Hertfordshire Partnership University NHS Foundation Trust
PUBLIC Board of Directors

Da Vinci rooms

29 September 2022 10:30 - 29 September 2022 13:15

INDEX

Hertfordshire Partnership University NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 29 September 2022
Da Vinci A,B & C
Time: 10.30am – 13:15pm

A G E N D A					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
1.	**Welcome and Apologies for Absence**	Chair			10:30
2.	**Declarations of Interest**	Chair	**Note**	Attached	
3.	**Shared Experience**				10:30
4.	**Minutes of Meeting held on 28 July 2022**	Chair	**Approve**	Attached	11:00
5.	**Matters Arising Schedule**	Helen Edmondson	**Review & Update**	Attached	
6.	**CEO Brief**	Karen Taylor	**Receive**	Attached	11.05
7.	**Chair's Report** **a) Apppointment of Senior Independent Director**	Chair Chair	**Receive** **Approve**	Verbal Attached	11.15
	QUALITY & PATIENT SAFETY				
8.	**COVID-19 and Winter Planning Update**	Sandra Brookes	**Receive**	Attached	11.25
9.	**Report of the Integrated Governance Committee held: 15 September 2022** **a) Quarter One Integrated Safety Report** **b) Emergency Preparedness Resilience and Response Core Standards** **c) WRES and WDES Report**	Diane Herbert Jacky Vincent Sandra Brookes Janet Lynch	**Receive** **Receive** **Approve** **Receive**	Attached Attached Attached Attached	11.30
	OPERATIONAL AND PERFORMANCE				
10.	**Report of the Finance & Investment Committees held: 22 September 2022.** **a) Performance Report, Quarter One**	Anne Barnard Hakan Akozek	**Receive** **Receive**	Attached Attached	11.50
11.	**Finance Report – Month 5**	Paul Ronald	**Receive**	Attached	12.00
12.	**People Report – Month 4**	Janet Lynch	**Receive**	Attached	12.10
13.	**East of England Collaborative**	Sandra Brookes	**Receive**	Attached	12.20
	STRATEGY				
14.	**Setting Trust's future strategy**	David Evans	**Approve**	Attached	12.30

15.	**System Update**	David Evans	**Receive**	Attached	12.40
GOVERNANCE AND REGULATORY					
16.	**Report of the Audit Committee held: 8 September 2022**	David Atkinson	**Receive**	Attached	12.50
17.	**Fit and Proper Person**	Janet Lynch	**Receive**	Attached	12:55
18.	**Non Executive Directors Champions**	Helen Edmondson	**Approve**	Attached	13.00
19.	**Annual Quality Assurance for Responsible Officer & Revalidation 2021/2022**	Prof. Asif Zia	**Receive**	Attached	13:05
20.	**Chair's Action**	Chair	**Approve**	Attached	13.10
21.	**Board Planner**	Helen Edmondson	**Approve**	Attached	13.15
22.	**Any Other Business**	Chair			
	QUESTIONS FROM THE PUBLIC	Chair			
Date and Time of Next Public Meeting: Thursday 24 November 2022					

ACTIONS REQUIRED

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

Chair: Sarah Betteley

Declarations of Interest Register

Board of Directors

September 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 Accredited Humanist funeral celebrant RNLI crew member
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
Helen Edmondson	Head of Corporate Affairs & Company Secretary	Nil Return
David Evans	Director Strategy & Partnerships	Nil Return
Diane Herbert	Non-Executive Director	NED designate at the North East London ICB
Janet Lynch	Interim Director People & OD	Harpenden MacMillan Fundraising Committee Member
Paul Ronald	Interim Director Finance & Estates	Chair Mind in mid Herts
Karen Taylor	Chief Executive Officer	Nil Return
Andrew van Doorn	Non-Executive Director	Chief Executive and Company Secretary, HACT (Housing Associations Charitable Trust) Chief Executive and Company Secretary of HACT Housing Action Ltd. A fully owned trading subsidiary of HACT
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	Trustee on Board of homelessness charity: 'Accumulate' (1170009) | Member of Green Angel Syndicate

		Independent Board Member of the University of Hertfordshire Shareholder of Farr Brew Limited
Asif Zia	Director, Quality & Medical Leadership	Nil Return

Minutes of the: PUBLIC Board of Directors
Date: 28 July 2022
Venue: The Colonnades and Virtual

MINUTES	
NON-EXECUTIVE DIRECTORS	**DESIGNATION**
Sarah Betteley | SBe	Chair
Jon Walmsley | JW	Non-Executive Director
Tim Bryson | TB	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
David Atkinson | DA	Non-Executive Director (virtual)
Diane Herbert | DH	Non-Executive Director
Catherine Dugmore | CD	Non-Executive Director
Kush Kanodia | KK	Associate Non-Executive Director
DIRECTORS	
Karen Taylor | KT	Chief Executive Officer
Jacky Vincent | JV	Director, Quality and Safety & Chief Nurse
Prof Asif Zia | AZ	Director, Quality & Medical Leadership (Item 097/22 onwards)
Janet Lynch | JL	Interim Director People and OD
Maria Wheeler | MW	Director Finance and Estates
Hakan Akozek | HA	Director Innovation & Digital Transformation
David Evans | DE	Director Strategy & Partnerships
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
IN ATTENDANCE	
Kathryn Wickham | KW	PA to Chair & Company Secretary (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Sarah Damms | SD	Deputy Director for Service Delivery & Managing Director, West SBU (virtual)
Chris Martin | CM	Board Development facilitator
Emma Nicol | EN	Associate Programme Director, Hertfordshire and West Essex Integrated Care System (ICS) (virtual)
Dr Risha Ruparelia | RR	ST7 Adult and Old Age Psychiatry (virtual)

Item	Subject	Action
087/22	**Welcome and Apologies for Absence** SBe welcomed all to the meeting with an extended welcome to those who were observing. There were no apologies for absence. SBe noted this would be the last public board for CD and KK.	
088/22	**Declarations of Interest** The Declarations of Interest Register was noted. **NOTED**	
089/22	**SU Story** S and C, two young people from Forest House and supported by Jo Mutton shared their stories with the Board.	

090/22	**Minutes of Meetings held 26 May and 16 June 2022** The minutes were reviewed with one amendment to the minutes from 16 June 2022. Subject to this the minutes were approved as an accurate record of the meeting. **APPROVE** **The Board APPROVED the minutes**	
091/22	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
092/22	**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 focus was on emergency care. Winter Planning Guidance was expected earlier than usual with HPFT plans well underway. The Terms of Reference for the UK COVID-19 Inquiry had been published. As a Trust we were reviewing the Terms of Reference to help inform our preparations, with KT noting we were well prepared. The Government had announced details of the national pay awards for NHS staff with KT noting there had been significant response from staff bodies. Locally the Trust was working to help our staff with the cost of living via a number of initiatives. A new NHS oversight framework for 2022/23 had been published. The George Cross had been presented in recognition of over 74 years of service including the exceptional efforts of NHS staff across the country during the COVID-19 pandemic. We would be marking the occasion with a thank you to all our staff. Amanda Pritchard NHS England Chief Executive had communicated to NHSE staff that NHS data, digital services and workforce functions would be combined, and that corporate services of NHS England and Health Education England regional teams would be integrated. The Hertfordshire and West Essex Integrated Care System was formally established on 1 July 2022 with the Integrated Care Board (ICB) having its first meeting on the same day. The first meeting of the Integrated Care Partnership (ICP) was scheduled for 28 July 2022 The South West Hertfordshire Health Care Partnership (S&WHHCP) had met in July with KT reporting that Matthew Coats had been appointed as CEO for West Hertfordshire Teaching Hospitals NHS Trust. Operationally it continued to be increasingly challenging with our staff working over and above. KT noted that access was a particular challenge although some improvement had been seen. The CQC had revisited Forest House with initial feedback acknowledging the improvement's that had been made.	

	Trust vacancy rates had increased with turnover and workforce vacancies remaining a key focus for the Trust. Contract negotiations continued across all the major contracts with KT reporting there were no issues to escalate to the Board. The search process for the recruitment of the Chief People Officer had been extended with interviews expected to take place in late September / October. **RECEIVED** **The Board RECEIVED the CEO Brief**	
093/22	**Chairs Report** SBe provided Board members with a verbal update on the work undertaken since the last Board meeting. SBe reported on the recent recruitment process for two Non-Executive Directors which had now been approved by the Council of Governors. Andrew van Doorn would commence on the 1 September and Carolan Davidge on the 1 November 2022. Both would bring huge value to the Board. Further detail would be shared in due course. SBe stated she had attended the HCP Chairs meeting noting good progress was being made. SBe would be meeting with Paul Burstow next week. SBe had attended the national Chairs meeting noting they had held a discussion around governance and the ICS going live on the 1 July. No questions were put forward. **RECEIVE** **The Board RECEIVED the verbal update**	
	QUALITY & PATIENT SAFETY	
094/22	**Report of the Integrated Governance Committee held 22 July 2022** DH presented the report which provided the Board with an overview of the work undertaken by the Integrated Governance Committee at its meeting held 22 July 2022. The report was taken as read and the below points highlighted. The Committee held a Deep Dive on Section 136 and partnership working which was well received. The Committee noted the Trust's Violence and Aggression Policy had been updated to include the requirements of the Use of Force Act 2018. The Committee were advised the Trust had co-produced leaflets regarding the Use of Force to be given to service users and carers on admission, with the Committee providing approval of the leaflets. The Committee were updated on the Staff Survey Action Plan action plan developed in response to the 2021 staff survey results. The Committee had discussed how progress would be monitored noting the Plan would be refined to show short and long-term progress.	

	There were no formal items for escalation to the Board. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
095/22	**Quarter One Integrated Safety Report** JV introduced the report taking the paper as read, noting it had previously been considered at the Integrated Governance Committee. Key points highlighted were: Datix incidents reported had decreased in April and May 2022. April and May had seen 22 Serious Incidents external to the Trust. There were eight deaths thought to be as a result of suicide in the quarter. Work had commenced to build four more safety suites across the Trust and two High Dependency Unit bedrooms at Forest House. The Restrictive Practice Committee was participating in a CQI work to reduce restrictive practice. A piece of work was underway to look at Long Term Segregation. There had been a reduction of assaults between service user to staff and service user to service user. The Trust's Violence and Aggression Policy had been updated to include the requirements of the Use of Force Act 2018. JV noted that pages 61 – 63 of the overall pack outlined the Learning from Incidents and Changing Practice for the quarter. In response to DA's question JV confirmed that Trust staff are not trained to undertake prone restraint. AZ outlined the ongoing work with CGL to ensure a clear pathway and effective partnership working. It was noted the safety report to the Board in September 2022 will provided an update on position. **RECEIVE** **The Board RECEIVED the report**	
096/22	**Quarter One Safe Staffing Report** JV presented the paper, which was taken as read, advising the report had been to the latest Integrated Governance Committee. Points of note were: There had been a significant increase in staffing levels, with the use of Bank and Agency to address the increased acuity and complexity of service users. Regular scrutiny of staffing rosters continued along with a review of skill mix and establishment. NHSE had worked with us around a revised Toolkit which would help us to think differently.	

