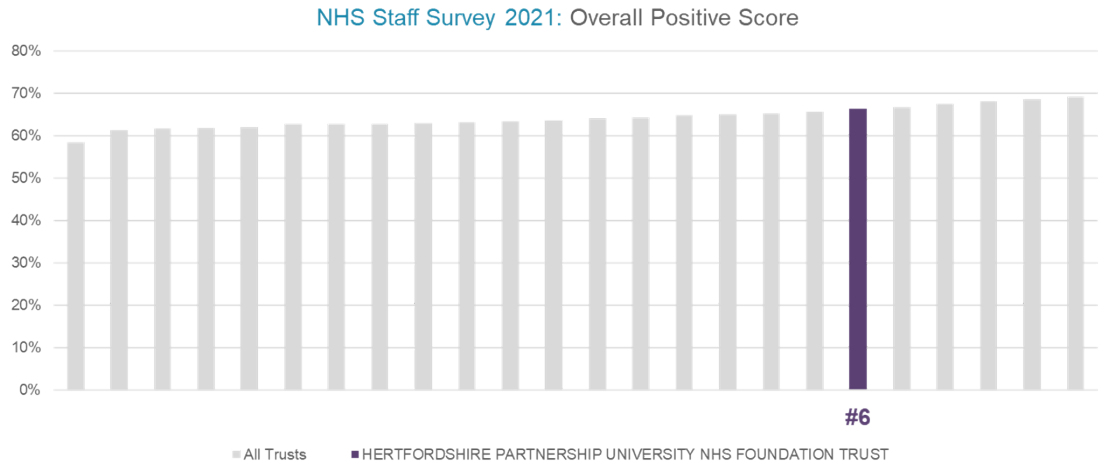
4.3 Team and individual incentives were publicised to encourage participation. Ten staff from across the Trust won a £50 voucher for completing their staff survey and the three teams with the highest response rate received a hamper of goodies each.

4.4 Overall, we achieved a 50% response rate, compared to a median response rate of 52% across all 51 Mental Health and Learning Disability Trusts nationally and our 2020 response rate of 52%. The actual number of responses we received this year (1793), however, was very similar to that received in 2020 (1803). This provides a healthy sized, representative sample of views to help inform our knowledge of staff experience.

5. Overview of Results

5.1 The Trust ranked 6th in comparison to the other 23 mental health and learning disability trusts surveyed by Picker in 2021, as shown in Figure 1 overleaf.

Figure 1: Trust overall scores compared to all 24 Trusts surveyed by Picker



5.2 This year, the NHS National Coordination Centre collated questions into nine themes, seven of which map to the NHS People Promises. As this methodology is new, historic comparison is not possible. Each of the nine themes are compared against the national average scores, as shown in Figure 2.

Figure 2: Thematic comparison with national averages

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.9	6.8	7.4	6.6	6.1	7.1	7.4	7.4	6.5
Your org	7.7	6.4	7.2	6.3	5.9	6.9	7.1	7.3	6.2
Average	7.5	6.3	7.0	6.2	5.6	6.7	7.1	7.0	6.0
Worst	7.1	5.9	6.4	5.8	4.8	6.1	6.6	6.5	5.5
Responses	1,752	1,774	1,733	1,747	1,633	1,768	1,759	1,777	1,774

5.3 Across eight of the nine themes set out above, the Trust's score was higher than the national average, with staff engagement being closest the national best score. We scored the same as the national average in one theme. The scores in relation to the questions categorised under each of these themes are set out in more detail in the Section 4.

5.4 Picker has provided us with detail of our top and bottom scores and those which are most improved or declined since 2020. Our top five scores relate to people's recommendation of HPFT as a place to work and receive care, our support for people's health and wellbeing and the fact that service users are our top priority.

5.5 Figure 3 shows our top five scores, all of which are statistically significantly better than the national average. These top results include the 'friends and family test' questions and create a strong narrative of a staff team who are proud to work for HPFT, proud of the standard of care we provide, where service users are our top priority, and our people feel looked after and would recommend HPFT as a place to work and receive care.

Figure 3: Top Five Scores

Top 5 scores	Trust 2021	National Ave (MH&LD)	Trust 2020

Would recommend organisation as place to work	70.6%	63.2%	76.1%
Organisation takes positive action on health and well-being	70.1%	63.5%	N/A
If friend/relative needed treatment would be happy with standard of care provided by organisation	71.4%	64.9%	75.8%
Care of patients/service users is my organisation's top priority	84.7%	78.5%	87.7%
Confident my organisation would address any concerns I raised	61.8%	55.1%	Not asked in 2020

5.6 Whilst none of our scores showed a statistically significant improvement since 2020, Figure 4 sets out those questions which showed the most improvement.

Figure 4: Most Improved Scores

Most improved scores	Trust 2021	National Ave	Trust 2020
Last experience of harassment/bullying/abuse reported	63.1%	60.7%	59.9%
Would feel secure raising concerns about unsafe clinical practice	81%	79.6%	78.8%
Experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	25.9%	27.2%	28%
Feel trusted to do my job	93%	91.2%	91.7%
Immediate manager asks for my opinion before making decisions that affect my work	65.7%	65.7%	65.3%

5.7 Our bottom five scores and areas of greatest decline are shown below in Figure 5 and Figure 6. Our bottom five scores were similar to the national average, except for the question relating to additional unpaid hours, which was significantly worse. All our most declined scores were statistically significantly different to our 2020 scores, two were worse than the national average, whilst one was significantly better than the national average.

Figure 5: Bottom Five Scores

Bottom 5 scores	Trust 2021	National Ave	Trust 2020

Working additional unpaid hours per week for this organisation, over and above contracted hours	66.4%	62.1%	63.9%
In last 12 months, experienced musculoskeletal (MSK) problems as a result of work activities	29.1%	26.6%	29.2%
Immediate manager gives clear feedback on my work	70%	71.7%	69.9%
Find work emotionally exhausting	37.1%	35.8%	Not asked in 2020
Feel burnt out because of work	29.2%	27.7%	Not asked in 2020

Figure 6: Most Declined Scores

Most declined scores	Trust 2021	National Ave	Trust 2020
Enough staff at organisation to do my job properly	33.2%	30.5%	44.5%
Able to meet conflicting demands on my time at work	45.5%	44.9%	50.8%
In last 3 months, have not come to work when not feeling well enough to perform duties	48.8%	52.6%	43.4%
Would recommend organisation as place to work	70.6%	63.2%	76.1%
I often think about leaving this organisation	24.6%	27.8%	21.2%

5.8 The above scores may reflect the context of the Covid-19 pandemic and our vacancy rates. In particular, people report working additional unpaid hours, a high percentage of staff feel exhausted or burnt out, significantly more staff than in 2020 state that there are not enough staff to do their jobs properly, significantly fewer are able to meet the conflicting demands in their roles and more are attending work even when not well enough.

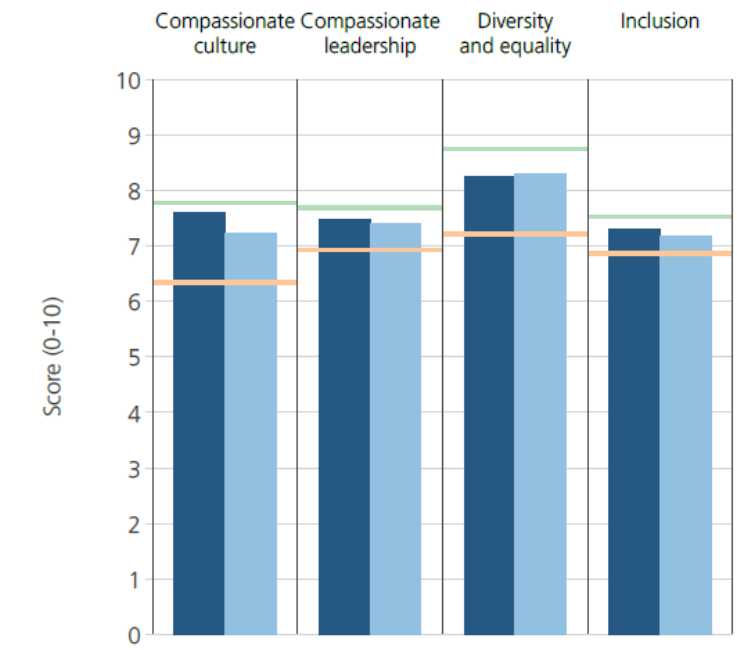
5.9 These scores may also reflect the unintended negative consequence of having such a highly motivated and committed team of people, who are so greatly focussed on service users as our top priority and emotionally engaged in their work that this may have an adverse impact on their own wellbeing.

6. Detailed Results

6.1 We are compassionate and inclusive

6.1.1 Under this theme, the Trust scored higher than the national average (7.7 compared to a national average of 7.5). Figure 7 shows our scores for each of the four elements that fall within this theme, compared to the national average. Our scores across all four themes are either the same as or above the national average, with our "Compassionate Culture" scores being most significantly higher than the national average.

Figure 7: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Best	7.8	7.7	8.7	7.5
Your org	7.6	7.5	8.3	7.3
Average	7.2	7.4	8.3	7.2
Worst	6.3	6.9	7.2	6.9
Responses	1,739	1,758	1,751	1,762

6.1.2 The follow questions are aggregated to determine our score under each of the four elements which make up the theme of "We are compassionate and inclusive". The colour of the 2021 score denotes whether this is higher than (3+% better - green), similar to (within 3% - blue) or worse than (3+% worse - red) the national average score. The direction of the arrow denotes whether the score has improved compared to 2020, where historical comparison is possible. Where historical comparison is not possible this is noted as "N/A".

2021 Score	2020 Score	Nat. Ave.	Survey Question
Compassionate Culture			

88.8%	N/A	87.5%	I feel that my role makes a difference to patients / service users
84.7%↓	87.7%	78.5%	Care of patients / service users is my organisation's top priority
82.1%↔	84.6%	77%	My organisation acts on concerns raised by patients / service users
70.6%↓	76.1%	63.2%	I would recommend my organisation as a place to work
71.4%↓	75.8%	64.9%	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation
Compassionate Leadership			
75.4%	N/A	75.1%	My immediate manager works together with me to come to an understanding of problems
77.8%	N/A	76.9%	My immediate manager is interested in listening to me when I describe challenges I face
76.2%	N/A	76.4%	My immediate manager cares about my concerns
71.9%	N/A	72.3%	My immediate line manager takes effective action to help me with any problems I face
Diversity and Equality			
59.5%↔	59.6%	58.6%	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?
9.5%↔	9.7%	7.4%	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?
9%↔	8.4%	7.6%	In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?
77.5%	N/A	72.2%	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).
Inclusion			
72.7%	N/A	74.2%	I feel valued by my team
67.8%	N/A	66.4%	I feel a strong personal attachment to my team
79.7%	N/A	76.9%	The people I work with are understanding and kind to one another
80.6%	N/A	78.8%	The people I work with are polite and treat each other

			with respect

6.2 We are recognised and rewarded

6.2.1 In this theme, the Trust scored higher than national average (6.4 compared to a national average of 6.3).

Figure 8: We are recognised and rewarded

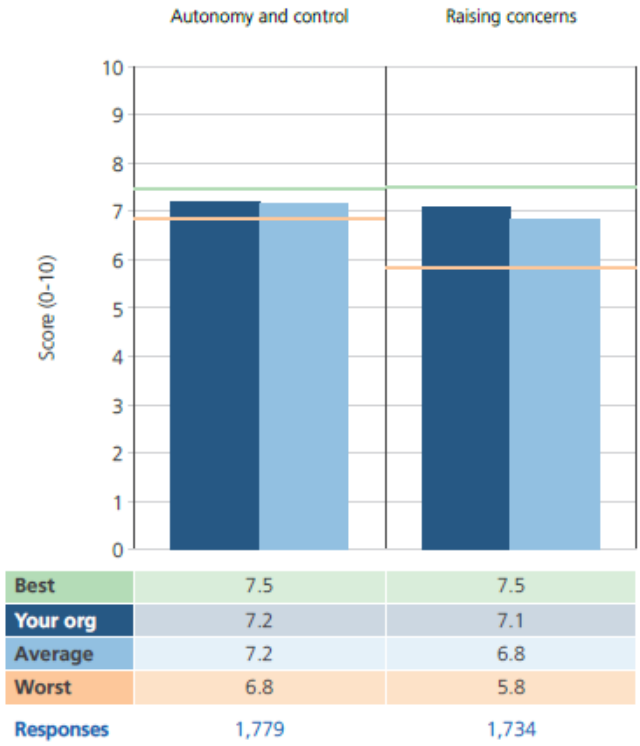
6.2.2 The follow questions are aggregated to determine our score:

2021 Score	2020 Score	Nat. Ave.	Survey Question
61%↔	63.8%	61%	The recognition I get for good work
54.6%↓	57.7%	49.1%	The extent to which my organisation values my work
34.3%↔	36.4%	37%	My level of pay
74.9%	N/A	74.3%	The people I work with show appreciation to one another
77.9%↔	80.1%	78.8%	My immediate manager values my work

6.3 We each have a voice that counts

6.3.1 Under this theme, the Trust scored higher than the national average (7.2 compared to a national average of 7.0). Figure 9 shows our scores for the two elements that fall within this theme, compared to the national average. Our scores for both are either the same as or above the national average, with our "Raising Concerns" scores being most significantly higher than the national average.

Figure 9: We each have a voice that counts



	Autonomy and control	Raising concerns
Best	7.5	7.5
Your org	7.2	7.1
Average	7.2	6.8
Worst	6.8	5.8
Responses	1,779	1,734

6.3.2 The follow questions are aggregated to determine our score:

2021 Score	2020 Score	Nat. Ave.	Survey Question
Autonomy and Control			
85.5%↔	85.4%	84.6%	I always know what my work responsibilities are
93%↔	91.7%	91.2%	I am trusted to do my job
75.8%↔	75.9%	76.4%	There are frequent opportunities for me to show initiative in my role
75.7%↔	77.9%	76.7%	I am able to make suggestions to improve the work of my team / department
52.9%↔	54.6%	54.4%	I am involved in deciding on changes introduced that affect my work area / team / department

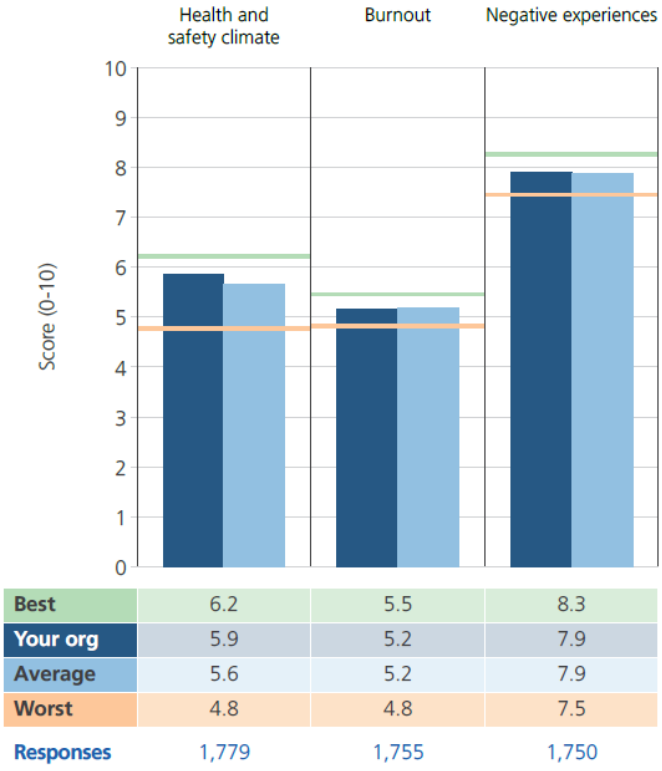
58%↓	61.9%	58.8%	I am able to make improvements happen in my area of work
62%↔	64.9%	63.69%	I have a choice in deciding how to do my work
Raising Concerns			
81%↔	78.8%	79.6%	I would feel secure raising concerns about unsafe clinical practice
70.3%↔	71.3%	64.2%	I am confident that my organisation would address my concern
69.7%↔	71.6%	66.8%	I feel safe to speak up about anything that concerns me in this organisation
61.8%	N/A	55%	If I spoke up about something that concerned me I am confident my organisation would address my concern

6.4 We are safe and healthy

6.4.1 The Trust scored higher than the national average (6.3 compared to a national average of 6.2) in relation to this theme. Figure 10 shows our scores for the three elements that fall within this theme, compared to the national average. Seven of our bottom five/five most declined scores were in this theme.