	There was a CQI piece of work underway around Safe and Supportive observations. Two new Units from East and North SBU had started with team-based rostering implementation, and one-unit in West SBU expressed their interest for the team rostering. It was hoped this would help with work/life balance for staff. HA added that digital solutions for electronic recording of observations and digital bed management solutions were being implemented. KT added that the Trust had over 20% nurse vacancies, which was in line with other NHS Trusts but was a significant risk for the organisation. **RECEIVE** **The Board RECEIVED the report**	
097/22	**Quarter One People & OD Report** JL presented the report which updated the Board on progress against the People and OD KPIs for May 2022. The report was taken as read and the below points drawn out for the Board's attention. Mandatory training, appraisals and vacancy rates had all seen improvement with a slight improvement seen in turnover rates. We had expanded our apprenticeship offer as a route into HPFT, including converting all Band 2 HCSW posts to apprenticeships. A significant amount of wellbeing support continued to be provided to staff. The quarterly Pulse Survey had shown that overall, our scores were very positive and significantly higher than the national benchmark. The Trust had been shortlisted for a Healthcare People Management Associate (HPMA) Award. Focus going forward was around, staff engagement, HR App, refreshing the benefits we offered to support staff, working with our recruitment partners, reviewing our offer to temporary staff and working on the recruitment and retention premia. JL invited questions. In response to CD's questions around the Innovation Hub KT confirmed that we were working with the University of Hertfordshire but would be spreading out to working with all Universities. In response to JW's comment around overseas recruitment JL advised that there were currently some issues however we continued to be ambitious with our targets. In response to CD's comment on the Innovation Hub it was agreed to invite the NEDs to a session. TB as Wellbeing Guardian welcomed the significant number of activities to support staff welfare. It was agreed that NEDs would be made aware of training dates for the	

	Simulation Hub. **RECEIVE** **The Board RECEIVED the report**	**AZ**
098/22	**Quarter One Experience Report** SBr presented the report drawing out the below points for the Board's attention. There had been a significant amount of feedback since the introduction of SMS texting. There had been an increased response if the 'Having Your Say' surveys which had helped with volunteers. Pockets of low-level feedback had been received with CAMHS. There had been a slight decrease in the number of complaints received, with the majority of positive comments related to the theme of "Emotional and Physical Support". There had been an increase in compliments, in particular CAMHS. A detailed action plan had been written following the CQI project and self-assessment work completed in 2021 which set out the work needing to be done in 2022-23. We continue to work on key feedback with DA asking about how we captured feedback. SBr set out the current routes and acknowledged we would do more around this. In response to TB request for the report by service line as well as SBU, SBr acknowledged. **RECEIVE** **The Board RECEIVED the report**	
099/22	**Annual Infection, Prevention and Control Report** JV introduced the report which was taken as read. The year had seen good progress in some key areas and the IPC profile had been raised. There had been a positive review and visit by NHSE. The report outlined the priorities for 2022/23. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
100/22	**Annual Safeguarding Report** JV presented the report which provided an overview of Safeguarding activity for the year 2021/22. The report also outlined the key achievements of the year and the challenges. JV reported there had been increased Safeguarding activity over the past year for both children and adults, commenting this was the highest it had been in four years with the impact of COVID and domestic abuse. The annual Clinical Commissioning Group (CCG) joint adult and children's	

	assurance visit had provided positive feedback. **RECEIVE** **The Board RECEIVED the report**	
	OPERATIONAL AND PERFORMANCE	
101/22	**Report of the Finance & Investment Committee** DA presented the report which provided the Board with an overview of the work undertaken by the Finance & Investment Committee as its meeting held 21 July 2022. The report was taken as read with the below points highlighted. The Committee received a detailed presentation on the Delivering Value Programme for 2022/23, noting that the financial plan was based on achieving £5m of the programme. The Committee had considered the Quarter One Annual Plan 2022/23 Report which updated on the seven objectives detailed in the Trust's Annual Plan. The Committee noted that four of the seven objectives were met with the remainder forecast to be delivered by year end. The Committee had provided a final review of the financial plan for 2022/23. The Committee had received the Quarter One Performance Report with DA recording acknowledgment to HA for his work on this, in particular, workforce, access and Out of Area Placements. The Committee were updated on the progress made in the recovery programme. The Committee were provided with an update on the progress on the negotiation of the Trust's contracts. The Committee received an update on the East of England Collaborative. The Committee considered an update on the progress with implementing the Capital Investment Programme for the year, noting it was progressing well and in line with expectations. The Committee had discussed the Digital Strategy Update noting that thirteen projects in the portfolio were progressing as planned and on track to deliver the year end aims. The Committee also discussed the two projects experiencing delays and the mitigating actions in place. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	
102/22	**Quarter One Annual Plan Update** DE presented the Quarter One Annual Plan update which was taken as read. Points of note were: DE reported that Quarter One had been challenging however good	

	progress had been made. Conversations had been held at the Finance & Investment Committee regarding how to ensure alignment of performance and the Annul Plan. With DE and KT leading on this piece of work. Four out of seven objectives were green with the remaining three expected to be back on track (detail laid out in the body of the report). Questions were invited. In response to CD's comment around measures, KT welcomed the challenge however noted that the Board had been provided with assurance we would deliver in Quarter One. The Board continued with a conversation around the measures and performance outcomes, with DE acknowledging it had been a useful conversation and would help frame future conversations at Board. SBe stated she felt assurance had been provided. **RECEIVE** **The Board RECEIVED the report**	
103/22	**Financial Plan 2022/23** MW introduced the Financial Plan 2022/23 confirming the Plan had been approved at the earlier Private Board meeting and stated the item was for noting. **NOTE** **The Board NOTED the report**	
104/22	**Finance Month 3** MW presented the paper which set out the Trust's financial position for Quarter One 2022/23 and the forecast outturn for 2022/23. Points drawn out for the Board's attention were: The Trust reported a breakeven position for quarter one and a breakeven forecast outturn for the year to 31 March 2023. Income was behind plan by £411k for the quarter with plans in place to recover over the remainder of the financial year. Pay spend in the quarter was above budget by £288k and reflects high acuity and complexity of service user demand. This had led to high levels of bank and agency staff to meet the current levels of demand. Overheads and reserves were below plan by £419k and this position reflects the release of reserves to cover cost pressures in pay. Overall, the Trust was on-track and forecasting a balance position at year end in line with plan. MW concluded the update noting the Trust was on track to complete its capital programme for 2022/23 and meet the CDEL target. **RECEIVE**	

	The Board RECEIVED the report	
	STRATEGY	
105/22	**Mental Health, Learning Disability and Autism Collaborative Update** DE presented the report which provided an update on the development and activity of the Hertfordshire Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative. The report was taken as read. The Collaborative had made significant progress and agreed its transformation priorities for 2022/23. The Collaborative's Clinical and Professional Advisory Committee (CPAC) was leading on a number of clinical areas. The Collaborative's Co-Production Group had relaunched with face-to-face meetings. The Collaborative held its first public engagement event on the 23 June 2022. Since the last update to the Board a number of key achievements had been made, including the development of a Collaborative business case to address the backlog of young people waiting for ADHD assessment in South and West Hertfordshire. DE also noted the priorities for the forthcoming period. Questions were invited. AZ reported that the ADHD work was due be presented at the September ICB Board meeting. **RECEIVE** **The Board RECEIVED the report**	
	GOVERNANCE AND REGULATORY	
106/22	**Trust Risk Register** JV presented the report which provided the Board with an update with regard to the risks on the Trust Risk Register. JV reported there were currently eight risks, with one change to risk 5, Quality of Care since the last presented to the Board in March 2022. The Board were asked to approve the risks as outlined in the Trust Risk Register. JV invited questions. JW queried if there was a risk with regard to the new build in East and North Herts, KT responded that the risk was that there would be insufficient beds, which is listed on the Register. KT reminded Board members the Risk Register was a live document and it was her view that the current risk score and working for this felt appropriate however welcomed comments from Board members.	

	Board members approved the Trust Risk Register. **APPROVE** **The Board APPROVED the Trust Risk Register**	
107/22	**Board Assurance Framework** HE presented the Board Assurance Framework which provided the Board with assurance that the Trust's principal risks had been identified and were being appropriately managed. HE reminded the Board the BAF had been considered and approved by the Integrated Governance Committee (IGC) at its most recent meeting. Appendix 1 detailed the significant changes to the BAF since it was reviewed at Board in March 2022. HE asked the Board to note the increased number of actions put in place noting there had been a lengthy and helpful conversation on these at IGC. HE reported there would be a re-fresh of the BAF format in Quarter Two. All in attendance provided their approval. **APPROVE** **The Board APPROVED the Board Assurance Framework**	
108/22	**Report from the Audit Committee** CD introduced the report which provided the Board with an overview of the work undertaken by the Audit Committee at its most recent meeting. The report was taken as read and the below points drawn out. The Audit Committee was held on the 14 July 2022 and had considered four areas of major risks through Deep Dives and areas on which the Trust would require assurance on going forward. The four areas considered were; People; Procurement; Counter Fraud and Finance. The Committee had received an update on the Data Security and Protection Toolkit (DSPT) and the Financial Sustainability Audit. The Committee had received the final External Audit of the Annual Audit Report (Value for Money Report) 2021/22. An action was drawn for this to be circulated to Board members. HE added that KPMG had not identified any areas of weakness. There were no matters for formal escalation to the Trust Board. No questions were put forward. **RECEIVE** **The Board RECEIVED the report**	**MW/HE**
109/22	**Mental Health Act Managers Annual Report** TB presented the report which informed the Board on the activity of Mental Health Act Managers (MHAM) and the use of the Mental Health Act (MHA) in HPFT during 2021/22. The report was taken as read and the below	

	points highlighted. Use of the Mental Health Act continued to rise nationally. There had been a decrease in the use of Section 136 (S136) in 2021/22 from 2020/21, although nationally numbers continued to increase. It was reported that the decrease in Trust numbers may be due to the increase in the number of people detained on S136 in Acute care settings. The team were preparing for changes which may be implemented from the MHA Legislation Review. The Liberty Protection Safeguards were due to replace the Deprivation of Liberty Safeguards 2020 however, due to COVID-19, this had been delayed until April 2022 and would not now be fully implemented until 2023. TB noted the learning which had commenced from Covid noting the introduction of virtual hearings. All MHAMs had access to training throughout 2020/21. TB concluded the update recording a formal thank you to Hattie Llewelyn-Davies, MHAM Manager, Tina Kavanagh and the Legislation team. **RECEIVE** **The Board RECEIVED the report**	
110/22	**Mental Health Act Managers Chair's Action** SBe presented the report which sought the support and approval from the Board to re-appoint Chris Wright as a Mental Health Act Manager. The Board provided their approval. **APPROVE** **The Board APPROVED the report**	
111/22	**Questions from the Public** No questions were put forward.	
112/22	**Any Other Business** SBe recorded a formal thank you to CD and KK for their dedication and valuable contribution to the Trust. Board members concurred expressing their thanks. No further business was put forward.	
Date of Next Meeting Thursday 29 September 2022		