6.4.2 Our scores for all three are either the same as or above the national average. Our “Health and safety climate” scores were most significantly higher than the national average.

Figure 10: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Best	6.2	5.5	8.3
Your org	5.9	5.2	7.9
Average	5.6	5.2	7.9
Worst	4.8	4.8	7.5
Responses	1,779	1,755	1,750

6.4.3 The follow questions are aggregated to determine our score:

2021 Score	2020 Score	Nat. Ave.	Survey Question
Health and safety climate			
45.5%↓	50.8%	44.9%	I am able to meet all the conflicting demands on my time at work
66.7%↔	68.5%	64%	I have adequate materials, supplies and equipment to do my work
33.2%↓	44.5%	30.5%	There are enough staff at this organisation for me to do my job properly
24%↔	26.9%	26.2%	I have unrealistic time pressures
70.1%	N/A	63.5%	My organisation takes positive action on health and well-being
92%↔	93.1%	89.6%	The last time you experienced physical violence at work, did you or a colleague report it?
63.1%↑	59.9%	60.7%	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?
Burnout			
37.1%	N/A	35.8%	How often, if at all, do you find your work emotionally exhausting?

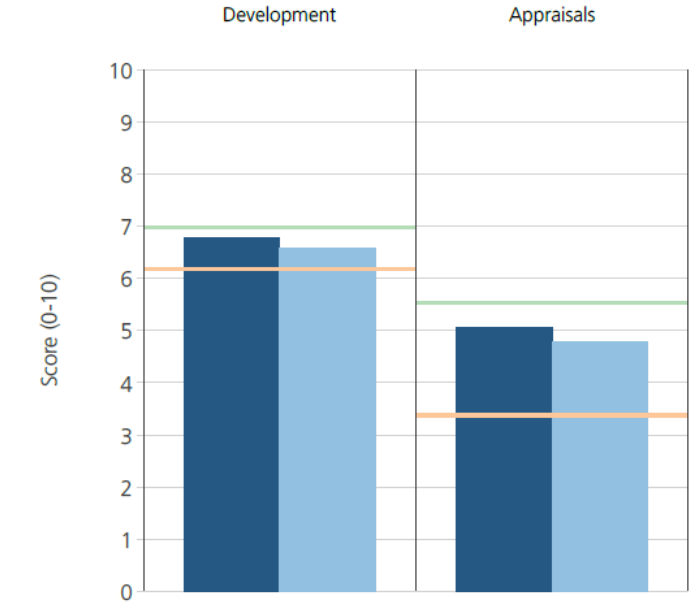
29.2%	N/A	27.7%	How often, if at all, do you feel burnt out because of your work?
32.8%	N/A	33.4%	How often, if at all, does your work frustrate you?
23.4%	N/A	23.8%	How often, if at all, are you exhausted at the thought of another day/shift at work?
39.7%	N/A	39.7%	How often, if at all, do you feel worn out at the end of your working day/shift?
16.2%	N/A	15.6%	How often, if at all, do you feel that every working hour is tiring for you?
27.6%	N/A	27.5%	How often, if at all, do you not have enough energy for family and friends during leisure time?
Negative experiences			
29.1%↔	29.2%	26.6%	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?
42.3%↑	38.6%	43.5%	During the last 12 months have you felt unwell as a result of work related stress?
48.8%↑	43.4%	52.6%	In the last three months have you ever come to work despite not feeling well enough to perform your duties?
18.2%↔	18.3%	14.3%	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?
0.7%↔	0.7%	0.4%	In the last 12 months how many times have you personally experienced physical violence at work from managers?
1.4%↔	1.4%	1%	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?
25.9%↔	28%	27.2%	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?
8.8%↔	10.2%	8.9%	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?
13.8%↔	14.4%	14.6%	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?

6.5 We are always learning

6.5.1 The Trust scored higher than the national average (5.9 compared to a national average of 5.6) in relation to this theme. Figure 11 shows our scores for the two elements that fall within this theme, compared to the national average.

6.5.2 Our scores for both elements of this theme are above the national average, with quality of appraisal and development opportunities most significantly higher than the national average, whilst compliance with appraisal was lower than the national average.

Figure 11: We are always learning



	Development	Appraisals
Best	7.0	5.5
Your org	6.8	5.1
Average	6.6	4.8
Worst	6.2	3.4
Responses	1,749	1,636

6.5.3 The follow questions are aggregated to determine our score:

2021 Score	2020 Score	Nat. Ave.	Survey Question

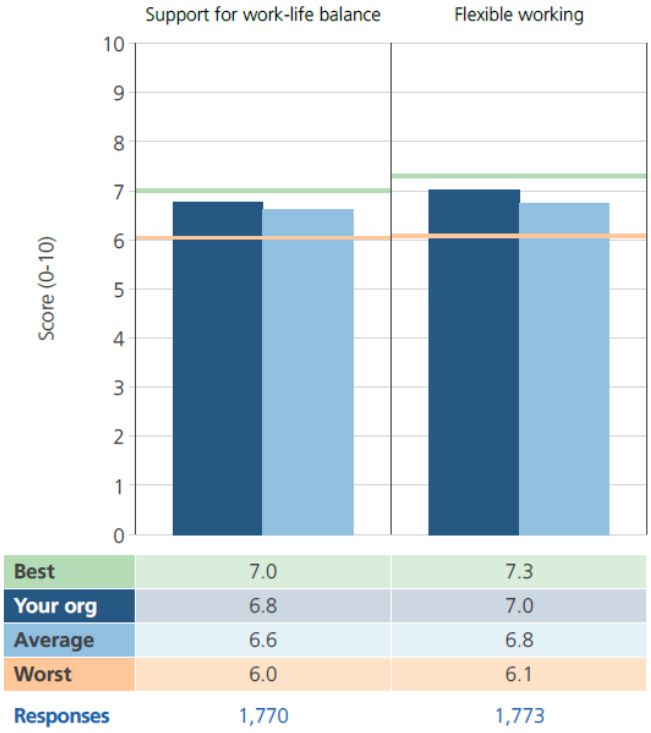
Development			
75.2%	N/A	73.9%	This organisation offers me challenging work
60.8%	N/A	54.6%	There are opportunities for me to develop my career in this organisation
75.6%	N/A	72.5%	I have opportunities to improve my knowledge and skills
62.6%	N/A	58.9%	I feel supported to develop my potential
63.3%	N/A	59.4%	I am able to access the right learning and development opportunities when I need to
Appraisals			
81.8%	N/A	84.9%	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?
27.4%	N/A	20.8%	It helped me to improve how I do my job
36%	N/A	33.1%	It helped me agree clear objectives for my work
36.7%	N/A	33.3%	It left me feeling that my work is valued by my organisation

6.6 We work flexibly

6.6.1 The Trust scored higher than the national average (6.9 compared to a national average of 6.7) in relation to this theme. Figure 12 shows our scores for the two elements that fall within this theme, compared to the national average.

6.6.2 Our scores for both elements of this theme are above the national average, with organisational commitment to work-life balance and opportunities for flexible working being significantly higher than the national average score.

Figure 12: We work flexibly



	Support for work-life balance	Flexible working
Best	7.0	7.3
Your org	6.8	7.0
Average	6.6	6.8
Worst	6.0	6.1
Responses	1,770	1,773

6.6.3 The follow questions are aggregated to determine our score:

2021 Score	2020 Score	Nat. Ave.	Survey Question
Support for work-life balance			
59.7%	N/A	54.9%	My organisation is committed to helping me balance my work and home life
57.7%	N/A	59.1%	I achieve a good balance between my work life and my home life
78.8%	N/A	77%	I can approach my immediate manager to talk openly about flexible working
Flexible working			
69%↓	72.1%	65.4%	The opportunities for flexible working patterns

6.7 We are a team

6.7.1 The Trust scored the same as the national average (7.1 compared to a national average of 7.1) in relation to this theme. Figure 13 shows our scores for the two elements that fall within this theme, compared to the national average. Our scores for both elements of this theme are either at or above the national average, with teams working together to achieve objectives being most significantly higher than the national average.

Figure 13: We are a team

	Team working	Line management
Best	7.2	7.5
Your org	7.0	7.3
Average	6.9	7.3
Worst	6.5	6.7
Responses	1,770	1,759

6.7.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
Team working			
76.1%↔	75.2%	75.6%	The team I work in has a set of shared objectives
67.8%↔	69.8%	67.8%	The team I work in often meets to discuss the team's effectiveness
76.1%↔	76.9%	75.9%	I receive the respect I deserve from my colleagues at work
70.7%	N/A	71.3%	Team members understand each other's roles
85.5%	N/A	84.3%	I enjoy working with the colleagues in my team
61.9%	N/A	61.5%	My team has enough freedom in how to do its work
60.1%	N/A	61%	In my team disagreements are dealt with constructively
58.7%	N/A	53.1%	Teams within this organisation work well together to achieve their objectives
Line management			
78.7%↔	78.5%	78%	My immediate manager encourages me at work

70%↔	69.9%	71.7%	My immediate manager gives me clear feedback on my work
65.7%↔	65.3%	65.7%	My immediate manager asks for my opinion before making decisions that affect my work
76.7%↔	79.9%	77.1%	My immediate manager takes a positive interest in my health and well-being

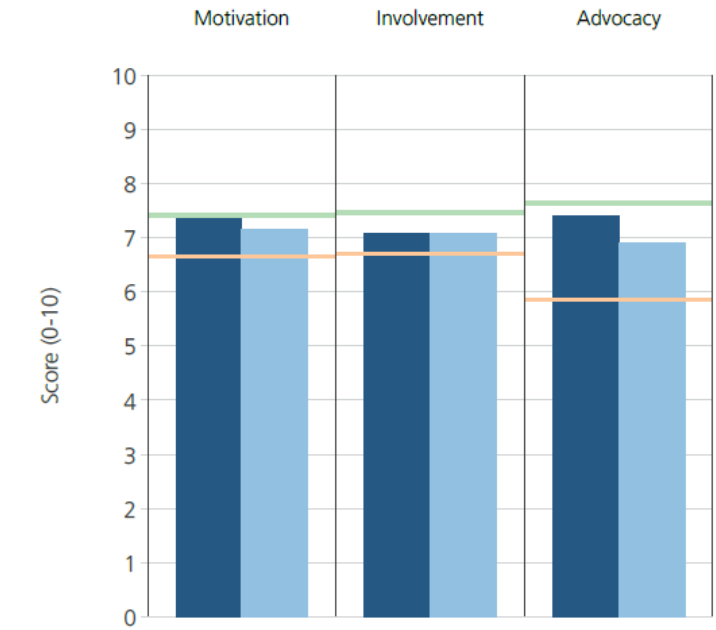
6.8 Staff engagement

6.8.1 The Trust scored the same as the national average (7.3 compared to a national average of 7.0) in relation to this theme. Figure 14 shows our scores for the three elements that fall within this theme, compared to the national average.

6.8.2 Our scores for all three elements of this theme are either at or above the national average, with “Motivation” achieving the national best score. All three “Advocacy” questions scored significantly higher than the national average. These questions map to the ‘friends and family test’ and are:

- Care of patients / service users is my organisation's top priority
- I would recommend my organisation as a place to work
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

Figure 14: Staff engagement



	Motivation	Involvement	Advocacy
Best	7.4	7.5	7.6
Your org	7.4	7.1	7.4
Average	7.2	7.1	6.9
Worst	6.7	6.7	5.8
Responses	1,760	1,779	1,739

6.8.3 The follow questions are aggregated to determine our score:

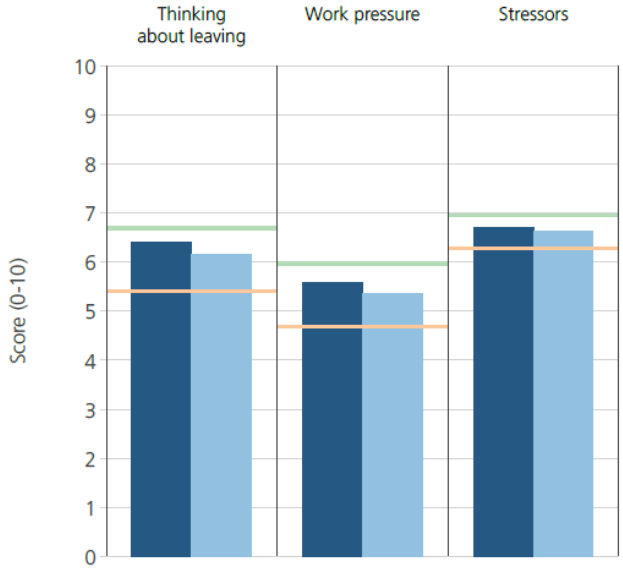
2020 Score	2019 Score	Nat. Ave.	Survey Question
Motivation			
60.8%↓	63.8%	56.7%	I look forward to going to work
74.1%↔	76.3%	70.6%	I am enthusiastic about my job
79.2%↔	80.7%	76.5%	Time passes quickly when I am working
Involvement			
75.8%↔	75.9%	76.4%	There are frequent opportunities for me to show initiative in my role
75.7%↔	77.9%	76.7%	I am able to make suggestions to improve the work of my team / department
58%↓	61.9%	58.8%	I am able to make improvements happen in my area of work
Advocacy			

84.7%↓	87.7%	78.5%	Care of patients / service users is my organisation's top priority
70.6%↓	76.1%	63.2%	I would recommend my organisation as a place to work
71.4%↓	75.8%	64.9%	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

6.9 Morale

6.9.1 The Trust scored the same as the national average (6.2 compared to a national average of 6.0) in relation to this theme. Figure 15 shows our scores for the three elements that fall within this theme, compared to the national average. Our scores for all three elements of this theme are above the national average.