Close of Meeting

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Committee Meeting: PUBLIC Board of Directors

MATTERS ARISING SCHEDULE 2022

Matters Arising from meeting held on: 28 July 2022					
Item	**Subject**	**By**	**Action**	**Due Date/ Update**	**RAG**
8c	**Quarter One People & OD Report**	**JL**	Update to Board on plan for engagement with staff with regard to Inclusion and Belonging	September 2022	**A**
8c	**Quarter One People & OD Report**	**AZ**	Ensure NEDs are aware of Simulation Hub training dates	August 2022	**G**
8d	**Quarter One Experience Report**	**SBr**	Revise format of experience report	November 2022	**A**

as One

Our Values
Welcoming Kind Positive Respectful Professional

PUBLIC Board of Directors

Meeting Date:	29 September 2022	Agenda Item: 6
Subject:	CEO Briefing	
Presented by:	Karen Taylor, Chief Executive Officer	

National update

The national activity is summarised below:

Her Majesty Queen Elizabeth II

The NHS, the nation and countries worldwide have paid their respects following the death of Her Majesty Queen Elizabeth II. Following the announcement of her death a ten day period of mourning started, ending with the state funeral held on 19 September 2022. The Trust along with other public services made arrangements to ensure the bank holiday could be observed but also that service users could still access services and receive appropriate support.

New Prime Minister and Secretary of State for Health and Social Care

On 5 September 2022 Elizabeth Truss (known as Liz Truss) was announced as the leader of the Conservative party and new Prime Minister. Liz Truss was previously Foreign Secretary. Following this a new Secretary of State for Health and Social Care Reform has been appointed, Therese Coffey. Therese Coffey was previously Secretary of State at the Department for Work and Pensions and is the MP for the Suffolk coastal constituency.

Winter Planning

Nationally, regionally and locally there is significant focus on planning and ensuring services are sustainable and resilient over the autumn and winter period. There is a drive to ensure that the NHS continues to be responsive and provide high quality care and outcomes. It expected that the coming months will be highly pressurised for health and care services. NHS England has published plans to boost capacity and increase resilience, there is a particular focus on emergency services, including emergency departments and what the whole system can do to ensure services operate successfully. Nationally there has also been data published highlighting the significant number of staff vacancies in the NHS and the very real impact the rise in cost of living is having on people.

Industrial Action

A number of unions have formally informed the Trust (and other trusts) that they will be seeking to ballot their members on industrial action. The timescales for the votes are autumn 2022. The likely outcome of the ballot is unknown. The Trust has started to prepare for possible industrial action in line with previous plans.

Patient Safety Incident Response Framework (PSIRF)

In August 2022 NHS England has published the new Patient Safety Incident Response Framework (PSIRF) NHS England » Patient Safety Incident Response Framework. The Framework presents a major step in establishing a safety management system that embeds the key principles of understanding how incidents happen, rather than apportioning blame; allowing for more effective learning and improvement, and ultimately safer care for patients.

The PSIRF offers freedom and discretion to organisations to learn and improve the best way they see fit. It removes the 'serious incident' threshold for investigation, instead requiring organisations to create a patient safety incident response plan that is jointly developed and agreed upon by a wide stakeholder group, including patient partners, front line staff, integrated care board members and Care Quality Commission inspectors.

These plans are based on each organisation's local incident profile and existing improvement work, so key areas can be identified for learning response resource to be focussed on, ensuring the resulting learning will have the most benefit on patient safety improvement.

There will be a transition to the PSIRF which is supported by a preparation guide, setting out a 12-month process for organisations to follow through five phases. The Trust is working through the preparation guide and this will be taken through the Integrated Governance Committee to provide assurance on the implementation of the PSIRF.

Cybersecurity Incident

On 4 August 2022, Advanced experienced an outage to their system which was later determined to be as a result of a cybersecurity incident. Due to the significant impact on NHS organisations the incident was managed centrally by the Emergency Preparedness, Resilience and Response teams supported by NHS Digital and National Cybersecurity Centre with national guidance on when it will be safe to connect to these systems. The incident affected two systems at the Trust: eFinancials and DocMan. On notification of the incident, the Trust ceased connection to both systems and put in place additional measures to improve our assurance and preparedness and resilience. The finance department activated their business continuity plan and teams moved to NHS mail to transfer letters to primary care. Following advice from the national team a risk assessment and test was undertaken and eFinancials were made available to the Trust on 30 August 2022.

Digital Protection and Digital Information Bill

In July 2022 the Digital Protection Bill had its first reading in parliament. The Government has said the Bill is intended to update and simplify the UK's data protection framework to reduce burdens on organisations while maintaining high data protection standards. The governance structure and powers of the Information Commissioner's Office (the regulator) would be reformed and transferred to a new body, the Information Commission. The Bill was scheduled to have its second reading on 5 September 2022. However, in a business statement dated 5 September 2022 the Government said that, following the election of Liz Truss as Conservative Party leader, the second reading would not take place as scheduled to allow Ministers to consider the Bill further.

Regional and System update

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

Hertfordshire & West Essex (HWE) Integrated Care System (ICS)

Earlier in September David Sloman, Chief Operating Officer for the NHS visited the Herts and West Essex ICS. He visited the Watford General Hospital site and spent some time meeting with local system leaders. Sandra Brookes, Director of Service Delivery and Service User Experience and David Evans, Director of Strategy and Partnership represented the Trust. David Sloman commended the system on its work noting a number of areas of best practice.

The first meeting of the Herts and West Essex Integrated Care Partnership (ICP) took place on 28 July 2022. The ICP agreed its constitution and membership, with a review of membership to take place in 6 months' time. The ICP considered its role and responsibilities and how the priorities in both Hertfordshire and Essex's respective Health and Wellbeing strategies would inform the development of the Herts and West Essex Integrated Care Strategy. The ICP also considered principles for public engagement and co-production and the work programme for the ICP for the first six months.

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

The Collaborative has successfully secured over £2.8m investment to support system activity, including £1.4m capital investment in crisis services and over £1.4m investment in addressing the backlog in ADHD assessments for children and young people in south and west Hertfordshire.

The Collaborative has begun to reach out to wider partners and stakeholders, to help align system-wide activity, and is currently developing communications related to crisis and winter planning, working with Collaborative stakeholders to develop materials that will best support clinicians, practitioners and patients to access the most appropriate services for their needs.

The Collaborative continues to support Herts and West Essex Integrated Care Board (ICB) colleagues in the development of the new, system-wide, Integrated Care Strategy. The current working draft of the Strategy includes an ambition to *'Improve our residents' mental health and outcomes for those with learning disabilities and autism.'*

A workshop for system leaders has been scheduled for 4 October 2022 to consider the next steps for the development of the Collaborative and the geographical Health and Care Partnerships (South & West Hertfordshire Health and Care Partnership, East & North Hertfordshire Health and Care Partnership and West Essex Health and Care Partnership). The aim of the workshop is to establish a shared understanding of, and agreement to, how these arrangements will develop, a timeframe/roadmap for these development and what system responsibilities may ultimately be undertaken through the Collaborative and the Health and Care Partnerships.

Health Care Partnerships (HCPs)

South and West Herts Health Care Partnership (S&WHHCP)
The S&WHHCP has confirmed its transformation programme priorities which includes a range of different projects aligned with the agreed strategy at place. Two key pilot programmes are launching in the autumn: a system approach to advanced care planning and a pilot of a proactive programme of managing care needs for people with multiple long-term conditions. HFPT is engaged in both priorities of work via the S&WHHCP Delivery Board via direct membership of working groups and as a member of the MHLD&A Collaborative.

East and North Herts Health Care Partnership (ENHHCP):
The ENHHCP has agreed a series of high-impact priorities with the MHLD&A Collaborative to focus on two key areas. Improving integration of services for people who are frail, and particularly those who have SMI and LD and improving the recognition of common mental health conditions in specific physical specialties.

East of England Provider Collaborative
Across the Collaborative, the progress made in relation to young people awaiting beds has been recognised. The longest waits continue to be for eating disorders. The patient flow hub has well established processes for accessing beds and is now focusing on reducing length of stay and delayed discharges. However, due to the ongoing position of having a number of children and young people's beds closed across the Collaborative, the dependency on independent sector and out of area beds remains a concern. Workforce challenges are the biggest risk to the ongoing work in relation to children and young people.

A mobilisation plan is being developed to support the implementation of a virtual day service for adult eating disorders across the Collaborative, by the HPFT team. Secure service transformation continues to be focused on the expansion of community forensic services.

Trust-wide update

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

Operational update

Across a number of operational services, demand has started to stabilise, although the run rate remains higher than pre-COVID. The most significant challenges are in community adult services due to ongoing high levels of demand, and a high number of vacancies and in the adult acute pathway. A focused programme of work is in place, Managing Director portfolios have been reviewed and additional clinical leadership capacity has been identified for these two service lines with aligned resources to support service improvement and transformation.

Performance is improving across a range of key performance indicators overseen by the Recovery Programme. Workforce remains the biggest challenge and a weekly oversight meeting has been

established to provide senior oversight of particular areas of concern. Access to specialist placements remains a challenge and we continue to experience delayed transfers of care as a result. Significant progress has been made in primary care transformation and the co-production of an older adult transformation programme.

Following the review of our Strategic Business Units (SBUs) we have moved to three SBUs, with Essex Learning Disability (LD) services moving into the Learning Disability and Forensic SBU. This provides an opportunity to further develop LD services across all the areas we cover with shared learning and expertise. Improved Access to Psychological Therapy services have moved to West and East and North SBUs, so that they are being led within the relevant geography to support the primary mental health model development.

Winter Planning

Winter planning is well underway with both a Trust and ICB plan being developed. The Trust plan is focused on the five pillars: data; demand and capacity; best practice; working with the voluntary sector; urgent and emergency care capital bids. Alongside this will be a surge and escalation plan and a communications plan. The overall winter plan is expected to include Flu and COVID plans, planning for adverse weather and Christmas and New Year. There has been a limited amount of winter funding that has come into the ICB. Bids for this are underway which are focused on flow in the Emergency department, support to discharge and additional capacity within the voluntary sector. We are fully engaged in all the system winter planning forums.