Figure 15: Morale



	Thinking about leaving	Work pressure	Stressors
Best	6.7	6.0	6.9
Your org	6.4	5.6	6.7
Average	6.2	5.3	6.6
Worst	5.4	4.7	6.3
Responses	1,733	1,779	1,768

6.9.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
Thinking about leaving			
24.6%↑	21.2%	27.8%	I often think about leaving this organisation
20.7%↔	18.3%	21.4%	I will probably look for a job at a new organisation in the next 12 months

12.9%↔	11.8%	14.4%	As soon as I can find another job, I will leave this organisation
Work pressure			
45.5%↓	50.8%	44.9%	I am able to meet all the conflicting demands on my time at work
66.7%↓	68.5%	64%	I have adequate materials, supplies and equipment to do my work
33.2%↓	44.5%	30.5%	There are enough staff at this organisation for me to do my job properly
Stressors			
85.5%↔	85.4%	84.6%	I always know what my work responsibilities are
52.9%↔	54.6%	54.4%	I am involved in deciding on changes introduced that affect my work area / team / department
24%↔	26.9%	26.2%	I have unrealistic time pressures
62%↔	64.9%	63.6%	I have a choice in deciding how to do my work
56.9%↔	58.5%	53.6%	Relationships at work are not strained
76.1%↔	76.9%	75.9%	I receive the respect I deserve from my colleagues at work
78.7%↔	78.5%	78%	My immediate manager encourages me at work

7. Workforce Race Equality Scheme and Workforce Disability Equality Scheme

7.1 28% of respondents reported their ethnic background as BAME (compared to 36% of our total staff population).

7.2 27.3% of respondents stated that they had a physical or mental health condition or illness lasting or expecting to last for 12 months of more.

7.3 In relation to the Workforce Race Equality Standard (WRES) questions:

- One question has significantly improved since 2020 by 4.1%, which is perceived equality of opportunity for career progression/promotion. In addition, the difference in experience between BAME and white staff has reduced significantly, from a 21.2% gap to 15.2%. This may be an early indication of the impact of initiatives that have been co-produced with the BAME staff network.
- Two questions have shown a modest improvement, whilst one has shown a small decline.

- The experience of BAME staff in relation to bullying and harassment from colleagues/managers is significantly better than the national average.
- However, there remains a significant difference in experience between BAME and white staff;

7.4 The four Workforce Race Equality Standard question scores were as follows:

2021 Score		2020 Score		Nat. Ave.		Survey Question
White	BAME	White	BAME	White	BAME	
64.2%	49%↑	67.1%	45.9%	61%	46.8%	Organisation provides equal opportunities for career progression/promotion
6.8%	13.2%↔	5.6%	12.1%	6%	14.4%	Experienced discrimination from manager/team leader or other colleagues in last 12 months
16%	19.3%↔	18.3%	20%	18.1%	22.9%	Experienced harassment, bullying or abuse from other staff in last 12 months
22.4%	30.8%↔	24.9%	29%	26.2%	31.8%	Experienced harassment, bullying or abuse from service users, relatives or the public in last 12 months

7.5 In relation to the Workforce Disability Equality Standard questions:

- Most questions had remained similar to our 2020 scores, however; staff engagement scores, making reasonable adjustments, feeling valued and reporting bullying and harassment have all declined since 2020.
- Five questions were better than the national average score in that our staff were significantly less likely to experience bullying and harassment from colleagues, more likely to feel valued, less likely to have felt pressure to come to work whilst unwell, had a higher staff engagement score and more likely to have had reasonable adjustments made.
- However, there remains a significant difference in the experience of staff with and staff without a long term condition or illness.

7.6 The Workforce Disability Equality Standard (WDES) question scores were as follows:

2020 Score – with an LTC or illness?	2019 Score – with an LTC or illness?	Nat. Ave. – with an LTC or illness?	Survey Question

Yes	No	Yes	No	Yes	No	
55%↔	61.9%	57.6%	61.8%	54.4%	60.2%	Organisation provides equal opportunities for career progression/promotion
32.2%↔	22.4%	31.1%	25%	32.2%	24.7%	Experienced harassment, bullying or abuse from service users, relatives or public in last 12 months
13.4%↔	6.7%	13.3%	8.2%	13.4%	7.1%	Experienced harassment, bullying or abuse from managers in last 12 months
16.6%↔	11.6%	17.8%	12.3%	20.2%	12.3%	Experienced harassment, bullying or abuse from colleagues in last 12 months
57%↓	64.2%	62.6%	57.3%	59.4%	61%	They/colleague reported the harassment, bullying or abuse the last time it was experienced
17%↔	16.4%	17.6%	16.5%	20.8%	14.7%	Felt pressure from manager to come to work when not well enough to perform their duties
47.6%↓	58.8%	51.9%	60.9%	43.6%	51.5%	Satisfied with extent the organisation values their work
83.5%↓	N/A	86.8%	N/A	78.8%	N/A	Employer has made adequate adjustments to enable them to carry out their work
7.1↓	7.4%	7.3	7.5	6.7	7.2	Staff engagement score

8. Conclusions

8.1 Across eight of the nine themes in the staff survey, the Trust's scores were higher than the national average and the same on one theme. Staff engagement was closest to the national best score and our "motivation" score (which is part of the overall staff engagement score) achieved a national best score.

8.2 Of the 104 questions, 26 questions were scored significantly better that the national average (by 3% or more), whilst only three scored worse than the national average (by 3% or more), as follows:

- Experience of violence and aggression from service users
- Having received an appraisal in the last 12 months
- Working additional unpaid hours

8.3 Our WRES and WDES scores remain very similar to 2020, with a difference in staff experience according to long term health condition status and ethnicity enduring. The following points are worth noting:

8.3.1 There was a significant reduction in the experience gap from 21.2% to 15.2% in relation to people having confidence in equality of opportunity in our recruitment and promotion practices. However, this remains the greatest gap in experience between white and BAME staff.

8.3.2 The greatest gap in experience between people with and without a long-term health condition was their feeling of being valued (an 11.2% difference in experience).

8.3.3 None of our scores were significantly worse than the national average scores and five of the nine WDES scores were better than the national average.

8.4 Overall, our results create a strong narrative of a staff team who are:

- Proud to work for HPFT and would recommend us as place to work;
- Proud of the standard of care we provide
- Confident that service users are our top priority
- Highly engaged, motivated and emotionally invested in providing great care to our service users
- Reporting a strong compassionate culture
- Supported and looked after through:
    - Health and wellbeing support
    - Work-life balance and flexible working support
    - Support with their development, including high quality appraisals
    - Feeling confident to raise concerns and have these be heard and addressed

8.5 The unintended negative consequence of having such a highly motivated, passionate and compassionate team of people is that this may be having an adverse impact on their own wellbeing. This may be being compounded by our collective experience of being two years into the Covid-19 pandemic and our high vacancy rate levels. This context means that people reported:

- Working additional unpaid hours,
- Feeling exhausted or burnt out
- That there are not enough staff to do their jobs properly
- That they are unable to meet the conflicting demands of their roles
- They are attending work even when not well enough
- They are more likely to be thinking of leaving than in 2020

Our relatively high levels of violence and aggression, the comparatively lower rates of appraisals and inequity in staff experience on the basis of ethnicity and long-term health condition status may also be exacerbating this context.

8.6 Our recent Quarter Four Pulse Survey scores were also very positive. The key areas identified by the Pulse Survey for particular focus overlap to some degree with the national staff survey results and highlight additional areas, as follows:

- Giving colleagues feedback if they are not demonstrating our values and seeing feedback as positive
- Using feedback from service users, carers or our customers, to learn and make improvements in teams

- Receiving useful and regular feedback from managers
- Feeling safe at work.

9. Next Steps

9.1 An overview of the staff survey results, together with detailed heatmaps of the theme and question level results have been shared with the Senior Leadership Team and SBU management teams. Engagement within SBUs and teams has started to ensure that action plans are co-produced with staff at all levels. We will also look in more detail at any learning from the five mental health and learning disabilities Trusts who had slightly better overall results than HPFT.

9.2 We have also started to share our staff survey results through our staff networks and staffside representatives in order to co-produce a meaningful Trust staff survey action plan. The following are the key areas for us to focus on in relation to the conversations with our people:

- Taking pride in our culture and achievements together
- Reducing violence and aggression
- Inclusion and belonging
- Self-care whilst maintaining passion and compassion for our service users
- Embracing feedback - skilfully giving, receiving and valuing feedback in the context of our values

We will also focus on restoring appraisal compliance as part of our retention work.

9.3 We will finalise and communicate our action plans during Q1 and monitor progress against these to ensure we continue to improve the experience of all our staff at team, SBU and Trust level.

9.4 We will monitor progress against these plans through the Executive Team and the People and Organisational Development Group. We will monitor the impact of our actions through our quarterly pulse surveys and key workforce indicators, including vacancy rates, voluntary turnover and stability rates.

10. Recommendations

10.1 The Board are asked to receive this report.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	27 April 2022	**Agenda Item:** 14
Subject:	Compliance with NHSI's *Code of Governance* Annual Reporting Requirements-Declarations	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	
Presented by:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	

Purpose of the report:

To set out for the Board the Trust's Compliance with NHSI's *Code of Governance* in relation to the *'comply or explain'* disclosures.

Action required:

The Board are asked to note the evidence provided and approve a positive declaration of compliance with the Code of Governance (the Code) as issued by NHSI.

Summary and recommendations to the Board:

Summary

NHSI's *Foundation Trust Code of Governance* operates on a '*comply or explain'* principle and there are also specific disclosure requirements required in the Annual Report as identified in the *FT Annual Reporting Manual 2021-22.*

This paper sets out the provisions of the Code and the source of evidence to support a declaration of compliance within the Annual Report in all cases.

At its meeting on 21 April the Audit Committee reviewed the declaration and recommended it for the Board to approve

Recommendation:

The Board are asked to note the evidence provided and approve a positive declaration of compliance with the Code of Governance as recommended by the Audit Committee.

Relationship with the Business Plan & Assurance Framework (indicate which strategic goal(s) this relates to, for example Communications Strategy - 2.1):

Summary of Implications:

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

N/A

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

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

Audit Committee 21/4/22

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2021/22

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A	**LEADERSHIP**			
A.1.	**The Board of Directors** **Every NHS foundation trust should be headed by an effective board of directors, since the board is collectively responsible for the exercise of the powers and the performance of the NHS foundation trust.**			
A.1.4	The board of directors should ensure that adequate systems and processes are maintained to measure and NHSI the NHS foundations trust's effectiveness, efficiency and economy as well as the quality of its health care delivery.	Performance NHSI KPIS are set by the Trust Board to encompass all aspects of performance relating to achievement of Trust plans and priorities as well as achievement of external targets and standards including quality. Performance reports are reviewed at each of the BoD's public meeting and these are supplemented by relevant reports from external regulatory and compliance bodies such as CQC as appropriate. The Board regularly reviews its performance against regulatory requirements and receives reports from the executive outlining changes to targets/standards/guidance as they arise. Board papers are published on the Trust's website before the meeting. Performance reports are not subject to any exemptions under FOIA. The Integrated Governance and Audit Committees are responsible for testing the adequacy of the system of internal control, however, top ten scoring risks are reviewed at Trust Board level alongside the Board Assurance Framework.	• Board performance reports • Annual Planning process • Quarterly report on performance against Annual Plan • CQUIN reports • Quality Account	✓
A.1.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.	The Trust has in place a performance dashboard where key metrics and milestones are collated and reported via a performance report. Trust Board receives at least quarterly report on performance and performance against the Annual Plan. Performance (quality, finance, workforce, annual plan) is also reported to FIC, IGC and Audit Committee	• Performance Reports • Annual Plan • Minutes of Board • Minutes of Committees	✓
A.1.6	The board of directors should report on its approach to clinical governance.	The Trust has a systematic approach to clinical governance which is focused on the relevant policy guidance and regulatory framework and which is supported by the Trust's Quality Strategy, which was launched in quarter 3. The Trust's clinical governance is led by the Integrated Governance Committee which meets 6 times per year. It also receives operational clinical reports from the Quality & Risk Management Committee (QRMC). This formal assurance meeting is fed by an integrated governance framework, which permeates the organisation and facilitates the achievement of improving clinical standards through the implementation of the quality strategy. The Integrated Governance Committee scrutinises the overall system of clinical governance and the outcomes of a programme of clinical audit as part of its audit plan.	• Clinical Audit reports • Minutes of Quality & Risk Management Committee • Quality Work Plan • Quality Strategy • Quality Account • IGC papers	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A	**LEADERSHIP**			
A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHSI (Monitor) for advising the board of directors and the council of governors and for recording and submitting objections to decisions	The Chief Executive is fully aware of his responsibilities as Accounting Officer and follows the procedure as set out by NHSI and the *NHS Foundation Trust Accounting Officer Memorandum.*	Signed copy of the Annual Governance Statement and procedure within the Annual Report	✓
A.1.8	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behavior in public life.	Included in Board Standing Orders are role descriptions and code of conduct for CoG and Trust Board. Clear and transparent procedures for declaration of interests are in place and all corporate meetings require declarations to be made. The Trust's new Standards of Business Conduct Policy has detailed guidance on Gifts and Hospitality, Commercial Sponsorships, Outside Work and Conflicts of Interests. The Trust's values of: Welcoming, Kind, Positive, Respectful and Professional embrace NHS values and underpin the Trust's strategic objectives and the leadership approach taken by the organisation.	• Annual Fit & Proper Persons' Test • Annual statement of compliance with Fit and Proper Person regulations • Register of Declared Interests for the Board, COG and all decision making staff • Standards of Business Conduct Policy • 'Good to Great' Strategy • Trust Values and Mission • Annual Plan	✓
A.1.9	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	The members of the Board of Directors have signed a code of conduct which is based on the spirit of the Nolan Principles. All minutes of meetings of the Board and key papers are published on the Trust's web site and only those papers which are specifically exempt under the FOIA are kept private.	• Web site – Trust Board Papers • Standards of Business Conduct Policy • Code of Conduct • Register of Declared Interests	✓
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	The Trust currently has NHSLA cover and a top- up commercial policy for Directors & Officers Liability insurance.	D & O Cover policies in place and with NHSLA, Top up Policies	✓
CODE	**CODE PROVISION**	**TRUST POSITION**	**Evidence**	**Comply?**
A.3	**The Chairperson** **The chairperson is responsible for leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.**			
A.3.1	The chairperson should, on appointment by the Council of Governors, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be chairperson of the same NHS foundation trust.	The Chair was appointed 1 January 2021 following agreed robust processes. On appointment, the chair met the independence criteria and had not previously been a chief executive of the Trust. The Chair continues to meet those independence criteria.	• Agreed CoG process for appointment of Chair • CoG's Appointment & Remuneration Committee minutes • CoG minutes • Declaration of Interest	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.4	**Non-Executive Directors** **As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of the board as a unitary board.**			
A.4.1	In consultation with the Council of Governors, the board should appoint one of the independent non- executive directors to be the senior independent Director.	The Council of Governors approved the appointment of SID at a meeting in 2019. The SID regularly attends meetings of the Council of Governors. The CoG's Policy for Engagement with the Board further defines the role of the SID in relation to the CoG escalation process, was approved in September 2017 by CoG.	• Council of Governors minutes/attendance • Constitution • Role description – SID	✓
A.4.2	The chairperson should hold meetings with the non- executive directors without the executives present.	The Chair has met with Non-Executive Directors without the Executives present during 2021-22.	• CoG minutes • NEDs' files and dates of 1:1 with Chair. • NED briefings	✓
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	The Trust values embrace NHS values and underpin the Trust's strategic objectives and the leadership approach taken by the organisation. The role of the Senior Independent Director and Head of Corporate Affairs and Company Secretary in supporting and escalating concerns where appropriate is clearly defined within the Constitution and within the role descriptions. All Board members are encouraged to articulate their views in Board meetings and the minutes clearly and accurately reflect this. In Well Led Review board members reported that members felt able to raise issues and were supported when discussing matters at Board.	• Trust Board Minutes • Raising Concerns policy • Head of Corporate Affairs and Company Secretary • Role of Senior Independent Director	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.5	**Governors** **The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed objectives and the overall strategy of the NHS foundation trust.**			
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.	During 2021-22, the Council of Governors formally met on 4 occasions. The Working Groups of the Council of Governors also met at least six monthly during the year. All business asidentified in the cycle of business (based on the Governors Accountability Framework) was dealt with during the year.	• CoG minutes • Meeting Schedule • Attendance List • Cycle of Business • Annual Report	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.5.2	The council of governors should not be so large as to be unwieldy.	The CoG is deemed to be of sufficient size to discharge its duties and responsibilities and is in line with the size of other local CoGs. The Trust has a membership of just over 8500 and has a complement of 19 public governors, 5 staff governors and seven appointed governors	• Constitution • Minutes of CoG • Membership database • Close monitoring of Governors in post and need for elections	✓
A.5.4	The roles and responsibilities of thecouncil of governors should be set out in a written document.	The Council of Governors have an approved their Terms of Reference. The Role of Governor is included in induction presentations given to new Governors and is included within the Council of Governors' Terms of Reference. The Council of Governors Standing Orders form part of the Trust Constitution.	• Standing Orders for CoG - Constitution • Induction Programme for Governors • ToRs	✓
A.5.5	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other executives and non- executives, as appropriate.	The executive and non-executive directors have an open invitation to attend CoG meetings. The Chief Exec or his appointed Deputy attends all CoG meetings. The Head of Corporate Affairs Company Secretary attends all CoG meetings and NEDs are aligned to and attend sub groups of the CoG.	• CoG Minutes • CoG Groups' minutes • CoG attendance list • Minutes of CoG sub groups	✓
A.5.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance	The Council of Governors approach for Engagement with Board of Directors is in place.	• CoG Minutes • ARC ToR and minutes • Role of SID	✓
A.5.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective.	The CoG has a 12 month rolling cycle of business in place to allow for timely planning and to ensure it discharges its duties and responsibilities. The Annual Plan, Quality and Performance reports/data have been regular standing items on CoG and its sub groups' agendas for 2021/22 in order to keep Governors up to date. The CoG is fully aware of the boundaries between governance and management.	• CoG Agendas • CoG Cycle of Business • CoG attendance list • Sub groups' TORs & Agendas • Training and Induction of Governors' material	✓
A.5.8	The council of governors should exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	The Trust's Constitution along with the Board Standing Orders details the process for removal of the Chairperson or other Non- Executive Directors.	• Constitution • Board and Council of Governors' Standing Orders • ARC ToR	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.5.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example, clinical statistical data and operational data.	The CoG receives the performance, engagement and quality reports at each meeting containing a wealth of qualitative and quantitative data and info. This is the same information as seen by the Board of Directors. There are regular presentations/Q&A sessions Facilitated by various Trust depts/employees and external partners to further enhance Governors knowledge. During 2021-22 these included: • 2020-21 Annual Accounts • Mental Health and Learning Disability Collaborative • Provider Collaborative • Board sub-Committee Chairs • 2021-22 Annual Plan • Quality Priorities	• CoG Agendas • CoG Cycle of Business • CoG minutes • Performance Reports • Quality Reports	✓
CODE	**CODE PROVISION**	**TRUST POSITION**	**Evidence**	**Comply?**
B	**EFFECTIVENESS**			
B.1.	**The Composition of the Board** **The board of directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.**			
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	The constitution sets out the composition of the Board of Directors. There is 1 Non-Executive Chair and 7 other non-executive directors. There are 7 executive directors including the CEO. All the NEDs are deemed to be independent.	• Annual Report • Constitution • Procedure for the appointment / reappointment of NED's • CoG Appointment and Remuneration Committee Minutes • CoG Minutes	✓
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	The constitution prevents an individual holding office as both director and governor at the same time. That situation does not pertain at the Trust.	• Constitution • Standing Orders • Register of Interests	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.2	**Appointments to the Board** **There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be 'fit and proper' to meet the requirements of the general conditions for the provider licence.**			
B.2.1	The Nomination Committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	The CoG's Appointment & Remuneration Committee considers NEDs' appointments and terms & conditions. Upon identification of a vacancy, the skills requirement is considered prior to drafting a job description and recruitment process taking place. The Board's Nominations & Remuneration Committee deals with executive appointments and terms & conditions. Upon identification of a vacancy, the skills requirement is considered prior to drafting a job description and recruitment process taking place.	• Committee ToRs • Committee minutes	✓
B.2.2	Directors on the board of directors and governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged).	The 'fit and proper' persons clause is contained within the Code of Conduct for Governors and the Code of Conduct for the Directors. These are signed and filed with the Director of HR. It is included as a clause within employment contracts and engagement letters for Board members. There is an annual revalidation process in place. All directors and governors are required to sign the Code of Conduct and be subjected to the Fit and Proper Persons' Test.	• Annual revalidation process F&PPT Declaration • Register of Interests • Contracts	✓
B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate.	The Trust has a Board Remuneration Committee for considering executive director appointments and terms & conditions. It considers the succession planning for the Directors at least annually. The CoG has an Appointment & Remuneration committee for considering the appointment and terms & conditions of non-executive directors including the Chair. There is a skills review undertaken and cognisance is taken of it when replacing NEDs or appointing new ones.	• Constitution • Terms of Reference • Minutes from committees • Skills audit of NEDs	✓
B.2.4	The chairperson or an independent non-executive director should chair the Nominations Committee.	The Trust was Chair of the Nominations Committee during 2021/22. The considered approved annually and the Chair will continue to be Chair of the Committee. The Lead Governor chairs the Appointment & Remuneration Committee of the Council of Governors	• Nominations Committee minutes • Attendance register • ToRs	✓
B.2.5	The Governors should agree with the Nominations Committee a clear process for the nomination of a new chairperson and non-executive directors.	The process for appointing other NEDs and Chair is owned by both the ARC and the full CoG.	• Agreed processes • Nom & Rem com minutes • ARC minutes • CoG minutes	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist only of a majority of governors.	The CoG's ARC consists entirely of Governors. The Lead Governor Chairs the ARC. It considers the appointments of NEDs including the Chair. The Trust Chair, CEO, Director of Workforce & OD and the Head of Corporate Affairs and Company Secretary are normally in attendance. The Board Remuneration committee consists entirely of NEDs and considers the appointments of Exec Directors and the Head of Corporate Affairs and Company Secretary.	• ToRs of ARC • Minutes • Remuneration ToRs • Minutes	✓
B.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The ARC recommends to the Council of Governors potential candidates. The Board represented by the Chair, SID and Chief Executive, Director of People & OD provides input into the selection and interview process of NEDs.	• ToR • Agreed process for NED appointments • Committee Papers	✓
B.2.8	The annual report should describe the process followed by the council of governors in relation to appointments of the chairperson and non-executive directors.	No new NEDs or Chair were appointed in2021/22	• Annual Report • Agreed process for Chair appointment • Agreed process for appointment of NEDs	✓
B.2.9	An independent external adviser should not be a member of or have a vote on the Nominations Committee(s).	The Nominations Committee's Terms of Reference allow for an independent advisor to attend meetings when engaged but make it clear that they are not a member of the CoG Nominations Committee and do not have a vote.	• ToRs • Minutes	✓
B.3	**Commitment** **All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.**			
B.3.3	The board of directors should not agree to a full-time executive directors taking on more than one non- executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation.	The Declaration of Interest process requires all Directors to declare their outside interests. The *Standards of Business Conduct* policy deals with outside employment and no outside employment can be sought or engaged in without prior agreement from the Board or relevant line manager.	• Register of Interests • Standards of Business Conduct Policy • Code of Conduct • Trust Constitution	✓
B.5	**Information and Support** **The board of directors and council of governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties**			
B.5.1	The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decision they have to make.	The covering sheets of both Board and CoG give clarity over paper's salient points and the action required during the meeting. Both the BoD and CoG have annual cycles of business to ensure that all key governance information is presented in the appropriate manner at the relevant time. Further in depth information is provided to the Board's statutory and assurance committees.	• Board front Cover • CoG front cover • Cycle of Business	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.5.2	The board of directors and in particular non-executive Directors may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	The Board's Standing Orders and SFIs/SoDA and Committees' ToRs allow for the provision of professional advice where appropriate.	• Board Standing Orders / SFIs/SoD • Committee ToRs	✓
B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	The Constitution and committees' terms of reference provide for external advice to be sought if deemed appropriate by all members.	• Constitution • Terms of Reference	✓
B.5.4	Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of Governors is provided with sufficient resource to undertake its duties with such arrangements agreed in advance.	Allocated Trust secretariat resource supports the Trust Board, its assurance committees and the CoG	• Board/Sub-Committee structure	✓
B.6	**Evaluation**			
B.6.3	The senior independent director should lead the performance evaluation of the chairperson within a framework agreed by the council of governors and taking into account the views of the directors and governors.	The appraisal process for the Chair has been agreed by the CoG's ARC and is led by the SID and Lead Governor. Feedback is sought from both Board peers and Governors.	• Nominations Minutes • Appraisal procedure • CoG Minutes	✓
B.6.4	The chairperson, with the assistance of the Company Secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties.	During 2021-22 Board workshop sessions were held including the following topics: • COVID-19 Pandemic • Inclusion • Strategy Development • New system architecture	• Board workshop Programme and papers • Attendance List • NED Appraisal Reports	✓
B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	The CoG regularly review its functioning.	• CoG minutes • Annual Report	✓
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiability fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Reference is made to the removal from office of a Governor under clause 15 of the Trust Constitution and also within Annex B. The CoG approved a procedure and this is contained within the Governors Handbook.	• Constitution • CoG Minutes • Governors Handbook	✓
B.8	**Resignation of Directors** **The board of directors is responsible for ensuring ongoing compliance by the NHS foundation trust with its license; its constitution; mandatory guidance issued by NHSI; relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board and directors and works with the council of governors to ensure there is appropriate succession planning.**			

B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	There was no agreement outside of those already agreed contractually.	• Minutes of Board Remuneration Committee • Executive Contracts	✓

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
C	**ACCOUNTABILITY**			
C.1	**Financial, quality and operational reporting** **The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.**			
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	The Directors consider a range of risk factors and also receive assurance from the Auditors at year-end and from submissions to NHSI on a monthly and quarterly basis. Audit Committee also consider and make a recommendation to the Board	• Annual Report and Accounts • Auditors' Opinion • NHSI Declaration	✓
C.1.3	At least annually and in a timely manner, the board of directors should set out clearly it's financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	All of this information is disseminated within the Annual Report.	• Annual Report • Board minutes	✓
C.3	**Audit Committee & Auditors** **The board of directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors.**			
C3.1	The board of directors should establish an audit committee composed of at least 3 members who are all independent non-executive directors.	The Audit Committee's Terms of Reference include all Non-Executives as members, one of whom is a qualified accountant by background. The Trust's Chair is not a member of the Committee	• ToRs of Audit Committee • Constitution	✓
C.3.3	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing the external	During 2021/22 the Audit Committee and the CoG reviewed the arrangements for the External Audit contract.	• Minutes of Audit • Committee • Minutes of CoG	✓
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	The External auditors were appointed for a period 3 years, plus one year prior to the final one year extension.	• Constitution • CoG Handbook • Minutes of Audit Committee • ARC minutes	✓
C.3.7	When the council of governors ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHSI informing it of the reasons behind the decision.	Council of Governors supported recommendation from the Audit Committee to extend the external audit contract for one year. It was noted a procurement exercise would be undertaken in 2022 for a new external audit contract.	• Audit Committee notes • CoG Notes	✓

C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	The Freedom to Speak Up Lead makes independent reports to the Integrated Governance Committee and then through the Committee to the Board. This year the Trust put in place a full time Freedom to Speak up lead and recruited Freedom to Speak Up Champions	• Freedom to Speak Up policy • IGC reports • Board reports	✓
CODE	**CODE PROVISION**	**TRUST POSITION**	**Evidence**	**Comply?**
D	**REMUNERATION**			
D.1	**The level and components of remuneration** **Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead an NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.**			
D.1.1	Any performance related elements of the remuneration of executive directors should be designed to align their interest with those of patients, service users and taxpayers to give these directors keen incentives to perform at the highest levels.	No element of Executive Directors pay is performance related.	• Remuneration Committee minutes • Contracts	✓
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	The levels of remuneration are in line with other local Trusts and agreed by the CoG	• CoG Nomination Committee minutes • CoG minutes	✓
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors terms of appointments would give rise to in the event of early termination.	The current employment contracts for Directors do not allow compensation to be reduced to reflect a departing director's obligation to mitigate loss or appropriate claw-back provisions in case of a director returning to the NHS within the period of any putative notice.	• Remuneration Committee minutes	✓
D.2	**Procedure** **There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration.**			
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for executive directors, including pension rights and any compensation payments.	The Board has delegated responsibility for setting executive directors remuneration including compensation payments and pension rights through the Remuneration Committee. This is reflected in the Committee's Terms of Reference and Scheme of Delegation	• Remuneration Committee ToRs	✓
D.2.3	The council of governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non- executive.	The remuneration levels of the chair and non-executive directors are in line with other comparable Trusts, however, the Council of Governors via the ARC would consult with professional advisors should any material change be considered.	• ARC minutes	✓
E	**RELATIONS WITH STAKEHOLDERS**			
E.1	**Dialogue with members, patients and the local community**			
E.1.2	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums	During the year 2021/22 the Trust had an Engagement Strategy in place. Service Users had several forums for giving feedback.	• Engagement Strategy • Terms of Reference	✓

E.1.3	The chairperson should ensure that the view of governors and members are communicated to the board as a whole.	The Chair of the Trust Board is also the Chair of CoG and is a great conduit for information flow between the Board and the Governors. All Non-Execs have an open invitation to attend formal open Governor meetings in order to develop an understanding of Governors' concerns. The Chair summarises the affairs of the Trust during their opening welcome at Governors meetings and presents a Key Issues Report to Board following CoG meetings.	• CoG Attendance List • CoG Minutes • Board minutes • Role of the Chair	✓
CODE	**TRUST POSITION**	**Evidence**	**Comply?**	
E.2	**Co-operation with third parties with roles in relation to NHS foundation trusts** **The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.**			
E.2.1	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.	The Board has built relations with 3rd party bodies with which it has a duty to co-operate e.g. NHSI; CQC. Members of the Board and senior leadership are the nominated contacts for these organisations. Copies of all key documents e.g. Provider License, Constitution are shared with members of the Board to ensure they are up to date with latestlegislation requirements.	• Key legal documents	✓
E.2.2	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	During the year 2021-22 the Trust had an Engagement approach in place which not only identified key stakeholders but also the level of engagement required and by whom e.g. service users; staff; commissioners.	• Stakeholder Engagement Strategy • Independent Well Led Review	✓

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	27 April 2022	**Agenda Item:** 13
Subject:	Report of the Audit Committee: 21 April 2022	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Helen Edmondson, Head of Corporate Affairs & Company Secretary
Presented by:	David Atkinson, Non-Executive Director	

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 21 April 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.

The Committee ask the Board to note that it approved the following:

- Internal Audit Plan for 22/23
- Counter Fraud Plan for 22/23
- Fraud Risk Register

The Committee recommended for Board approval when it consider the accounts:

- Losses and Special Payments
- Provision of Irrecoverable Debts

The Committee recommended for Board approval at its meeting on 27 April 2022:

- NHSI Compliance Declaration
- Scheme of Reservation and Delegation

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 21 April 2022 in accordance with its terms of reference and was quorate.