Forest House Adolescent Unit (FHAU)

The CQC undertook their re-inspection of FHAU in July 2022 as indicated in the Warning Notice issued in February 2022. Inspectors undertook a two-day inspection on 6 and 7 July 2022. The inspection included a tour of the unit; interviewing staff; meeting families and carers of young people; meeting young people; reviewing documents and observed a Multidisciplinary Team meeting. Following this, inspectors attended the unit on Sunday 24 July and focussed on reviewing CCTV and cross referencing a number of reported incidents. Further information requests were made by the CQC and submitted and the Trust has submitted a 'factual accuracy' report in line with standard CQC factual accuracy processes. This will be considered by the CQC and a final report published by the CQC thereafter.

Our People

Our vacancy and unplanned turnover continue to be a challenge and remains a key focus. Our vacancy rate reduced from 14.1% in July to 13.5% in August, whilst our unplanned turnover rate increased slightly from 13.9% in July to 14.2% in August. We have been running a number of successful face to face recruitment events and continue to run campaigns through social media and online platforms, as well as welcoming this year's cohort of newly qualified nurses. We are now partnering with a well-regarded international organisation to support our marketing and attraction work to ensure that we promote the Trust as a great place to work and to receive care.

Our appraisal rates have recovered further to 84.6% in August and we continue our work to ensure full recovery so that every person has a strengths-based appraisal conversation each year. This work forms part of our retention plans, to ensure our people are supported to thrive and further develop their careers with us. Our work on increasing mandatory training compliance has brought about 93.1% compliance in August (up from 91.2% in July), which is above our target of 92%.

As part of our retention work, we continue to provide a robust health and wellbeing offer to our staff. We saw sickness absence reduce in August to 4.7% compared to 5.2% in July. During August, we saw mental ill health related absence continue to be at a relatively lower level than historically, whilst absence due to colds/flu and gastro-intestinal issues increased. A comprehensive wellbeing support offer continues to be provided. During September, we launched our third Wellbeing Festival, which is visiting the majority of our sites as well as offering a number of online events and is focussing particularly on self-care.

During August we received notice from the Royal College of Nursing that they would be balloting their members in the Trust on taking strike action. The notice of ballot will be reissued so that it takes place after the period of mourning for Her Majesty the Queen. We anticipate further notices from other Trades

Unions and are engaging in constructive conversations with our staff side colleagues to ensure we can continue to safely provide services for our service users during any period of industrial action.

Finance

The Trust financial performance is in line with plan, reporting a breakeven position at the end of month five. Pay costs remain high reflecting the continued high demand for services which is driving higher agency costs. Demand for acute beds is still high but work to improve flow is reducing the number of out of area placements since the turn of the year. Although the trust remains on plan to deliver a breakeven position at year end the underlying run rate of spend is significantly higher than budget, driven by the above pay costs and out of area placements

Executive and Non-Executive Director update

The recruitment process for the Executive Director, People and OD (Chief People Officer) is well underway and the timeline for the search has been extended with final interviews scheduled to take place in November 2022. The recruitment process will be starting shortly to appoint a substantive Executive Director, Finance & Estates. The process will be supported by an external recruitment agency and will be in line with the robust process used for Executive Director appointments. Maria Wheeler leaves the Trust this month, with Paul Ronald joining as interim Executive Director, Finance & Estates on Monday 26 September.

Awards

The Trust has been shortlisted for an award at the prestigious national Health Service Journal (HSJ) Patient Safety Awards in October. The submission related to the national changes made following work by the Trust to make reasonable adjustments to mental health tribunals for people with learning disabilities.

The Trust has also been shortlisted for two HSJ awards with judging taking place in late September 2022. The two shortlisted entries are: Clinical Leader of the Year – Dr Inder Sawhney and Innovation and Improvement in Reducing Healthcare Inequalities Award – our physical health check clinics for people with learning disabilities. The awards evening is 17 November 2022, and members of the teams will be attending.

The Trust has also been shortlisted for four awards in Positive Practice in Mental Health. The shortlisted entries are: Adult Eating Disorders service; equine therapy project at Warren Court; physical health clinic for people with learning disabilities in Essex and our work to make national changes to the mental health tribunals process for people with learning disabilities. The awards ceremony is on 6 October 2022 and members of the teams will be attending.

Karen Taylor
Chief Executive Officer

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 7a
Subject:	Appointment of Senior Independent Director	**For Publication:** Yes
Author:	Kathryn Wickham, PA to Chair and Head of Corporate Affairs & Company Secretary	**Approved by:** Helen Edmondson. Head of Corporate Affairs and Company Secretary
Presented by:	Sarah Betteley, Chair	

Purpose of the resolution:

To update the Board on the process and appointment of the Trust Senior Independent Director.

Action required:

Board members are asked to consider the contents of the report, and note the recommendation for approval by the Council of Governors.

Summary and recommendations:

Introduction

The NHS Foundation Trust Code of Governance specifies the Board of Directors should appoint one of the independent Non-Executive Directors to be the Senior Independent Director (SID), in consultation with the governors, attached as appendix one is the role outline for the SID.

Background

Catherine Dugmore was the Trusts SID until her term of appointment ended on the 31 July 2022.

Appointment Process

At their meeting of the 12 April 2022, the Appointments & Remuneration Committee were provided with an update on the upcoming SID vacancy following Catherine Dugmore's term of appointment ending.

Sarah Betteley, Chair of the Trust wrote to all Non-Executive Directors on the 2 August 2022 inviting them to consider the role. Following this, one Non-Executive Director, Jon Walmsley put forward his expression of interest.

At their meeting of the 21 September 2022, the Council of Governors, in line with the Trust constitution (see excerpt below) were updated on the appointment process for a Senior Independent Director and provided their recommendation to the Board for approval.

Recommendation

The Board of Directors are asked to provide approval, on the recommendation of the Council of Governors for the appointment of Jon Walmsley as Senior Independent Director.

Table 1

Excerpt from the Trust constitution

2.11 Appointment and Powers of Senior Independent Director - Subject to SO 2.14 below, the Chair (in consultation with the Non-Executive Directors and the Council of Governors)

may appoint a Non- Executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of his term as a Director, as they may specify on appointing him. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Job Description", as amended from time to time by resolution of the Board of Directors.

2.12 Any Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Chair (in consultation with the Non-Executive Directors and the Council of Governors) may thereupon appoint another Non-Executive as Senior Independent Director in accordance with the provisions of Standing Order 3.9.

2.13 The posts and duties of the Vice-Chair and Senior Independent Director will not be combined. This decision may be reviewed at any time by the Board of Directors, in consultation with the Council of Governors.

2.14 The role of the Senior Independent Director will include acting as a conduit for concerns to be raised by Governors if the usual mechanisms of contact and discussion have been exhausted and, subject to the agreement of the Council of Governors, making arrangements for the annual evaluation of the performance of the Chair. The process to achieve this evaluation and its outcome will be agreed with and reported to the Council of Governors.

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

N/A

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

N/A

Equality & Diversity /Service User & Carer Involvement implications:

N/A

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

N/A

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

Council of Governors 21/9/22

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 8
Subject:	Covid 19 and Winter Planning	**For Publication:** Yes
Author:	Sam Garrett, Tactical lead	**Approved by:** Sandra Brookes, Executive Director of Service Delivery and Experience/COO
Presented by:	Sandra Brookes, Executive Director of Service Delivery and Experience/COO	

Purpose of the report:

To update the Trust Board on the Trust's approach to managing the impact of Covid-19,and planning for winter.

Action required:

The Board is asked to receive and note this report.

Summary and recommendations to the Executive Team:

Summary

This report will update the Board on the actions in place to ensure that Covid-19 infections and suspected or confirmed cases are managed effectively over 7 days a week.

Due to significantly decreased Covid-related activity, incident response has been stepped down following the August Bank Holiday, and full Operational, Tactical, and Strategic Command meetings will not take place from week commencing 5th September. A full shadow rota remains in place with named individuals available 09:00 – 17:00 weekdays and 09:00 – 13:00 weekends and bank holidays, with Business as Usual Out of Hours and On Call arrangements outside of these times.

In addition to the shadow rota, an Incident Command Core Team of Tactical Commander, EPRR Lead, IPC Lead, and support, meet weekly. This team will review each week explicitly whether to recommend to Strategic Command stepping up actions such as mask-wearing and/or additional meetings, based on RAG rating derived from the number of current cases. Tactical Command meetings can also be stood up at any time if deemed necessary, and although not related to COVID19, this was evidenced in August when it was necessary to hold additional meetings at short notice due to a connectivity outage on the Kingsley Green site.

Recommendation

The Board are asked to note the general update provided within this report and the key areas of focus within the Winter Plan.

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

N/A

Covid 19 incident management

1. Introduction

1.1 This report will focus on the management of Covid-19 outbreaks, issues that have arisen from Covid-19, and the impact on the Trust.

2. Current Status of Incident

2.1 Cases have been reducing nationally and regionally and with HPFT figures improving Incident Command has been stepped down.

2.2 Mask-wearing is required in clinical settings but no longer in non- clinical settings. There is a process in place to step back up if this becomes necessary, based on the number of regional inpatient admissions with Covid-19.

3. Trust Incident Response Structure

3.1 Incident Management is in place 7 days a week, 09:00 – 17:00 weekdays and 09:00 – 13:00 weekends, including inbox monitoring and admin support during those times. Outside of these hours the Trust's usual arrangements for Out of Hours and On Call remain in place. There is also a Senior Nurse on call during the day at weekends, though they have not been frequently called upon and therefore this cover is under review.

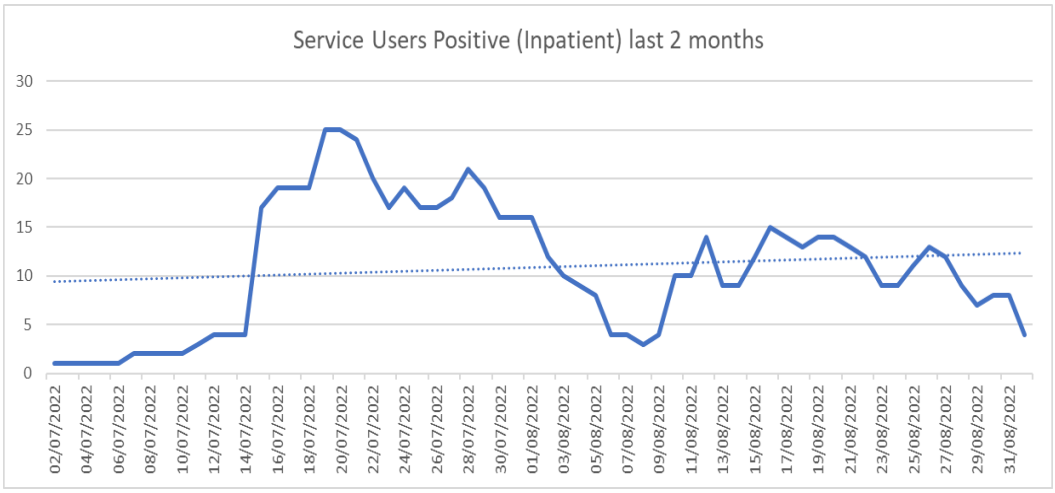
3.2 Full Operational, Tactical, and Strategic meetings have been postponed with effect from 5th September, with a full shadow rota remaining in place. This can be stood up as and when deemed necessary, which although not Covid 18 related, was evidenced on 25th August when Incident Command was stood up due to a connectivity outage at the Kingsley Green site.