2. Deep Dive – Draft Annual Accounts 2021/22

The Committee received a comprehensive presentation that built on previous information provided to Finance and Investment Committee and the Audit Committee on the draft Annual Accounts for 21/22. The Committee was updated with regard to the financial framework in place for 21/22. The Committee was updated on the revised control total for the Trust, which would see the Trust reporting a breakeven position. It was noted that there were had been adjustments right up to year end due to the fluid external situation and changes in income being received by the Trust.

The Committee was taken through the revised position with regard to provisions, deferred income and accruals. It was noted that the Trust had a strong cash position. The Committee heard it had been a strong year for the Trust which would provide a strong opening position for 2022/23. There has also been good progress with the capital programme. The Committee discussed the provisions and the movement from the previous year and the identified risks

Committee members welcomed the detail presentation. It was noted that a 'page turn' of the accounts for Non-Executive Directors was scheduled prior to the Board meeting due to sign off the Accounts. The Chair of the Committee passed on appreciation to the finance team for work undertaken throughout the year.

3. Internal Audit

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 three audit reports had been finalised since the last Audit Committee, all of which had a positive opinion. The Committee noted the positive opinions and in particular the substantial assurance achieved for Risk Management and Board Assurance Framework audit. Also that Cyber security had been a positive opinion.

It was noted that the DSPT audit remained in draft and would be finalised by year end. It was agreed for a update on mitigation of risk of legacy unsupported systems would be provided to a future Committee.

3.2 Annual Report including Draft Head of Internal Audit Opinion

RSM presented the draft Annual Report. Liz Wright stated that the fact that the Trust had been able to complete a full internal audit programme was a positive indication of its resilience and enabled the production of the Internal Audit Annual Report. The Annual Report detailed a 'golden thread' of the Trust's general system of internal control being sound, with secondary controls also in place. Liz Wright reported that the opinion in the draft report was noted as positive. It was noted that this report would remain in draft until the audit of accounts had been completed.

The Committee chair thanked RSM and added her recognition that the completion of the internal audit plan with the positive opinions was an achievement for the Trust teams.

3.3 Internal Audit Plan for 2022/23

The Committee considered and approved the draft Internal Audit Plan for 2022/23 internal audit plan. It was noted that the plan had been informed by the discussion at the Committee on 10 February 2022. It is based on the Trust's strategic objectives and risk areas. It was noted that the plan remains flexible and 'agile' in response to the Trust's needs. It was noted that some of the areas identified at the last meeting would be part of the Trust clinical audit programme and also the internal audit programme for 23/24.

4. Counter Fraud

4.1 Counter Fraud Progress Report

The Committee received a report that provided an update in respect of counter fraud work undertaken at the Trust from February 2021 to 31 March 2022. The Committee were updated on the completed proactive work in relation to procurement and collation of data for submission for the Counter Fraud Functional Standards Return (CFFSR). It was noted that good progress had been made with the proactive work in the plan and there had been two new referrals received and two cases closed.

The Committee noted the positive position of the Trust with regard to the Gifts and Hospitality benchmarking report.

It was noted that the Fraud Risk Register was now in place at the Trust and was reported later on the agenda.

4.2 Counter Fraud Plan for 2022/23

The Committee considered and approved the draft Counter Fraud Plan for 2022/23. It was noted that the plan had been informed by the discussion at the Committee on 10 February 2022. It is based on the Trust's strategic objectives and risk areas. The Committee welcomed that the Plan was align with the Internal Audit Plan.

5. External Audit

5.1 External Audit Progress Report

The Committee received the External Audit progress report for 2021/22. It was noted that KPMG had completed their interim audit work and no significant findings had been identified and that they would be starting their final audit work after the draft accounts had been submitted on 26 April 2022. It was noted that external audit had been working with the finance team to consider and agree approach with regard to the judgmental aspects of the accounts.

5.2 Draft Value of Money Report 2021/22

KPMG reported that for 21/22 the requirement for an enhanced Value for Money report was still in place. The Committee received the draft report noting that more work was required to complete the review with regard to the Governance, to better understand the risk identified linked with CQC report on Forest House Adolescent Unit. It was noted that for Fiancial sustainabiltiy and Improving economy, efficency and effectivenss there had been no significant risks identified.

It was noted that the final report would be considered by the Committee at its meeting on 9 June 2022.

6. End of Year

The Committee considered a number of items to support the end of year process:

6.1 Use of Waivers

The Audit Committee noted a report detailing the waivers for 21/22 including quarter 4. It was noted that during the period 1 April 2021 and 31 March 2022 there had been 38 waivers with a total of £2,407k, an increase on the previous year. The higher value is driven by two large value waivers in Quarters 1 and 2, one where insufficient tenders were returned for the second insufficient tenders were returned, in part, due to the specialist nature of these products.

The report set out there were 17 waivers for quarter four. The Committee noted the value and reasons for the waivers, noting that the majority related to the capital programme and need for specialists.

6.2 Losses and Special Payments

The Committee considered and approved the signing off of the losses and special payments for the period 1 April 2021 to 31 March 2022. It was noted that the report would be updated to include a payment made in March.

6.3 Provision for Irrecoverable Debt

The Committee considered and approved the signing off of the writing off irrecoverable debt for the year 1 April 2021 – 31 March 2022, noting it would be recommended to the Board. The Committee approved a net decrease to the provision for irrecoverable debts. The Committee discussed the decrease was due to SRS services. The Committee supported the approach noting it was prudent in the circumstances.

6.4 Going Concern

The Committee received a report that detailed the requirements for NHS bodies to consider the application of going concern to its Annual Accounts. Namely that Trusts still need to document their basis for adopting the going concern position and that this assessment should solely be based on the anticipated future provision of services in the public sector. It was noted that when this is applied it is highly unlikely that NHS organisations would have any material uncertainties over its going concern disclosure in the future.

It was agreed that the Trust would continue to consider all factors with regard to Going Concern statement regardless of new requirements.

6.5 Draft Annual Governance Statement 2020/21

The draft Annual Governance Statement was reviewed, noting it was in line the Annual Reporting Manual. The Committee noted that is a key part of the Trust's Annual Report and the statement serves an important purpose, in giving the Trust the opportunity to reflect and report publicly on the extent to which it complies with its own code of governance. It should include how the organisation has monitored and evaluated the effectiveness of governance arrangements in the year, and any planned changes in the coming period.

It was noted in line with the Head of Internal Audit Opinion the draft statement concludes that there are no significant issues to be raised.

It was noted that the Annual Governance statement would be considered by the Integrated Governance Committee prior to being recommended to the Board as part of the Annual Report and that any comments would be gratefully received.

6.6 Use of Seal: Quarter Four

The Committee noted report detailing the use of seal during the fourth quarter of 2021/22.

7. NHSI Compliance Statement

Audit Committee received the NHSI Compliance Statement and noted the evidence provided. It was noted that the NHSI's *Foundation Trust Code of Governance* operates on a '*comply or explain'* principle and that there are also specific disclosure requirements required in the Annual Report as identified in the *FT Annual Reporting Manual.*

Audit Committee reviewed and approved the statement recommended for approval by the Board.

8. Scheme of Reservation and Delegation (SoRD)

The Committee considered and approved the revised SoRD. It was noted that the revised SoRD has been based on an example of best practice from other NHS organisations and has been updated to reflect the Trust's financial limits and systems of internal control.

RSM confirmed that the revised version had been informally shared with them and they had fedback that the revised version is in line with what would expect to see if a Foundation Trust's SoRD.

Audit Committee reviewed and approved the revised Scheme of Reservations and Delegation recommended for approval by the Board.

9. Items Noted

9.1 Trust Risk Register and Board Assurance Framework

The Committee received the latest version of Trust Risk Register (TRR) and Board Assurance Framework, noting that they had reviewed by the Integrated Governance Committee and approved by the Board.

9.2 Fraud Risk Register

The Committee received and approved the specific Fraud Risk Register in place for the Trust. It was noted that the register has 14 risks. It was noted that the Fraud Risk Register will be reviewed and updated on a six monthly basis and reported to the Audit Committee on the same basis.

9.3 Update on Annual Report, Annual Accounts and Quality Account 2021/22

The Committee to noted the Trust's approach and timetable for the preparation for Annual Report, Annual Accounts and Quality Account for 2021/22, following publication of the NHS Foundation Trust Annual Reporting Manual (ARM).

9.4 Annual Report from FIC
The Annual Report was noted

9.5 Notes of Finance and Investment Committee – 18 January 2022
Notes of the meeting were noted

9.6 Annual Report from Integrated Governance Committee
Annual Report was noted

9.7 Notes of Integrated Governance Committee – 20 January 2022
Notes of the meeting were noted

9.8 Audit Committee Annual Report
Catherine Dugmore presented the Annual Report as draft asking for any feedback prior to it being presented to the Board in June 2022.

9.9 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.

9.10 Improving Cyber Resilience
The Committee received an update on the assurance provided by the Trust to NHS England & Digital that appropriate measures were in place to maintain service provision in the event of a major cyberattack or infrastructure outage, which may happen as a result of the deteriorating situation in the Ukraine.

9.11 Committee Forward Planner 2022
The rolling forward planner was noted. It was noted that the next meeting will focus end of year.

10. Matters of Escalation

The Committee ask the Board to note that it approved the following:

- Internal Audit Plan for 22/23
- Counter Fraud Plan for 22/23
- Fraud Risk Register

The Committee recommended for Board approval when it consider the accounts:

- Losses and Special Payments
- Provision of Irrecoverable Debts

The Committee recommended for Board approval at its meeting on 27 April 2022:

- NHSI Compliance Declaration
- Scheme of Reservation and Delegation

PUBLIC Board of Directors

Meeting Date:	27 April 2022	**Agenda Item:** 14
Subject:	Annual Report of the Audit Committee 2020/21	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Presented by:	David Atkinson, Non-Executive Director	

Purpose of the report:

This report outlines how the Audit Committee has complied during the financial year 2021/22 with the duties delegated to it by the Trust Board through the Committee's terms of reference.

Action required:

To:

- Review the content of the report
- Confirm that the report provides a balanced summary of the work of the committee during the year

Summary and recommendations to the Audit Committee:

During 2021/22 the Audit Committee considered a wide range of issues. As well as its compliance requirements it sought assurance with regard to risk areas for the Trust, identified through review of the BAF and Trust risk register.

The Board are asked to RECEIVE the report.

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

Provides evidence robust governance and of a well-led organisation

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

Audit Committee 21/4/22

Annual Report of the Audit Committee for the Financial Year 2021/22

1. Introduction

This report outlines how the Audit Committee has complied during the financial year 2021/22 with the duties delegated to it by the Trust Board through the Committee's terms of reference.

2. Constitution

2.1 During 2021/22 Catherine Dugmore continued as a Non-Executive Director and Chair of the Audit Committee.

2.2 In February 2022 the Terms of Reference were reviewed and updated and approved by the Board in March 2022.

2.3 Other executive directors and senior managers of the Trust were invited to attend particular meetings to address key issues as they arose and provide deep dives. In addition, the Internal and External Auditors were invited to attend all meetings along with the Local Counter Fraud Specialists. A schedule of attendance at the meetings is provided in appendix 1. This demonstrates full compliance with the quorate requirements and regular attendance by those invited by the Committee.

2.4 Five meetings per annum are required and in 2021/22 six meetings were held. The Committee has an annual work plan with meetings timed to consider and act on regular and special items within that plan. This year an additional meeting was added to the schedule in July 2021. The concentrated on providing dedicated time for detailed discussion is key areas for the Trust and was welcomed as a helpful addition by Internal Audit.

2.6 The Committee Chair takes formal report to each relevant Board meeting detailing the work undertaken by the Committee and draws the attention of the Board to any significant matters.

3. Achievements

3.1 In discharging its duties, the Committee has met its responsibilities through its achievements in the following areas:

3.2 Assessment

During the year the Committee has complied with 'good practice' through:-

- Reviewing and updating the Committee's terms of reference.
- Conducting private discussions with both sets of auditors.
- Agreeing an annual work programme for 2021/22.

An annual review of effectiveness was carried out in December 2021, and feedback reported to the Committee in February 2022. The self-assessment provided a positive view of the work of the Committee and was an improvement on the previous year. It did also identify a small number of areas for improvement, which centred on appropriate induction for new Non Executive members and consideration that at the

end of each meeting agreement which items need to be escalated to the Board and clarify the approach with regard to briefing Committee members on material matters in between meetings.

The Committee led the process to procure internal audit and counter fraud services via a new contract. The Committee undertook an assessment of the effectiveness of the External Audit services and following this made a recommendation to the Council of Governors to extend the contract with KPMG for external audit services for one year. It was noted that a procurement exercise for a new external audit contract would take place in 2022.

3.3 Internal Processes

During this period no changes were made to the Trust's corporate governance arrangements.

In accordance with the Committee's authority, in addition to the Executive Director of Finance, the Executive Director for Quality and Safety/Executive Director of Quality & Medical Leadership and the Company Secretary, other executive directors and Senior Managers of the Trust were called to attend the Committee where appropriate, particularly to provide updates regarding progress on implementation of recommendations following audit and other assurance reports and reviews.

The Audit Committee also received regular updates from management in relation to the financial position and in particular key risks and issues arising during the year, and their treatment and mitigation. During the year the key risks and issues considered were:

People: in particular the Trust's work to improve the levels of retention but also improve the recruitment experience. The Committee considered the wellbeing offer to staff and projects underway to transform workforce roles.

Digital: This included details of the systems in place to manage Cyber Security and Fraud were considered. As well as the wider digital programme underway at the Trust

Changing Financial Planning Regime: The increasing role of ICS in terms resource allocation and introduction of 'System First' for financial planning.

3.9 Accounting issues – Maria Wheeler, Executive Director of Finance presented key areas of management judgement in the preparation of the annual financial statements with particular reference to:-

- The changes to financial planning guidance in the year.
- Level and nature of provisions
- Deferred income levels
- Estates valuation
- Use of Waivers
- Preparation for IFRS16

For each area the approach being taken by management was set out and discussed and agreed by the committee.

3.10 Following receipt of reports from both Internal and External Auditors, the Committee sought clarification of the issues and recommendations raised, reviewed and assessed

management responses, and followed up previous recommendations. The Internal Auditors continued to present a regular exception report in respect of those fundamental and significant Internal Audit and Local Counter Fraud recommendations that have not been implemented by management within the agreed timescales.

3.11 To contribute to the principles of integrated governance and support Audit Committee in its role in assuring the Board with regard to the Trust having robust governance systems, the Committee received reports from the Non-Executive Chairs and the minutes of the Integrated Governance Committee, Finance and Investment. In addition, the Chair and two members of the Audit Committee attend FIC meetings and two Committee members attend IGC meetings.

3.12 The Committee reviews, at least six monthly the Board Assurance Framework and the Trust Risk Register.

3.13 Annual Reports

The following documents in respect of the 2020/21 financial year were presented in June 2021 for the Committee's approval:

- The Financial Statements covering the year ended 31 March 2020.
- The Annual Governance Statement.
- The Record of Losses and Compensation Payments.
- The Record of the Use of the Corporate Seal.
- The Record of the Use of Waivers.
- The Treasury Management Report

The Charitable Fund accounts and annual report for 2020/21 were presented by the Executive Director of Finance in December 2021 for the Committee's approval and were recommended to the Board for approval.