3.3 In addition, an Incident Command Core Team of Tactical Commander, EPRR Lead, IPC Lead, and support, meet weekly. This team will review each week explicitly whether to recommend to Strategic stepping up actions such as mask-wearing and/or additional meetings, based on RAG rating derived from the number of current cases. This will ensure that an agile response remains as the situation changes.

4. Covid-19

4.1 The number of Covid 19 positive service users in in-patient care is reducing a shown below:

Figure 1 Positive service user inpatient cases



4.2 Of the 24 outbreaks opened in this wave, almost all have now closed.

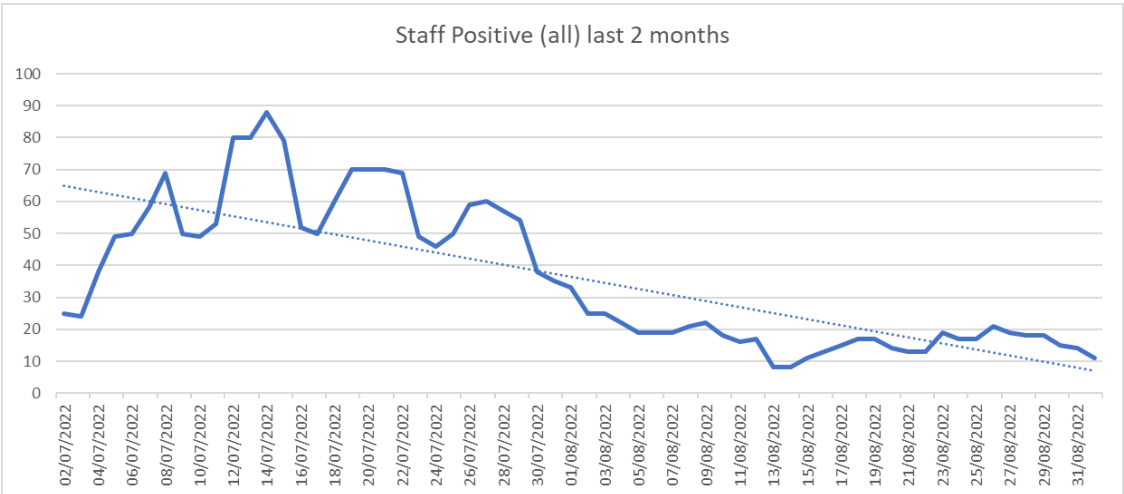
4.3 Mask-wearing is currently only necessary whilst interacting with service users.

4.4 The total of Covid-19 related service user deaths is at 232.

5. Safe, Effective and Timely Care Delivery

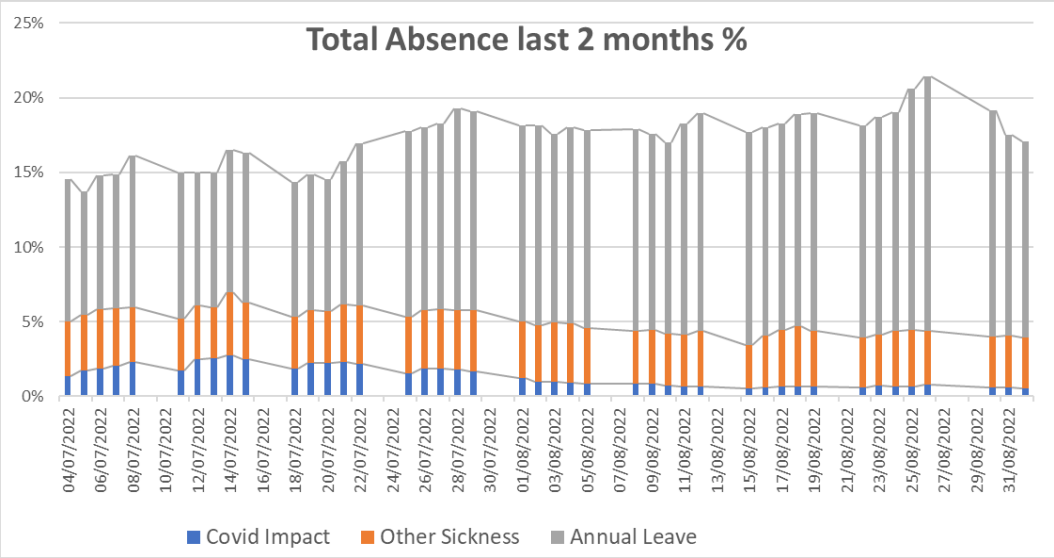
5.1 Staff positive cases are at the lowest level since June 2022.

Figure 2 staff positive cases



5.4 Absence including annual leave and all sickness has averaged 17%this last month and the Covid impact has been low all summer and less than 1% since the start of August. This is illustrated in the following graph tracking all absence over the last 2 months split by Annual Leave, non-Covid sickness, and Covid impact (including confirmed and suspected Covid, Long Covid, and self-isolation).

Figure 3 Absence



5.3 The Trust will be offering both the flu and COVID-19 vaccinations from 3 October.

6. People

6.1 Twice weekly LFD testing is no longer required and as such compliance will no longer be reported. Testing does continue for symptomatic staff and those on outbreak wards, who will continue to report.

6.2 Nationally arrangements for sick leave and self-isolation relating to Covid-19, including Long Covid sickness, have now reverted to contractual arrangements. All staff currently off sick with Long Covid have been seen by managers and HR representatives to ensure that they understand the implications of the change.

6.3 The current pension abatement arrangements are due to end in October but a national consultation is now underway with a proposal that the arrangements may now continue through the winter period; this has yet to be confirmed.

7 System and Partnership

7.1 Pressures remain in the wider system, though these are not now exclusively related to Covid.

8 Communications

8.1 Staff communications have focused on the change in arrangements relating to mask-wearing and LFD testing.

9 Reflection on Key Risks

9.1 The risks related to a high number of outbreaks are not currently an issue at present.

10 Recommendation

10.1 The Board is requested to note the update provided within this report.

Winter Planning

1. Introduction

The Trust Winter Assurance process will enable the Trust to continue to manage:

- Safe, effective and timely care
- Support and enable a healthy, resilient workforce
- Provide a dynamic response to Flu, Covid, adverse weather, and surges in demand
- Support system responsivity

2. Structure

2.1 The winter plan is being mobilised around 5 pillars:

- Use of data
- Demand and capacity
- Best practice
- Working with the voluntary sector
- Urgent and emergency care capital bids

2.2 In addition, the winter plan will need to include; surge and escalation plans; flu and Covid 19 vaccination plans; communication plans.

3. Use of data

3.1 A consolidated bed status report is to be produced every day including community and placement capacity.

3.2 Three times a day operational oversight meetings have been established providing an opportunity to escalate issues and improve handover to out of hours.

4. Demand and capacity

4.1 A number of actions are being considered to increase capacity this includes the potential to block book additional independent sector beds which will be funded by system winter funds.

4.2 In order to improve flow within the Emergency Departments (ED), additional AMHP provision will be sourced and a recruitment campaign to increase substantive AMHP staffing is being pursued.

4.3 The process of discharge is to be reviewed to push discharges to take place earlier in the day to support flow, alongside scoping options for a discharge lounge and or assessment suite to improve access to beds.

4.4 A task and finish group will be established to scope out the implementation of a "virtual ward" model, to review people, waiting for admission in the community, acute hospitals, 136 suites and to support those following discharge.

5. Best Practice

5.1 Planning for winter provides a real opportunity to try out new models and approaches and not just consider additional funding but more focus on different ways to provide services. A team have visited an ED divert centre in Camden and Islington and are linking with teams in Lincolnshire and Leicestershire where they have made improvements in flow and the use of out of area beds.

5.2 We are also receiving support from a "Getting it Right First Time" expert who is supporting us to use data to identify key priorities for new ways of working and challenging us to consider a move toward "patient initiated" reviews, and improving access into services.

5.3 A number of actions have been agreed with West Herts Hospital Trust WHHT) to work together to reduce the number of service users who attend ED regarding physical health needs from our in-patient services; increasing physical health intervention into street triage to avoid use of ED and introducing a new model of front-door triage in ED.

6. Working with the voluntary sector

6.1 A review of communication procedures between our crisis service and those run by the voluntary sector (crisis cafes, nightlight) is to be carried out to see if this support frequent attenders more effectively but also assists in highlighting if somebody is deteriorating to earlier intervention can take place.

6.2 All place-based systems are being requested to identify "warm rooms" to support the general public during the energy crisis. IAPT services will provide an in-reach service into these in order to support anybody with mental health needs.

6.3 The older people's services are considering how they can provide further support to care homes to prevent crisis and subsequent admission.

7. Urgent and Emergency Care Capital

7.1 Herts and West Essex ICB have out in bids for a number of capital schemes to support the improvement of the acute pathway for people with mental health needs. Region have supported the bid to provide safer rooms in ED at WHHT and East and North Herts Trust for people with mental health needs so that they are ligature free environments but also quieter spaces to support assessment and recovery from crisis. (£850K). Additional bids have been submitted for MIND to improve infrastructures with regards to helplines and to set up an additional crisis café in WelHat**.**

8. Summary

The 2022/23 winter plan is being developed by a task and finish group reporting to the Trust Management Group. Whilst there is some winter funding money coming into the system specifically for mental health this is limited and is likely to be focused on improving flow in ED and supporting discharge for those with no recourse to social funding, in particular. However, the winter plan is an opportunity to try some new ways of working, in order to be able to respond effectively to demand and additional pressures for example Covid 19, and Flu. The biggest risk to the winter plan is workforce in terms of recruiting to current substantive roles and retaining our people.

Incident management will continue to function as described, in line with National requirements on order to be able to respond to any increasing Covid 19 cases and system pressures.

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 9
Subject:	Report of the Integrated Governance Committee held on 15 September 2022	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Diane Herbert, Non-Executive Director
Presented by:	Diane Herbert, Non-Executive Director and Integrated Governance Committee Chair	

Purpose of the report:

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

There were no items for formal escalation to the Board.

It was noted that the following items would be discussed at the September Board meeting.

a) EPRR return – recommended to the Board for approval.
b) WRES WDES – report to be considered by the Board, noting that the information would be published on the Trust website by 31 October 2022.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

None

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

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Integrated Governance Committee held on 15 September 2022

1. Introduction

1.1 This paper provides the Board with a summarised report highlighting key Committee business and issues arising from the meeting.

1.2 Since the last Integrated Governance Committee report to the Trust Board in Public, the Integrated Governance Committee ["the Committee"] held a meeting on 15 September 2022 in accordance with its terms of reference and was quorate.

1.3 Andrew Van Doorn was welcomed as a new member of the Committee. Diane Herbert, Non-Executive Director, chaired the Committee.

1.4 The Committee received and considered a number of items to provide assurance. Appendix 1 details the agenda for the meeting. Detailed below are the key areas to be highlighted to the Board and areas that the Committee discussed.

2. Nurse Recruitment

2.1 Since the nursing workforce is a high risk for the Trust, the Committee received a presentation on the current situation concerning vacancy figures for registered and unregistered nursing staff. It was noted that the vacancy levels had remained high despite significant recruitment and that unplanned turnover remained a concern.

2.2 The Committee were updated on the initiatives in place to reduce the vacancy levels and the impact this was expected to have on the number in coming months. It was noted that the Trust was working with an external company to enhance the marketing of the Trust and to emphasise the offer to new staff. Also, the Trust had successfully undertaken international recruitment for registered nursing and Allied Healthcare Professionals and would be increasing this programme.

2.3 The Committee discussed the tracking of recruitment to services for which the Trust had received additional investment, noting that most of the services were able to recruit to the vacancies.

2.4 The Committee noted the significant recruitment pipeline for nursing and health care support workers, but that continued effort must be made to retain staff. The Committee considered the reasons given for leaving and what the Trust is doing to mitigate against these, including support for cost of living pressures, the wellbeing offer, support for development and incentives.

2.5 In response to questions, it was confirmed that the recruitment pipelines for nursing places at local university was healthy, but there remained concerns about training for Learning Disability nurses.

2.6 The Committee noted the importance of nursing vacancy rates improving and welcomed the establishment of a weekly oversight group, with Exec Director

involvement. This group would track the recruitment and retention of staff in significant detail, facilitating immediate interventions to resolve issues.

3. Emergency Preparedness Resilience and Response

3.1 The Committee considered the Trust's proposed submission as part of the NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework, which requires providers and commissioners of NHS-funded services to show they can effectively respond to major, critical, and business continuity incidents while maintaining services to patients.

3.2 The Committee considered the outcome of the first of the four stages of the process, namely the 'self-assessment'. The Committee considered the assessment across all 68 core standards and the one deep dive standard. The deep dive for this year relates to Evacuation and Shelter. The completion of the self-assessment and collation of evidence supported the Trust declaring itself fully compliant with all systems and processes remaining effective.

3.3 It was noted that the Trust continues to respond to incidents in line with EPRR requirements, most recently concerning Monkeypox and extreme heat. The Trust has also participated in exercises and is planning a tabletop exercise on evacuation and shelter later this year. In response to a question, it was confirmed that the Trust had undertaken 'real life' evacuation exercises when it had been safe and appropriate.

3.4 The Committee agreed to recommend the self-assessment to Board for approval.

4. WRES and WDES

4.1 The Committee considered the WRES and WDES data for the Trust as of 31 March 2022. It was noted that both standards use a combination of locally held workforce data and annual staff survey data to help identify the experience of BAME and disabled staff compared to white and non-disabled staff. Since the staff survey data relates to the 2021 annual staff survey, any impact of initiatives to achieve improvement launched this financial year, such as the inclusion ambassador scheme and the workplace adjustments panel, will not be reflected in the data.

4.2 The Committee noted the movement in the figures since last year's submission, based on data from 31 March 2021 and the 2020 annual staff survey. The Committee considered that the data shows that BAME staff have been 2.8 times more likely to enter the disciplinary process this year than white staff. The Committee discussed that in 2021, a positive position for this indicator was reported. However, it became apparent that the data for 2021 was incorrect, and we should have reported a position of BAME staff being 2.4 times more likely to enter the process.

4.3 The Committee explored the factors that led to the incorrect data being submitted and the level of confidence that the correct information was now being reported. It was reported that going forward that there would be quarterly reports to PODG, the Executive Team and IGC, on all WRES and WDES data. And that there would be clear identification of the lead for this area who would be appropriately supported. This data would also inform the inclusion and equalities governance group, which is currently being set up.

4.4 It was noted that the data, including the erroneous data submitted last year, is being openly and transparently discussed with staffside colleagues, our staff networks and as part of our engagement to develop our belonging and inclusion strategy to co-produce a comprehensive action plan to address the areas for improvement.

4.5 The Committee discussed what the data was saying about the experience of BAME staff. The continued work of the first decision panel was welcomed, and recognition of the additional support and guidance that may be helpful to Health Care Support Workers.

4.6 In response to a question, detail of the work being done to improve the level of disability reported by staff was outlined, namely, more to improve data on ESR introducing self-service and launching of App to support data collection.

4.7 It was noted that this report would also be considered at the September Board meeting.

5. Forest House Adolescent Unit (FHAU) – CQC update

5.1 The Committee considered a report that set out the improvements made at Forest House dating back to 2021. It was reported that the unit had been re-inspected in July 2022 to follow up on the Warning Notice issued in February 2022.

5.2 The Committee were updated on Section 29A Warning Notice that the Trust had received following the inspection in July 2022. The Notice was related to the absence of call bells and undertaking of seclusion. The Trust had responded to the Warning Notice and was awaiting feedback from CQC. It was noted that the Trust was awaiting the report from CQC following their most recent visit.

5.3 Non-Executive Directors Committee members reported that they had a briefing on this matter directly with the Chief Executive and supported the actions being taken by the Executive Team.

6. Prevention of Future Death (PFD) Report

6.1 The Committee considered a report regarding a Prevention of Future Death (PFD) report that the Trust had received in late August 2022. The report related to the death of a service user in 2019 who was under the care of Child and Adolescent Mental Health Services.

6.2 The Committee discussed the areas of improvement identified by the Coroner, noting that several other providers had been issued a PFD report relating to the death. The areas for improvement relating to the Trust centred on: the lack of risk assessment training for staff allocated to the service user; the lack of a robust system in place to communicate to general practice significant changes in risk to the young person; the high threshold for the high-risk pathway; lack of a clear system in place for the inpatient crisis team to liaise with the consultant psychiatrist within the CAMHS team, and no hospital link worker to aid communication. It was noted that the last two findings related to other NHS providers.

6.3 The Committee noted the actions that had already taken place, e.g. review of high-risk pathway and that the Trust is legally required to respond to the Coroner by 26 October 2022.

6.4 The Committee noted that the Board would be updated on this case at its meeting on 29 September 2022.

7. Mortality Governance Internal Audit

7.1 The Committee considered the recent Internal Audit on the Mortality Governance systems in the Trust. The Committee noted the findings of the audit and the partial assurance rating.

7.2 It was reported that a number of the recommendations identified had been actioned, for example, updating the policy and timely recording of deaths on Datix. It was noted that the backlog for Structured Judgement Reviews had reduced to below ten.

7.3 Committee members welcomed the progress and noted that the report had been discussed at the Audit Committee earlier this month. In response to a question, it was confirmed that additional resources had been identified to help with the backlog.

8. Matters for Escalation to the Board

9.1 There were no items for formal escalation to the Board.

9.2 It was noted that the following items would be discussed at the Board meeting at the end of the month:

c) EPRR return – recommended to the Board for approval.
d) WRES WDES – report to be considered by the Board, noting that the information would be published on the Trust website by 31 October 2022.

Appendix One: Integrated Governance 8 September 2022, agenda items

Welcome and opening meeting
Apologies for absence
Declarations of Interests
Minutes and matters arising
Minutes of meetings held on 22 July 2022
Action Schedule
DEEP DIVE
Nurse Recruitment
GOVERNANCE AND REGULATION
Annual EPRR report
PEOPLE
People and OD Report
PODG Terms of Reference
WRES and WDES Data
GMC Training Survey 2022 Report
Respect Training Trajectory
QUALITY SAFETY
CQC Forest House Update
Vaccination Campaign Update Report August 2022
Use of Force Act Implementation
Ockenden and EPUT Inquiry
QUALITY EFFECTIVENESS
Prevention of Future Death Report
Mortality Governance Internal Audit Report
Bi-annual Physical Health Report
CPAC Update Report August 2022
Quality Impact Assessments Update Report August 2022
National Clinical Audits
QUALITY EXPERIENCE
Involvement and Inclusion Update
TO NOTE
COVID -19 Update Report August 2022
Q1 Information Governance Incidents/SARS/FOI
Integrated Safety Update Report August 2022
Report from PODG – 4 August and 7 September 2022
Report from QRMC – 2 September 2022
IMGS – 30 August 2022
Committee Planner
Any Other Business
Matters for escalation
Date and time of next meeting: **10 November 2022**

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 9a
Subject:	Quarter 1 2022/23 Integrated Safety Report	**For Publication:** Yes
Authors:	Bina Jumnoodoo, Deputy Director Nursing and Quality	**Approved by:** Jacky Vincent, Executive Director Quality & Safety (Chief Nurse)
Presented by:	Jacky Vincent, Executive Director Quality & Safety (Chief Nurse)	

Purpose of the report:

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

Action required:

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

Summary and recommendations:

The number of incidents reported on Datix has decreased by 16% this quarter from 3,106 to 2,589. The Trust reported 31 Serious Incidents external to the Trust, an increase of two. 28 Serious Incident reports were completed and submitted to Trust Commissioners in the quarter.

Unexpected or avoidable deaths remain the largest category of Serious Incidents, with 14 reported this quarter, a decrease of three. Serious incidents relating to self-harm remained static at nine and to slips, trips and falls at one. There was one Serious Incident declared categorised as an alleged homicide.

130 deaths were reported, a decrease of 32. The highest numbers of deaths reported were in the East and North SBU, which includes older age adult services. Four Covid 19 confirmed or suspected deaths were reported.

Work commenced to build four more safety suites across the Trust and two High Dependency Unit bedrooms at Forest House.

The Trust is participating in a Reducing Restrictive Practice Continuous Quality Improvement project with the Eastern Academic Health Science Network with other Mental Health Trusts in the region.

Work has been undertaken in response to the learning from previous quarters with particular focus on racial abuse, violence and aggression, sexual safety, and restrictive practice.
There has been a focus in improving sexual safety with the development of a sexual safety work plan.