The Committee approved the following reports presented by the Executive Director of Finance for recommendation to the Board:

- The application of the Going Concern assumption
- The review of Accounting Policies

In April 2021 the Committee approved the position with regard to Provision for Irrecoverable Debts and the loses and compensations register 2020/21.

3.14 Independent Audit and Assurance

External Audit

The primary duty of the External Auditors is to audit the annual financial statements of the Trust. An unqualified audit opinion on the financial statements for the year ended 31 March 2021 was given to the Trust in June 2021.

The Committee approves the External Audit Plan in advance of the work commencing and receives regular updates on the progress of work. In addition, the Committee received, reviewed and noted the following reports in respect of 2020/21:

- Annual Audit Governance Report.
- Annual Audit Letter to Governors.

In February 2022, the Committee received an update from External Audit with regard to the forthcoming audit of financial accounts for 2021/22.

Internal Audit
The Internal Audit service is provided by RSM, a private sector professional services firm. Their primary duty is the provision of an independent and objective opinion to the Chief Executive as Accounting Officer, the Board and the Audit Committee on the degree to which risk management, internal control and governance support the achievement of the Trust's agreed objectives.

The Committee approves the content of the Internal Audit Plan. This plan is structured to facilitate the provision of the annual Head of Internal Audit Opinion, which gives an assessment of:

- the design and operation of the underpinning Assurance Framework and supporting processes;
- the range of individual opinions arising from risk-based audit assignments, contained within the Internal Audit Plan, that have been reported on throughout the year; and
- the process by which the Trust has arrived at its declaration for the Annual Governance Statement.

The Internal Audit Annual Report for 2020/21 was presented to the Committee in June 2021. This report included the Head of Internal Audit Opinion (HIAO) which stated that *'The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective'.*

During the course of the year, the Committee ensured that it received regular progress reports, including findings and recommendations, on the delivery of the Plan for 2021/22 and on the implementation of recommendations.

In February 2021, the Committee considered an outline Internal Audit Plan for the forthcoming financial year 2022/23 and requested that final version be considered at meeting in April 2022. The plan was kept under regular review at meetings to ensure it remained flexible to any emerging priorities for the Trust.

Counter Fraud
As with the Internal Audit service, the Local Counter Fraud service is provided by RSM. The Committee approves the Counter Fraud Plan in advance of the work commencing.

In February 2022, the Committee considered the outline Local Counter Fraud Plan for the forthcoming financial year 2021/22 and requested that final version be considered at meeting in April 2022. The Committee ensured that during the year it received regular updates on the delivery of the 2021/22 Plan, including work on the prevention and detection of fraud a number of specific investigations were conducted during that year.

The plan was kept under regular review at meetings to ensure it remained flexible to any emerging priorities for the Trust.

4 Training and Development

During the year members of the Committee undertook appropriate mandatory training. They also received a number of deep dives on particular topics identified following review of the risk registers and audit reports.

Committee members also received regular briefing documents from internal and external audit keeping them abreast of regulatory updates and issues.

5 Committee Developments

Specific issues which the Committee will address in the financial year 2022/23 include:

- Monitoring Trust's progress in respect of workforce and staffing issues identified through the internal audits
- Considering key challenges as a result of post COVID financial planning regime.
- Monitoring the work of both the IGC and FIC to seek reassurance that the issues of service quality / patient safety, operational performance and financial sustainability are being addressed in a balanced way.
- Controls and assurances in place with regard to contracts the Trust has with shared services and other service providers e.g payroll.

Appendix 1

	April 2021	June 2021	July 2021	September 2021	December 2021	February 2022
Catherine Dugmore (Chair)	✓	✓	✓	✓	✓	✓
David Atkinson	✓	✓	✓	✓	✓	✓
Tim Bryson	A	✓	✓	✓	✓	✓
Patrick Vernon	✓	✓	A	A	A	✓
Kush Kanodia	✓	✓	A	A	A	✓
Jon Walmsley	A	✓	✓	A	A	✓
Company Secretary						
Helen Edmondson	✓	✓	✓	✓	✓	✓
Keith Loveman	✓	✓	N/A	N/A	N/A	N/A
Tom Cahill	N/A	✓	N/A	N/A	N/A	N/A
Karen Taylor	A	✓	A	N/A	N/A	N/A
Ann Corbyn	A	N/A	N/A	N/A	N/A	N/A
Dr Jane Padmore	A	✓	✓	N/A	N/A	N/A
Dr Asif Zia	✓	A	A	✓	✓	✓
Paul Ronald	✓	✓	✓	✓	A	✓
Sandra Brookes	A	✓	A	A	A	A
Jacky Vincent	N/A	N/A	✓	✓	✓	✓
Janet Lynch	N/A	N/A	N/A	✓	✓	✓
Maria Wheeler	N/A	✓	✓	✓	✓	✓
Hakan Akozek	N/A	✓	✓	✓	✓	A
Dean Gibbs (KPMG)	✓	✓	✓	A	✓	A
Jessica Hargreaves (KPMG)	A	A	A	✓	✓	✓
Elizabeth Wright (RSM)	✓	✓	✓	✓	✓	✓
Shalani Ghandi (RSM)	A	✓	✓	A	✓	A
Sam Abbas (RSM)	✓	✓				
Ant Upton (RSM)	✓				✓	
Andrea Duggan (RSM)			✓			
Erin Sims (RSM)					✓	

Quorum: Two members (Non-Executive Directors) including one member from Finance and Investment Committee and Integrated Governance Committee.

Notes:

1. As Chief Executive, Tom Cahill attended the June meeting which deals with the Annual Accounts, Quality Accounts and the Annual Governance Statement.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	27 April 2022	**Agenda Item:** 15
Subject:	Integrated Governance Committee – Annual Report 2021/22	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Diane Herbert, Non-Executive Director Chair – Integrated Governance Committee
Presented by:	Diane Herbert, Non-Executive Director Chair – Integrated Governance Committee	

Purpose of the report:

This paper provides the annual report from the Integrated Governance Committee for 2021/22.

Action required:

To:

- Review the content of the report
- Confirm that the report provides a balanced summary of the work of the committee during the year.

Summary and recommendations:

During 2021/22 the Integrated Governance Committee considered a wide range of issues. As well as its compliance requirements it sought assurance with regard to risk areas for the Trust, identified through review of the BAF and Trust risk register.

The Board are requested to receive the report.

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

Controls & Assurance – reporting key matters considered by the Integrated Governance Committee to the Trust Board.

Summary of Financial, IT, Staffing & Legal Implications:

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

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

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

The Trust Board has received a report following each Integrated Governance Committee.
Audit Committee 21 April 2022

Annual Report of the Integrated Governance Committee for the Financial Year 2021/22

1. Introduction

1.1 This report outlines how the Integrated Governance Committee (IGC) has complied during the financial year 2021/22 with the duties delegated to it by the Trust Board through the Committee's terms of reference.

2. IGC Constitution.

2.1 Diane Herbert, Non-Executive Director continued as Chair of the Committee.

3.2 During this period the IGC met a total six times, on: 13 May, 15 July; 16 September; 11 November, 20 January 2022 and 17 March 2022.

3.3 In January 2022 the Terms of Reference of the IGC were reviewed and updated for approval by the Board.

3.4 Other executive directors and senior managers of the Trust were invited to attend particular meetings to address key issues as they arose and provide deep dives. A schedule of attendance at the meetings is provided in appendix 1. This demonstrates full compliance with the quorate requirements and regular attendance by those invited by the Committee.

3.5 The Committee has an annual work plan with meetings timed to consider and act on regular and special items within that plan.

3. Achievements-

4.1 In discharging its duties, the Committee has met its responsibilities through its achievements in the following areas:

4.2 Assessment

During the year the Committee has complied with 'good practice' through:-

- Reviewing and updating the Committee's terms of reference.
- Undertaking deep dives
- Agreeing an annual work programme for 2021/22.

An annual review of effectiveness was carried out in November 2021, and feedback reported to the Committee in January 2022. The self-assessment provided a positive view of the work of the Committee, and an improvement on the previous year. It did also identify a small number of areas for improvement, which centred on: volume and appropriate use of summary papers and the considering how learning from incidents and plans for service user experience are strengthened.

4.3 Internal Processes

In accordance with the Committee's authority, in addition to the Executive Director of Finance, the Executive Director for Quality and Safety/Executive Director of Quality &

Medical Leadership and the Company Secretary, other executive directors and Senior Managers of the Trust were called to attend the Committee where appropriate, particularly to provide updates regarding progress on implementation of recommendations following audit and other assurance reports and reviews.

The IGC also received regular updates from management in relation to the quality and people, in particular key risks and issues arising during the year, and their treatment and mitigation and strategic developments. The IGC provided assurance to the Board with regard to quality, information governance, people, governance - including risk management. During the year the key risks and issues considered were:

People: The Committee received regular reports on the Trust's plans to recruit, retain, support staff wellbeing and improve their experience at the Trust. The Committee also monitored the Trust's safe staffing process and guardian of guardian of safe working reports. It also assured itself with regard to key workforce metrics and discussed actions in place to improve the position. The Committee also considered the national staff survey action plan and results from the 2021 survey. It also received a deep dive into Freedom to Speak Up and agreed that each meeting would receive a report on this area. The Committee also received a deep dive into the systems and processes in place to manage the rotas of the nursing team.

Quality – Safety: As the key assurance committee for Trust with regard to quality it considered and discussed regular reports on infection prevention and control, incidents and health and safety. The Committee considered the progress with the MOSStogehter strategy.

Quality – Effectiveness: The Committee considered regular reports on the CQI, and clinical audit programmes. Also during this period it considered the work of CPAC. The Committee was also updated with regard to CQUIN and latest position with regard to accreditation of services. It considered a deep dive into suspected suicides.

Quality – Experience: The Committee continued to receive quarterly experience report, which detailed all aspect of feedback on experience including complaints and FFT. The Committee also approved the new Complaints policy following considered at the Trust Councils. The Committee also considered the work underway to reduce the number of unlawful detentions and to better understand the impact of services users from a BAME background.

Risk: In line with its responsibilities the Committee regularly considered the updated Risk Register and Board Assurance Framework, providing feedback and noting the assurance they provided.

COVID-19 Pandemic: The Committee had a key role in reviewing the Trust's approach to the management of incident, in particular with regard to infection prevention and control, implementation of guidance for PPE and support for staff wellbeing.

CQC: During this time the CQC undertook unannounced visits to two services in the Trust and the Committee considered the reports and the actions taken to make improvements to services. paused their routine visit schedule the Committee received reports on the Transitional Monitoring Arrangements process that the Trust underwent. Towards the end of the year the Committee noted that Trust would be

participating in a Provider Collaborative Review by CQC of Learning Disability services in Essex.

All items that required it were escalated to the Board for discussion and approval in line with Scheme of Delegation and Standing Financial Instructions.

4. Training and Development

During the year members of the Committee undertook appropriate mandatory training.

5. Committee Developments

Specific issues which the Committee will consider in the financial year 2021/22 include:

- People, feedback from the staff survey. Ensuring delivery of improvement in workforce metrics.
- Continued focus on feedback from regulatory reviews including CQC.
- Trust's continued management of COVID -19 pandemic.
- Freedom to Speak Up, including the Board assessment.
- Continued focus on all aspect of quality, providing assurance to the Board and escalating as necessary.

Appendix 1

Cttee Member	13 May	15 July	16 Sept	11 Nov	20 Jan 22	17 Mar
Diane Herbert (Chair)	✓	✓	✓	✓	✓	✓
Anne Barnard	✓	✓	✓	✓	✓	**A**
Tim Bryson	✓	✓	✓	✓	✓	✓
Jon Walmsley	✓	✓	✓	✓	✓	✓
Patrick Vernon	**A**	✓	**A**	**A**	✓	**NA**
Kush Kanodia	✓	**A**	✓	**A**	✓	✓
Keith Loveman	✓	**NA**	**NA**	**NA**	**NA**	**NA**
Dr Jane Padmore	✓	✓	**NA**	**NA**	**NA**	**NA**
Ann Corbyn	**A**	**NA**	**NA**	**NA**	**NA**	**NA**
Sandra Brookes	✓	✓	✓	✓	✓	**A**
Karen Taylor	✓	**A**	✓	**A**	**NA**	**NA**
Asif Zia	**A**	✓	**A**	✓	**A**	✓
Janet Lynch	**NA**	✓	**A**	✓	✓	**A**
Maria Wheeler	**NA**	**A**	✓	✓	✓	✓
Jacky Vincent	✓	**A**	✓	✓	✓	✓
Helen Edmondson	✓	✓	✓	✓	✓	✓
Kaushik Mukhopadhaya	✓	**A**	**A**	✓	**NA**	**NA**
Mike Walker	**A**	**A**	**A**	**A**	**NA**	**NA**
Shahid Shabbir	**NA**	**NA**	**NA**	**NA**	✓	✓

Quorum: A quorum shall be five members including at least two Executive Director and two Non-Executive Director plus the Chair or a NED acting for the Chair in their absence.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	27 April 2022	**Agenda Item:** 16
Subject:	Finance & Investment Committee – Annual Report 2021/22	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** David Atkinson, Non-Executive Director Chair, Finance & Investment Committee
Presented by:	David Atkinson, Non-Executive Director Chair – Finance & Investment Committee	

Purpose of the report:

This paper provides the Board with the annual report from the Finance and Investment Committee for 2021/22.

Action required:

To:

- Review the content of the report
- Confirm that the report provides a balanced summary of the work of the committee during the year.

Summary and recommendations:

Summary

During 2021/22 the Finance and Investment Committee considered a wide range of issues. As well as its compliance requirements it sought assurance with regard to risk areas for the Trust, identified through review of the BAF and Trust risk register.

The Board are asked to RECEIVE the 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

The Trust Board has received a report following each Finance and Investment Committee.
Audit Committee 21 April 2022

Annual Report of the Finance and Investment Committee for the Financial Year 2021/22

1. Introduction

1.1 This report outlines how the Finance and Investment Committee (FIC) has complied during the financial year 2021/22 with the duties delegated to it by the Trust Board through the Committee's terms of reference.

2. FIC Constitution.

2.1 During 2021/22 David Atkinson continued as a Non-Executive Director and Chair of the Finance and Investment Committee.

3.2 During this period the FIC met a total of seven times, on: 10 May; 21 July; 16 August (Extraordinary); 22 September; 17 November, 18 January 2022 and 22 March 2022.

3.3 In January 2022 the Terms of Reference of the FIC were reviewed, updated and approved by the Board.

3.4 Other executive directors and senior managers of the Trust were invited to attend particular meetings to address key issues as they arose and provide deep dives. A schedule of attendance at the meetings is provided in appendix 1. This demonstrates full compliance with the quorate requirements and regular attendance by those invited by the Committee.

3.5 The Committee has an annual work plan with meetings timed to consider and act on regular and special items within that plan.

3. Achievements

4.1 In discharging its duties, the Committee has met its responsibilities through its achievements in the following areas:

4.2 Assessment

During the year the Committee has complied with 'good practice' through:-

- Reviewing and updating the Committee's terms of reference.
- Undertaking deep dives
- Agreeing an annual work programme for 2021/22.

An annual review of effectiveness was carried out in November 2021, and feedback reported to the Committee in January 2022. The self-assessment provided a positive view of the work of the Committee, and an improvement on the previous year. It did also identify a small number of areas for improvement: need to clarify the role of the Committee with regard to the Trust's investment strategy and policy and ensure work to improve content of reports continues.

4.3 Internal Processes

In accordance with the Committee's authority, in addition to the Executive Director of Finance, the Executive Director for Quality and Safety/Executive Director of Quality &

Medical Leadership and the Company Secretary, other executive directors and Senior Managers of the Trust were called to attend the Committee where appropriate, particularly to provide updates regarding progress on implementation of recommendations following audit and other assurance reports and reviews.

The FIC also received regular updates from management in relation to the financial position and in particular key risks and issues arising during the year, and their treatment and mitigation and strategic developments. The Committee provided assurance to the Board with regard to the areas under its responsibility.

In particular during the year the key risks and issues considered were:

Specific Deep Dives: The Committee received four of deep dives. At the July meeting members of staff presented on how the Model of Improvement had been used to support service transformation. In September the Committee were updated on the financial planning guidance for H2 and the anticipated impact on the Trust. Other Deep Dives covered the Delivering Value Programme and progress with it and the work underway for the End of year process.

East of England Collaborative: Several meetings received an update on the Collaborative, including the clinical models, financial performance and service performance . The Committee considered the risks and opportunities and provided assurance to the Board with regard to the Collaborative.

Capital programme: the Committee regularly monitored progress against the annual capital programme. It also considered specific projects for approval for example CCTV, Lexden, new windows for Kingfisher Court, Oak Ward and Safety Suites. At its March meeting is approved the capital plan for 22/23. In September the Committee received an update on the Digital programme including progress with capital resources. The Committee also considered and approved two disposals in line with the Trust Capital programme.

Monitoring: The Committee regularly considered updates on the commercial activity of the Trust. It also assured itself with regard to the performance of the Trust across all metrics and in particular those included in the Trust's Annual Plan for 21/22. The Committee also supported the Audit Committee with its consideration of the financial reporting including the Delivering Value programme for the year.

Planning: In line with its Terms of Reference the Committee considered the planning requirements for 22/23. This included review of the Trust Annual Plan for 2022/232.

Green Plan: The Committee considered and approved the Trust's Green Plan, recommending it to the Board. The Committee welcome the Trust's commitment to sustainability and gave its full support

All items that required it were escalated to the Board for discussion and approval in line with Scheme of Delegation and Standing Financial Instructions.

4. Training and Development

During the year members of the Committee undertook appropriate mandatory training. They also received a number of deep dives on particular topics identified following review of the risk registers and audit reports.

5. Committee Developments

Specific issues which the Committee will consider in the financial year 2022/23 include:

- Continue to monitor progress of the Trust's capital programme. In particular the scheme for inpatient services in East and North Herts.
- Continued support for the mental health and learning disability and Autism Collaborative, including governance and financial risk framework.
- Performance against the Trust's Delivering Value Programme.
- Performance of the Trust including delivery of services and against budget.

Appendix 1

Cmttee Member	10 May	21 July	16 Aug ExtraO	22 Sept	17 Nov	18 Jan 22	22 Mar
David Atkinson (Committee Chair)	✓	✓	✓	✓	✓	✓	✓
Catherine Dugmore	✓	✓	✓	A	✓	✓	A
Anne Barnard	✓	✓	✓	✓	✓	✓	✓
Jon Walmsley	✓	✓	A	✓	✓	✓	✓
Kush Kanodia	✓	✓	✓	A	A	✓	✓
Keith Loveman	✓	NA	NA	NA	NA	NA	NA
Dr Jane Padmore	A	✓	NA	NA	NA	NA	NA
Sandra Brookes	✓	A	✓	✓	A	✓	A
Karen Taylor	✓	✓	A	✓	A	NA	NA
Asif Zia	A	A	A	A	✓	✓	✓
Ann Corbyn	A	NA	NA	NA	NA	NA	NA
Paul Ronald	✓	✓	A	✓	✓	✓	✓
Helen Edmondson	✓	✓	A	✓	✓	✓	✓
Janet Lynch	NA	✓	A	✓	✓	✓	✓
Maria Wheeler	NA	✓	✓	✓	✓	✓	✓
Jacky Vincent	NA	NA	✓	✓	✓	✓	✓
Hakan Akozek	NA	NA	NA	NA	NA	NA	✓

Quorum: A quorum shall be three members including at least one Executive Director and two Non-Executive Directors.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	27 April 2022	**Agenda Item:** 17
Subject:	Scheme of Reservation and Delegation (SoD)	**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:

The report provides the updated and revised Scheme of Reservation and Delegation (SoRD) for the Trust.

Action required:

The Board is asked to:

- consider the updated SoRD,
- make any recommendations for amendments
- approve the updated SoRD

Summary:

Summary

The current SoRD is due to be reviewed. The attached revised SoRD has been based on an example of best practice from the other NHS organisations and has been updated to reflect the Trust's financial limits and systems of internal control.

The document is made up of four tables:

Table 1 – Matters reserved to the Board of Directors and Council of Governors
Table 2 – Scheme of Delegation
Table 3 – Operational Scheme of Delegation
Table 4 – Schedule of delegations in respect of the Mental Health Act

The revised version has been reviewed by Director of Finance, Head of Corporate Affairs and Company Secretary and Deputy Director of Finance. It has also been informally shared with Internal Audit who have feedback that the revised version is in line with what would expect to see if a Foundation Trust's SoRD.

The Audit Committee at its meeting on 21 April considered the revised SoRD and recommended it for approval by the Board.

Recommendation

The Board is asked to:

- consider the updated SoRD,
- make any recommendations for amendments
- approve the updated SoRD

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

Internal Audit Programme is a key element to the Board 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:

Evidence to support well led KLOEs

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

Executive Team 13 April 2022
Audit Committee 21 April 2022

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

HPFT

Scheme of Reservation and Delegation

Version	6.0
Executive Lead	Executive Director of Finance
Lead Author	Head of Corporate Affairs and Company Secretary
Approved Date	21/04/2022
Approved By	Audit Committee
Ratified Date	27/04/2022
Ratified By	Trust Board
Issue Date	27/4/2022
Expiry Date	26/04/2025
Target Audience	All employees, all Non Executive Directors

Document on a Page

Title of document	Scheme of Reservation and Delegation		
Document Type	HPFT Policy		
Ratifying Committee	Trust Board		
Version	**Issue Date**	**Review Date**	**Lead Author**
(Insert Version No)	27 April 2022	26 April 2025	Head of Corporate Affairs and Company Secretary
Staff need to know about this policy because (complete in 50 words)	It provides a schedule of reserved and delegated matters arising from the Standing Financial Instructions and Standing Orders so that the Trust's decision making and financial transactions are carried out in accordance with the law and to achieve probity, accuracy, economy, efficiency and effectiveness		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	This document sets out the scheme of reservation and delegation of HPFT, arising from the Standing Orders and Standing Financial Instructions and Constitution. Which support them in their responsibility to adhere to the Trust's systems of internal control.		
Summary of significant changes from previous version are:	None		

Hertfordshire Partnership University Foundation Trust (HPFT)

Scheme of Reservation and Delegation V6.00

This document sets out the scheme of reservation and delegation of HPFT, arising from the Standing Orders and Standing Financial Instructions and Constitution.

Introduction

1.1. The *NHS foundation trust code of governance* requires the board of directors of NHS foundation trusts to draw up a "schedule of matters specifically reserved for its decision" (2014, A.1.1) ensuring that management arrangements are in place to enable the clear delegation of its other responsibilities. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. These arrangements should be kept under review at least annually.

1.2. The purpose of this document is to provide details of the powers reserved to the Board of Directors, and those delegated to the appropriate level for the detailed application of trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. Powers and decisions may only be exercised by the Board of Directors in formal session. Any non-compliance will be reported to the next formal meeting of the Board for action or ratification.

1.3 FTs can only delegate authority to a committee of directors or to an Executive director i.e. individual Non-executive directors cannot be delegated powers by the board and committees that have formal memberships other than directors cannot be delegated powers by the Board. Where committees are authorised to establish sub-committees, they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors

1.3 All powers of the Trust which have not been retained as reserved by the Board or delegated to an individual or committee shall be exercised on behalf of the Board by the Chief Executive.

1.4 This Scheme of Delegation shows only the ‘top level’ of delegation and is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

1.5 In the absence of an officer to whom powers have been delegated, those powers shall be exercised by a designated deputy or by the responsible director.

1.6 In the absence of a Director or deputy/Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been identified in the Scheme of Delegation or approved by the Director/Officer's superior.

1.7 If the Chief Executive is absent powers delegated to them may be exercised by the Chair after taking appropriate advice from the Director of Finance and/or other appropriate Executive Director.

Table 1 – Matters Reserved to the Board of Directors and to the Council of Governors

No.	Reserved Matter	Reserved to the Board of Directors	Reserved to Council of Governors
1.	Set the Trust's strategic aims	✓	
2.	Approval of Scheme of Delegation, Standing Orders (SOs) and Standing Financial Instructions (SFIs)	✓	
3.	Disclose any non-compliance with these SFIs to the CEO and Company Secretary as soon as possible	✓	
4.	The establishment, terms of reference and reporting arrangements of all committees and sub-committees of the Board; as a minimum Nominations and Remuneration Committee, Audit Committee, Integrated Governance Committee, Charitable Funds Committee. The Board may establish such other committees as required to discharge the Trust's responsibilities.	✓	
5.	Approval and review of risk management strategy	✓	
6.	Approval of Standards of Business Conduct and Conflicts of Interest Policy	✓	
7.	Use of Trust's land, buildings, property or other resources, or staff other than for relevant health services or collaboration with local authorities	✓	
8.	Acquisition and disposal of significant assets (value greater than £1,000,00)	✓	
9.	Approval of Capital Programme as part of Annual Plan	✓	
10.	Approval of change to banking arrangements	✓	

No.	Reserved Matter	Reserved to the Board of Directors	Reserved to Council of Governors
11.	Closure or change of use of health services premises or the commencement of related formal procedures	✓	
12.	Authorisation of the CEO to enter into partnership arrangements with local authorities regarding the provision of health-related local authority functions in accordance with S31 of the Health Act 1999	✓	
13.	Approval and adoption of the Annual Report and Annual Accounts following consideration of recommendation from the Audit Committee	✓	
14.	Approve changes to the Trust's Constitution (including Standing Orders)	✓	✓
15.	**General:** To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors		✓
16.	**General:** To represent the interests of the members of the Trust as a whole and the interests of the public		✓
17.	**Financial:** Appointment and removal of external auditors following recommendations of the audit committee		✓
18.	**Financial:** Receive the annual report, annual accounts and auditor's report at the annual members meeting		✓
19.	**Financial:** Review and approve revenue and capital plans	✓	
20.	**Finance and Performance:** Finance and performance reporting	✓	
21.	**Appointments & Remuneration:** Appoint and remove the Chair of the Board of Directors		✓
22.	**Appointments & Remuneration:** Appoint and remove NEDs		✓

No.	Reserved Matter	Reserved to the Board of Directors	Reserved to Council of Governors
23.	**Appointments & Remuneration:** Approve remuneration and other allowances of the Chair and NEDs		✓
24.	**Appointments & Remuneration:** Approval of process for evaluation of the Chair		✓
25.	**Appointments & Remuneration:** to agree skills, knowledge and competencies required by the board and the process for performance evaluation of the NEDs		✓
26.	**Appointments & Remuneration:** Approve the appointment of the CEO		✓
27.	**Appointments & Remuneration:** Appoint and remove the Lead Governor		✓
28.	**Strategy:** to provide views on the forward plan and annual report		✓
29.	**Strategy:** Approve 'significant transactions' as defined in the Constitution*;* mergers, acquisitions, separations or dissolutions; proposals to increase the proportion of the Trust's income earned from non-NHS work by 5% a year or more, as proposed by the Board of Directors		✓

Table 2 – Main Scheme of Reservation and Delegation

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
STRATEGY AND PLANNING												
1	**PREPARATION & APPROVAL OF ANNUAL PLAN AND BUDGETS**	Approval of Capital programme as part of Annual Plan	⚑									
2		Compilation and submission to Board of Directors a Forward plan in respect of each financial year						⚑				
3		Preparation and submission of financial plan for approval by the Board of Directors prior to start of the financial year	⚑									
4		Budget holders to sign up to their allocated budgets at commencement of each financial year									⚑	
5		Determination of the level of delegation to Budget Holders						⚑				
6		Approval of cost improvement and income generation activities in line with Annual Plan						⚑				
HUMAN RESOURCES												

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
7	APPOINTMENT AND REMUNERATION	Appoint and remove the Chair and NEDs		⚑								
8		Approve remuneration and other allowances of the Chair and NEDs		⚑								
9		Approve the appointment of the CEO		⚑								
10		Approve remuneration and other allowances of Executive Directors including pension rights and any compensation payments					⚑					
11	REDUNDANCY AND EARLY RETIREMENT PAYMENTS	Decisions in respect of redundancy and severance payments to senior managers					⚑					
12	TERMS AND CONDITIONS	Approve terms and conditions of employment and contractual arrangements for employees					⚑					
13		Authority to grant discretionary increments to existing or newly appointed staff within budget, regulations and Agenda for Change Terms and Conditions									⚑ with HR approval	

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
14		Authority to authorise temporary variations to pay rates within standard Agenda for Change Terms and Conditions							✓ with executive approval			
15	**CONTRACTS OF EMPLOYMENT**	Authority to issue contract of employment in a form approved by the Board of Directors									✓	
16		Authority to vary terms and conditions of employment not within budget and regulations						✓ with executive approval				
17		Renewal of fixed term Contract <2 years									✓	
18		Renewal of fixed term Contract =>2 years									✓ with Senior HR approval	
19		Approval of payroll forms, including standing data forms affecting pay, new starters, variations and leavers, overtime payments									✓	
20		Approval to authorise travel and subsistence expenses									✓	

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
21	**WORKFORCE/ ESTABLISHMENT**	Approve workforce plans with annual budget as part of the Annual Plan	✓									
22		Agree the workforce establishment in line with workforce plans above						✓				
23		Authority to permanently appoint staff to posts above the formal budgeted establishment with NO income to offset							✓ with executive approval			
24		Authority to change establishment within Board of Director's agreed financial budget									✓ with executive approval	
25		Authority to fill funded posts on the establishment within area of operational / corporate responsibility									✓	
26		Authority to add additional staff to the agreed establishment with specifically allocated finance									✓ via Establishment Control form	

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
27		Authority to make changes to the establishment whether permanent or temporary including requests for re-grading within agreed budget									✓ with exec approval	
28		Engagement of staff whether permanent or temporary within agreed budget									✓	
29		Approval of Payroll provider (depending on value may need Board of Directors approval in addition)						✓				
REGULATION AND CONTROL												
30	**POLICY**	Approval of policies:- • Clinical policies • Operational policies										
31		Approval of all financial policies				✓						
32	**SYSTEM OF INTERNAL CONTROL**	Maintaining systems of internal control							✓			
33		Overview and scrutiny of systems of internal control including risk management			✓							

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
34		Preparation and publication of Scheme of Delegation, Standing Financial Instructions and financial procedures							✓			
35		Maintenance of Risk Management framework						✓				
36		Maintenance and review of Emergency Preparedness resilience and response procedures and business continuity planning						✓				
37		Maintenance and review of Information Governance, data protection and cyber security arrangements						✓				
38		Review arrangements for Whistleblowing and Freedom to Speak Up										✓ Integrated Governance Committee
39	**ANNUAL ACCOUNTS AND ANNUAL REPORT**	Preparation and submission of financial reports in accordance with accounting policies, guidance and timetable prescribed and approved by the Department of Health							✓			