The reduction in use of physical restraint and the downward trend in seclusion continued. There were two reports of prone restraint and there has been a reduction in the use of Rapid Tranquilisation.

The Trust's Violence and Aggression Policy has been updated and ratified to include the requirements of the Use of Force Act 2018.

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

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

Relation to the Trust Risk Register:

The Trust's Risk Register has a number of risks that relate specifically to safety which are reported in the quarterly Trust Risk Register Reports.

Relation to the BAF:

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

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

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

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

There are no implications arising from this report.

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

This report sets out actions taken in quarter 1 2022/23 as part of the Care Quality Commission Key Lines of Enquiry.

Seen by the following committee(s) on date:

QRMC 2 September 2022
IGC 15 September 2022

Quarterly Integrated Safety Report Quarter 1 2022/23

Executive Summary

This report provides an overview of safety including incidents, mortality, harm free care, restrictive practice and safeguarding. It also provides a review of trends, themes and identified learning setting priorities for the work in subsequent quarters.

The Trust's annual plan objective for safety is:

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

Key priorities were:

- *We will continue our drive to reduce suicides and prevent avoidable harm.*
- *Keep service users & carers physically and mentally safe, reducing the harm they experience*
- *Further develop our approach to managing violence and aggression & evidence-based restrictive practice*
- *Expand the training, development, and leadership of teams to keep our staff safe.*

This report is divided into the following sections:

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

Part A- Governance and Assurance

1. Introduction

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

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

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

2. Priorities

2.1 A number of priorities were set in relation to safety in the Trust's 2022/32 Annual Plan:

- *We will continue our drive to reduce suicides and prevent avoidable harm*
- *We will ensure restrictive practices across the Trust are in line with best practice*

- *We will target activities to reduce violence against services users and staff.*

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

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

3 Trust Risk Register

3.1 The Trust's Risk Register (TRR) is reviewed regularly and has a number of risks that relate specifically to safety. This is reported in a separate paper to the IGC at July's meeting.

4 Health and Safety Executive

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

- Risk Assessment for violence and aggression to employees and those not in Trust employment from or by service users. Carry out a suitable and sufficient assessment of the risks to health and safety for staff whilst working with service users
- Put arrangements in place to ensure that all the reusable slings used for moving and handling service users are thoroughly examined at least every six months
- Put arrangements in place to review and update moving and handling risk assessments, making these less generic and including situations where the risk of violence and aggression is increased
- Violence and aggression against staff and need to improve processes, plans, learning and risk assessment. Produce a policy detailing how and when incidents of violence and aggression will be investigated.

5 Safety Alerts

5.1 There were 28 Central Alerting System (CAS) Alerts received during the quarter, which have been reviewed and the learning and actions taken forward, disseminating to the relevant services, and accompanied by changes to policy and practice, where required.

5.2 Those that were applicable are detailed as follows:

- *NatPSA/2022/003/NHSPS – Inadvertent oral administration of potassium permanganate.* Action plan put in place and completed, led by Clinical Effectiveness Pharmacist
- *CEM/CMO/2022/008 – Immediate Actions in Response to Cases of Monkey Pox Virus in UK with no known travel history.* Internal safety alert communicated to staff
- *FSN: 2204/46897/00 – SOL-M Blunt Fill Needle 18G 40mm No Filter RECALL DEVICE.* The Trust latterly confirmed it did not have any current stock of the device
- *Update in Dietary advice to only consume smoked fish if thoroughly cooked – to reduce risk of listeriosis in people who are vulnerable to infection due to an ongoing outbreak linked to smoked fish.* Information communicated to teams
- *UKHSA2022/003 PH Message: Immediate actions in response to detection of Vaccine Derived Polio Virus type 2 (VDPV2) in London sewage samples.* Communications awareness planned.

5.3 Those that are still awaiting confirmation as to whether they are applicable to the Trust are detailed as follows:

- *NatPSA/2022/005/UKHSA: Contamination of hygiene products with Pseudomonas aeruginosa*
- *NatPSA/2022/004/MHRA: NovoRapid PumpCart in the Roche Accu-Chek Insight insulin pump: risk of insulin leakage causing hyperglycemia and diabetic ketoacidosis*
- *Increase in acute hepatitis cases of unknown aetiology in children.*

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

- *HPFT/2022/004 – eBurn e-Cigarettes Update*
- *HPFT/2022/003 – Haloperidol*
- *HPFT/2022/005 – Patient Safety Incidents (access to keys, fire prevention, tailgating)*
- *HPFT/2022/006 – Anti Tear Clothing*
- *HPFT/2022/007 – Monkey Pox*
- *HPFT/2022/009 – Bandage Ligature Risk*
- *HPFT/2022/008 – Pregabalin in Pregnancy*
- *HPFT/2022/010 – Philips AED Pads*
- *HPFT/2022/011 – Face Mask Recall.*

5.5 There was previously one overdue NPSA alert which was closed on 1 April 2022:

- *NatPSA/2021/007/PHE Potent synthetic opioids implicated in increase in drug overdoses.* An action plan has been created and completed for inpatient and community services. A standard operating procedure (SOP) was ratified by the Trust's Drug and Therapeutic Committee (DTC) and an e-learning package is available. Furthermore, Naloxone is now in stock.

6 Care Quality Commission

6.1 The IGC will be aware of the CQC's unannounced focused inspection at Warren Court in September 2021. The CQC's report outlined their findings, which included seven 'must dos' and one 'should do' actions. The Trust's Practice Audit and Clinical Effectiveness (PACE) team conducted an audit in April 2022 against the identified actions. They were able to provide 100% assurance that all expected actions have been completed, and detail has previously been presented to the IGC.

6.2 The IGC will also be aware of the CQC's unannounced inspection at Forest House Adolescent Unit in November and December 2021. An oversight group meets twice weekly, and an action plan remains in place with clear outcomes and deadlines, reporting to the Trust's Executive Director Quality and Safety (Chief Nurse) on a weekly basis. At the time of this report, the CQC have returned to Forest House for a further unannounced inspection, and an update has been provided to the IGC.

CQC Insight Report

6.3 The CQC Insight tracks trends in quality at provider, location and/or core service level to support decision making). It aims to make it easier for inspectors to monitor their portfolio and identify potential changes in quality with routine access to key information. It will also contribute to a shared view of quality across services.

6.4 Responding to CAS Safety alerts in a timely way was identified in the Insight report as much worse when compared nationally.

6.5 Between April 2021 to March 2022' there was an increase in alerts being closed late. All overdue alerts are reported quarterly in the Safety Alert report presented at the Safety Committee including the rationale for an alert being overdue and the mitigation. The most recent overdue alert NatPSA/2021/007/PHE Potent synthetic opioids implicated in an increase in drug overdose - for this specific alert the Deputy Director of Clinical Quality and Patient Safety for NHS England and NHS Improvement – East of England was kept updated on progress.

6.6 The Trust has a policy for the cascading of all safety alerts (including NPSAs). The Trust's Safer Care and Standards Facilitator is responsible, on behalf of the Trust, to confirm that they have received the alert on the CAS system and that it is being cascaded to all relevant areas within the Trust, as appropriate. There are deadline dates on all alerts by which the Trust has to confirm all necessary action has been completed, actions will be followed up and escalated by the Safer Care and Standards Facilitator

6.7 All alerts are stored and updated on Datix, noting whether the alert is applicable or non-applicable to the Trust and any actions that need to be taken. Evidence of actions taken, and compliance is saved on Datix as a contemporary record of the alert.

6.8 Compliance with the implementation of alerts is provided with a quarterly report which is presented at the Trust's Safety Committee detailing any alerts which are applicable to the Trust, actions being taken and any alert which are overdue for completion. Both the proportion of staff doing paid and unpaid overtime was identified as worse when compared nationally (April 2022 PICKER NHS staff survey), this is now being picked up as part of the Trusts NHS staff survey action plan with the work on staff wellbeing / self-care / work life balance.

6.9 The Insight report identified morale, staff engagement and the proportion of staff who believe the provider is adequately staffed were all identified as declining, again all these indicators are linked to the April 2022 staff survey results, picked up as part of the Trusts NHS staff survey action plan and forms part of the people risk on the Trust risk register.

6.10 High rates of restrictive interventions were identified as worse when compared nationally identified via NHS Digital and the Mental Health Minimum Data Set (MHMDS) HSDS April 2022, please see the 'least restrictive care' section of this report.

6.11 The report identified the proportion of days sick in the last 12 months for Medical and Dental staff (%) was identified as worse when compared nationally from the Electronic Staff Record.

Conclusion

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

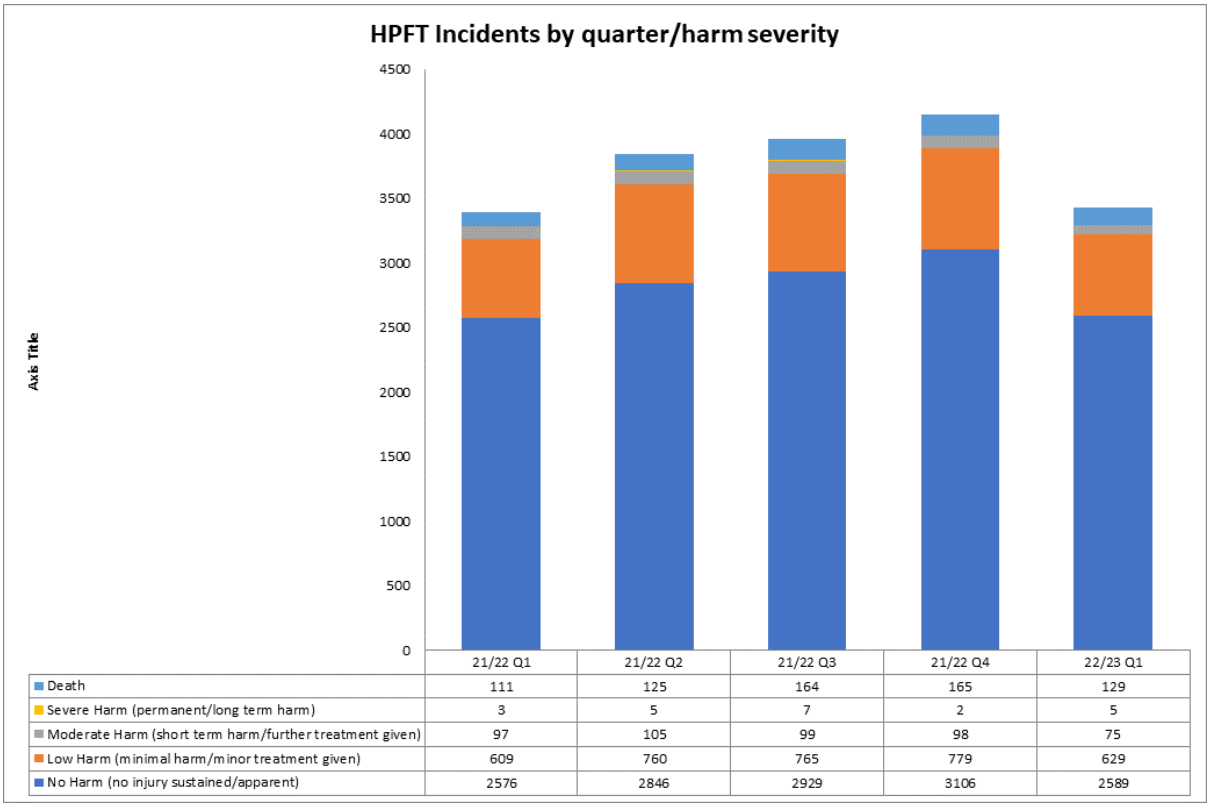
Part B- Incidents, including Serious Incidents

Introduction

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

2. Incidents

2.1 The number of incidents reported on Datix has decreased by 16% (*figure 1)*. With the exception of Essex and IAPT Strategic Business Unit (SBU), incident reporting was lower in all other SBUs. The weekly Moderate Harm Panel reviews incidents resulting in moderate harm and above and identifies those that meet criteria for reporting as a Serious Incident.