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
40		Preparation and publication of annual report and audited accounts and presentation to the Board of Director and to the Annual Public meeting of the Trust						✓				
41		Approval of Annual Report and Accounts	✓									
42		Receive the Annual Report and Accounts at the Annual General Meeting		✓								
43	**AUDITORS**	Appointment and removal of external auditors		✓								
44		Approval of internal auditors and Local Counter Fraud Specialist			✓							
45		Ensure adequate internal audit service and counter fraud service are provided			✓							
46	**MANAGEMENT OF BUDGETS**	Maintaining expenditure within budgets, in line with SFIs, at individual budget level									✓	

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
47		Transfers (virement) of budgets within same Department/Locality									✓	
48		Transfers (virement) of designated reserves budgets							✓			
49		Transfers (virement) of undesignated reserves/contingency							✓			
50	**BUDGETARY DELEGATION (REVENUE)**	Responsibility for delegation of the management of revenue budget to permit the performance of a defined range of activities						✓				
51		(a) Designation of budget holder						✓				
52		(b) Responsibility for management of revenue budget at individual budget level									✓	
53		(c) Responsibility for the totality of activities covered by each Corporate or Operational Directorate										✓ Executive Directors

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
54		(d) Responsibility for all other revenue budgetary areas, e.g. reserves							✓			
55	**BUDGETARY DELEGATION (CAPITAL)**	Responsibility for delegation of the management of capital budget in line with the approved Capital Programme						✓				
56		(a) Designation of budget holder						✓				
57		(b) Responsibility for management and monitoring of the capital budget							✓			
58		(c) Responsibility for the management of capital budget at individual level						✓				
59		Overview and scrutiny of capital programme				✓						
60	**SYSTEMS OF PAYMENT AND PAYMENT VERIFICATION**	Responsibility for prompt payment of accounts, contract invoices and claims and that payments are only made once the goods and services are received and been appropriately certified							✓			

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
61		Agree and maintain a list of managers authorised to place requisition for the ordering and receipt of goods and services and authorisation of invoices							✓			
62		Agree and maintain a register of employees (including specimens of their signatures) authorised to certify invoices							✓			
63		Pre-payments (i.e. payments in advance) only permitted where exceptional circumstances apply							✓			
64	**EXTERNAL BORROWING**	Preparation of detailed procedural instructions concerning applications for loans and overdrafts							✓			
65		Approval of Borrowings from the Department of Health	✓									
66	**BANKING & CASH**	Approval of banking arrangements				✓						
67		Opening of bank accounts							✓			

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
68		Designation of authorised officers for signing of cheques for cash, other cheques and authorisation of Government Banking Services and BACS payment schedules							✓			
69		Approval of Credit Card and Credit Card limit							✓			
70	**INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS**	Maintain and ensure compliance with income and expenditure systems for prompt banking of all monies							✓			
71		Approval and regular review of the level of all fees and charges, other than those determined by the Secretary of State or statute							✓			
72		Responsibility for debt recovery and associated procedures							✓			
73		Overview of Losses and special payments register			✓							
74		Security of cash, cheques and other negotiable instruments							✓			

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
75	**PROCUREMENT AND CONTRACTS**	**PROCUREMENT OF IN-HOUSE SERVICES** - Determination of in-house services to be subject to competitive tendering	✓									
76		**PROCUREMENT OF IN-HOUSE SERVICES** - Delegation of lead officer(s) to oversee and manage the process and contract on behalf of the Trust						✓				
77	**APPROVED FIRMS**	Maintenance of approved list of firms for tendering – including financial standing, technical/medical competence							✓			
78	**MANAGEMENT OF TENDERS**	Issue of all tenders for goods, materials, services, building, engineering works with appropriate Terms and Conditions regulating the conduct of the tender and appropriate Terms and Conditions on which Contract to be awarded							✓*		✓*	
79		Receipt and safe custody of all tenders										✓ Procurement team

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
80		Opening of Tenders via tender submission or via tender portal and Preparation and submission of formal written Tender Evaluation Report										Procurement team
81		Review and sign off of formal written Tender Evaluation Report										
82		Approval of expenditure over agreed tender quotation/quotation budget										
83	**SINGLE TENDER WAIVERS**	Approval of Single Tender Waivers if either of the above limits are breached (excluding those related to finance directorate)										
84		Approval of Single Tender Waivers associated with Finance Directorate										
85		Scrutiny and oversight of Single Tender Waivers, Losses, compensations and special payments										

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
86	**PRIVATE FINANCE FOR CAPITAL PROCUREMENT**	Approval of PFI Capital Procurement	✓									
87	ASSET REGISTER	Maintenance of Asset Register and responsibility for re-valuation of assets in accordance with the Accounting Manual issued by the Department of Health							✓			
88		Prepare procedures for disposal of assets							✓			
89		Responsibility for the security of Trust assets, property , avoiding loss, exercising economy and efficiency in using resources and conforming to SFIs and financial procedures									✓	
90		Overview and scrutiny of asset management				✓						
91	**LEASES, TENANCY AGREEMENTS AND LICENCES**	Letting of premises to outside organisations							✓			

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
	(NEW AND RENEWALS)											
92	**STANDARDS OF BUSINESS CONDUCT**	Approval of the Standards of Business Conduct Policy and Conflict of Interest Policy			✓							
93		Maintenance of Gifts and Hospitality Register Maintenance of Declaration of Interest Registers: (a) Board of Directors (b) Governor (c) Decision Making Staff								✓		
94		Authorisation of sponsorship deals						✓ with executive approval				
95		Authorisation of the use of the Trust's seal							✓			
96		Register of use of the Trust's seal								✓		
97		Authorisation of research projects and other research documents										✓ Medical Director

Ref	Delegated Area	Delegated Matter	Reserved to the Board of Directors	Reserved to Council of Governors	Delegated to Audit Committee	Delegated to Finance & Investment Committee	Delegated to Nominations & Remuneration Committee	Delegated to Chief Executive Officer	Delegated to Director of Finance	Delegated to Company Secretary	Delegated to Head of service/ Budget Manager	Delegated to Other
98		Maintain and publish a Freedom of Information Scheme										CIO
99		Retention of document procedures in accordance with DoH guidelines										
100	**SERVICE USER PROPERTY**	Written instructions for the collection, safe custody and recording of money and other personal property handed in by service users.										
101		Operational management of service user property in accordance with procedures										Chief Operating Officer
MENTAL HEALTH ACT – further details in Table 5												
102	**MENTAL HEALTH ACT**	Discharge of patients under S23 of MHA 1983 (as amended) may be exercise by three or more "persons authorise by the Board of the Trust in that behalf each of whom is neither an Executive Director of the Board nor an employee of the Trust"										

* note this means either or

Table 3 – HPFT Operational Scheme of Delegation

Ref	Delegated Area	Delegated Matter	Limit (Excl VAT)	Delegated to
1	**APPROVAL OF PURCHASE REQS/INVOICES FOR GOODS AND SERVICES**	(a) All requisitions/invoices	Up to £10,000	Budget Holder at Bands 5/6 (or equivalent)
		(b) All requisitions/invoices	Up to £20,000	Budget Holder at Bands 7/8a (or equivalent)
		(c) All requisitions/invoices	Up to £35,000	Budget Holder at Bands 8b/c (or equivalent)
2		(d) All requisitions/invoices	Up to £50,000	Budget Holder at Bands 8d/9 (or equivalent)
3		(c) All requisitions/invoices	Up to £100,000	Executive Director
4		(e) All requisitions/invoices	>£100,000	Director of Finance **or** Chief Executive Officer
5	**NON PAY REVENUE AND CAPITAL EXPENDITURE / REQUISITIONING / ORDER / CONTRACTS AND PAYMENTS FOR GOODS AND SERVICES**	(a) Requisitions	Up to £25,000	Budget holder depending on authorisation level
6		(b) Requisitions	Up to £100,000	Managing Director of Executive Team member
7		(c) Requisitions	Over £100,000	Director of Finance or CEO
8		(d) Requisitions	Over £500,000	Trust Board
9		(e) Orders	Exceeding 12 months period	Director of Finance or CEO
10	**REVENUE INVESTMENT (NOT BUDGETED)**	Revenue Investment	<£250,000	Director of Finance CEO

Ref	Delegated Area	Delegated Matter	Limit (Excl VAT)	Delegated to
11		Revenue Investment	>=£250,000 and <£1 million	Director of Finance following Exec. Approval and CEO (without Exec approval
12		Revenue Investment	>=£1 million	Board
13	**INCOME CONTRACTS FOR PROVISION OF EXISTING SERVICES**	Approval of Existing Business/Contract Rollover	<£10 million (over life of the contract)	Director of Finance **and** CEO. If contract in line with agreed financial plan
14		Approval of Existing Business/Contract Rollover	>=£10 million (over life of the contract)	Board of Directors
15	**NEW BUSINESS / INCOME CONTRACTS FOR PROVISION OF SERVICES**	Approval of New Business or Diversification.	<£1 million (over life of the contract)	Director of Finance following Exec. Approval
16		Approval of New Business or Diversification.	>=£1 million (over life of the contract)	Board of Directors and Council of Governors (Significant Transaction definition)
17	**COMPETITIVE QUOTATION AND TENDERING REQUIREMENTS**	Ensure best value only	<£10,000	Budget holder (with support from procurement)
18		Minimum of 3 quotes required (on contracts finder if value is over £25,000 ex-VAT)	£10,000 to <£25,000	Service Line Leader
19		Tender with a minimum of 3 returned and on contracts finder	£25,001 to £100,000	Managing Director / Executive Director
20		Minimum limit above which open tender required in line with WTO and Government Procurement Agreement	>=£100,001	
21		Minimum number of firms invited to quote competitively	3	

Ref	Delegated Area	Delegated Matter	Limit (Excl VAT)	Delegated to
22		Minimum number of firms invited to tender	3	
23	**APPROVAL OF TENDERS AND COMPETITIVE QUOTATIONS**	Contract Approvals and sign off	<£1 million (over life of the contract)	Director of Finance
24		Contract Approvals and sign off	>=£500,000 and <£1 million (over life of the contract)	Chief Executive and Director of Finance
25		Contract Approvals and sign off	>=£1 million (over life of the contract)	Board of Directors
26	**TENANCY AGREEMENTS AND LICENCES (NEW AND RENEWALS) AND EARLY TERMINATION CHARGES**	Lifetime value of lease/or termination value	<£1 million (over the term of the lease)	CEO **and** Director of Finance
27		Lifetime value of lease/or termination value	>=£100,001 million	Board of Directors
28	**ACQUISITIONS AND CAPITAL INVESTMENT (INCLUDING LEASES)**	Approval of individual Capital schemes	<£500,000	Director of Finance
29		Approval of individual Capital schemes	>=£500,000 and <£1 million	Director of Finance following Exec. Approval
30		Approval of individual Capital schemes	>=£1 million	Board of Directors
31	**CAPITAL DISPOSALS**	Capital Disposals	<£1 million NBV	Chief Executive **and** Director of Finance
32		Capital Disposals	>=£1 million NBV	Board of Directors

Ref	Delegated Area	Delegated Matter	Limit (Excl VAT)	Delegated to
33	**LOSSES & SPECIAL PAYMENTS**	Losses governing: Cash, Fruitless Payments (including abandoned capital schemes, damage to buildings, equipment including loss)	<£10,000	Director of Finance or his/her nominated Deputy
34		Losses governing: Cash, Fruitless Payments (including abandoned capital schemes, damage to buildings, equipment including loss)	>=£10,000 and <£25,000	Chief Executive **and** Director of Finance
35		Losses governing: Cash, Fruitless Payments (including abandoned capital schemes, damage to buildings, equipment including loss)	>=£25,000 and <£100,000	Director of Finance following Exec. Approval
36		Losses governing: Cash, Fruitless Payments (including abandoned capital schemes, damage to buildings, equipment including loss)	>=£95,000 **	Board
37		Write-off of NHS and non-NHS debtors	<£50,000	Director of Finance
38		Write-off of NHS and non-NHS debtors	=>£50,000	Chief Executive **and** Director of Finance
39	**BANKING & CASH**	Amount above which cheques and electronic transfers require two authorised signatories	£2,000	
40	**PETTY CASH**	Maximum limit for petty cash holding (general expenditure)	£5,000	
41		Maximum limit for petty cash holding (patient monies)	£5,000	
42		Maximum value of an individual petty cash reimbursement	£200	

Ref	Delegated Area	Delegated Matter	Limit (Excl VAT)	Delegated to
43	**REDUNDANCY AND EARLY RETIREMENT PAYMENTS**	Redundancy payments	<£75,000	Head of HR **and** Director of Finance **and** Rem Com if relevant to post covered by the Committee
41		Redundancy payments	>=£75,000 and <£95,000**	Chief Executive, Director of Finance **and** Head of HR **and** Rem Com if relevant to post covered by the Committee
45		Redundancy payments	>=£95,000**	Board of Directors
46	**CLAIMS/SETTLEMENTS AND COMPENSATION PAYMENTS ARISING FROM CONTRACTS OF EMPLOYMENT**	Approvals of Claims/Settlements and Compensation Payments	<£75,000	Head of HR **and** Director of Finance
47		Approvals of Claims/Settlements and Compensation Payments	>=£75,000 and <£150,000	Chief Executive, Director of Finance **and** Head of HR
48		Approvals of Claims/Settlements and Compensation Payments	>=£95,000**	Board of Directors
49	**CHARITABLE FUNDS**	Approval of expenditure against Individual Funds	< £1,000	Fund-Holder
50		Approval of expenditure against Individual Funds	>= £1,000 and < £5,000	Fund-holder **and** Service Director
51		Approval of expenditure against Individual Funds	>=£5,000 and < £25,000	Above **plus** Director of Finance
52		Approval of expenditure against Individual Funds	>=£25,000 and < £100,000	Charitable Funds Committee

Ref	Delegated Area	Delegated Matter	Limit (Excl VAT)	Delegated to
53		Approval of expenditure against Individual Funds	>=£100,000	Board of Directors

** This ensures we are compliant with national guidance on Losses and Special Payments.

Table 4: Mental Health Act Scheme of Delegation

Section/Reference	Form/Code	Description	Responsible Staff
Section 2, 3 and 4	H3 CoP Chapter 14	Record of Detention in Hospital	Mental Health Law staff band 4 and above and clinical staff at Band 5 or above (or equivalent) who have at least one year's experience at that level and have attended the relevant Trust training
Section 5(2)	H1 (part 2) CoP Chapter 18	Record of receipt of report on hospital in-patient |	
Section 5(3)	CoP Chapter 37	Nominated deputy power under section 5(2)	Duty doctor as per duty doctor rota or as otherwise set out in writing
Section 14	CoP Chapter 37	Request for social circumstances report following receipt of an application for detention made by Nearest Relative.	Mental Health Law staff
Section 15	CoP Chapter 35	Arranging for rectification of recommendations and applications	Mental Health Law staff band 4 and above
MHA 15(2)	CoP Chapter 35	Scrutiny of Medical Grounds for Detention	A Psychiatrist, other than the patient's RC or junior to the patient's RC or part of their team, or the Dr who made a recommendation
MHA sections 17C or 19	Regulations 11 and 12 CoP Chapter 17	Conveyance to Hospital on recall, transfer or other reasons	Any member of staff of the Trust or any person authorised in writing by the Hospital Managers