	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1
Death	111	125	164	165	129
Severe Harm (permanent/long term harm)	3	5	7	2	5
Moderate Harm (short term harm/further treatment given)	97	105	99	98	75
Low Harm (minimal harm/minor treatment given)	609	760	765	779	629
No Harm (no injury sustained/apparent)	2576	2846	2929	3106	2589

Figure 1

Never Events

2.2 The Trust had no incidents that would meet Never Events reporting criteria.

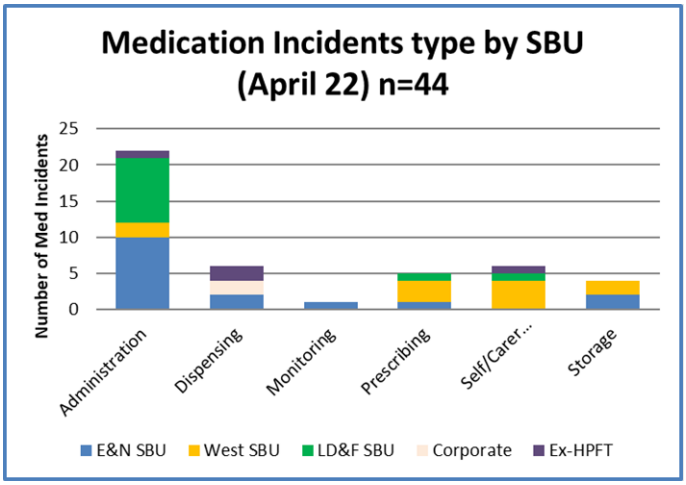
Eliminating Mixed Sex Accommodation (EMSA)

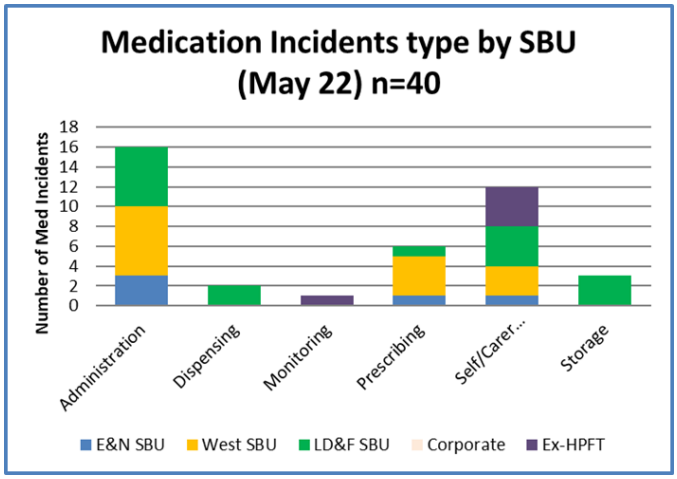
2.3 There were no reported breaches.

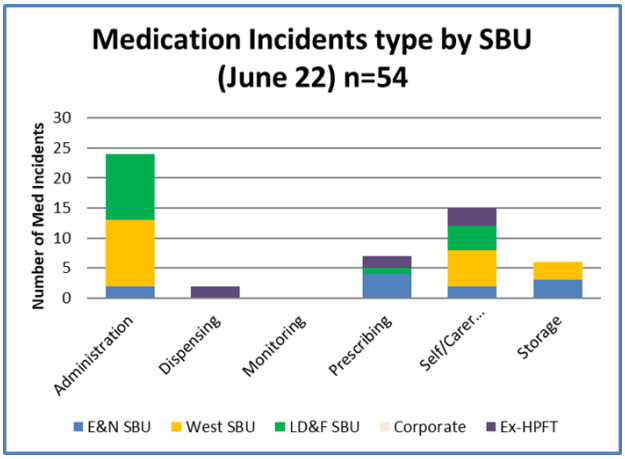
Medicines Safety

2.4 There were 138 reported medication incidents (both internal and external to the Trust); 122 were internal to the Trust, 119 (97.5%) resulted in *no harm,* two (1.5%) resulted in *low harm*. One incident (1%) was classified as moderate harm. (16 medication incidents were external and reported to the Trust, for example a medication error in a care home).

2.5 Administration incidents remained the top sub-category of those reported in April, May and June (*figures 2a ,b and c*).







Figures 2a, b and c

2.6 **Serious Incidents**

The Trust reported 31 Serious Incidents external to the Trust on the NHS Strategic Executive Information System (StEIS) (*figure 3*), a reduction of two.

2.7 14 unexpected or avoidable deaths were reported (a reduction of three) as largest category of Serious Incidents. Serious incidents relating to self-harm remained static at nine, as did Serious Incidents relating to slips, trips and falls (one). There was one Serious Incident declared categorised as an alleged homicide.

2.8 Analysis indicates themes including:

- Safety plans for service users at increased risk of harm whilst awaiting an initial assessment (IA)
- Engagement with service users following discharge
- Discharged service users after repeated 'did not attend' (DNA)
- Communication with CGL regarding dual diagnosis and self-referral of service users
- Telephone/virtual contact.

2.9 A learning note was disseminated to all services for discussion at their Patient Safety meetings and Quality and Risk meetings to raise awareness of these themes and actions to take to reduce risk.

2.10 The actions from Serious incidents are discussed at weekly meetings with each of the SBU's and feedback monthly at the Safety Committee. A summary of learning from Serious Incidents is presented by each SBU quarterly at the Safety Committee.

2.11 A monthly action review and learning group is being convened to discuss all actions identified and associated learning from Serious Incidents, Swarms, Structured Judgement Reviews (SJR), Prevention of Future Deaths (PFD), Freedom to Speak Up (F2SU), Article 2s.

Category	Q4 2021/22	Q1 2022/23
Unexpected or avoidable deaths	17	14
Disruptive, aggressive or violent behaviour	3	5
Apparent, actual or suspected self-inflicted harm	9	9
Slip, trip or fall	1	1
Abuse or alleged abuse of adult patient by a third party	1	0
Child safeguarding	1	0
Sub-optimal care of deteriorating patient	1	0
Apparent, actual or suspected homicide	0	1
Practice/Clinical care	0	1
TOTAL	33	31

Figure 3

2.12 28 Serious Incident reports were completed and submitted to Trust Commissioners. The Trust and SBUs completed 56% of actions by the due date. Weekly meetings are being held with each of the SBUs to ensure actions are being achieved and progress is recorded on Datix. Some actions relate to ongoing Continuous Quality Improvement (CQI) projects including Safe and Supportive Observations, Risk Assessment and

Carers projects. Extra practice governance resource has been added to East and North SBU to support them in achieving their actions.

2.13 Work has been undertaken with Commissioners to close historical Serious Incidents on StEIS where all actions have been carried out and clarifications responded to.

3 Mortality

3.1 All deaths that are reported continue to be screened each week and those that meet red flag criteria undergo a Structured Judgement Review (SJR). There were 42 deaths in April, 43 in May and 49 in June, which is a higher average per month than the average pre-pandemic levels.

3.2 19 deaths from quarter 1 were screened at the time of this report, following the significant increase in the number of deaths in the last quarter, particularly in March (76), which was higher than average. The Cause of Death for most of the deaths were not available at the time of reporting to provide a breakdown, therefore the reason for the peak is unclear. This is likely to be partly due to better reporting of deaths from the Spike indicator on 'possible deaths', however it is not possible to attribute the total increase to this. Screening of deaths are now being done daily (instead of weekly) and it is anticipated that this will enable the Mortality Governance Lead to catch up with the back log by the end of quarter 2.

3.3 130 deaths were reported (*figure 4*), a decrease of 32. The highest numbers of deaths reported were in the East and North SBU, which includes older age adult services. There were four Covid 19 confirmed or suspected deaths.

	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	Total
E&N SBU	72	86	102	105	85	450
Essex & IAPT SBU	12	14	14	17	13	70
LD&F SBU	8	6	18	12	13	57
West SBU	18	19	26	28	19	110
Total	110	125	160	162	130	687

Figure 4

Structured Judgement Reviews

3.4 There were 14 Structured Judgement Reviews (SJR) completed, which included deaths that occurred outside of this reporting period. These identified positive examples of engagement with family, good mental health monitoring, monitoring and escalation of physical health and review of antipsychotic

3.5 Three key learning themes were also identified:

- Lithium monitoring
- Safeguarding practice
- Following up with GP to obtain results requested.

3.6 Details of learning themes are disseminated through governance structures within the SBUs and the Physical Health Committee. Mortality Governance was incorporated into

the monthly medical continuing professional development (CPD) programme. A learning note on authorising student nurse entries has been disseminated.

Learning Disability Mortality Review (LeDeR)

3.7 There were 22 deaths of service users known to the Trust's learning disability services reported to the national LeDeR programme

3.8 The local Integrated Care Systems (ICSs) will be responsible for ensuring reviews are undertaken by a central pool of reviewers, and actions are implemented. The recommendations from reviews will be taken forward through the Physical Health Oversight Group in the Learning Disability and Forensic SBU and the Physical Health Committee.

3.9 Better pain assessment in people with a learning disability and dementia has been identified as a theme, which the Trust is leading on as a CQI project. An e-learning training session is being developed and will be shared with other organisations.

Suicide

3.10 There were eight deaths that were thought to be as a result of suicide (*figure 5*), a reduction of eight compared to the same reporting period last year; these figures are before the Coroner has determined whether there was evidence on the balance of probability that deaths were as a result of suicide. To date, one of the 16 deaths received a suicide conclusion, four did not receive a suicide or open conclusion at the time of the inquest, and 11 have not yet been heard at inquest.

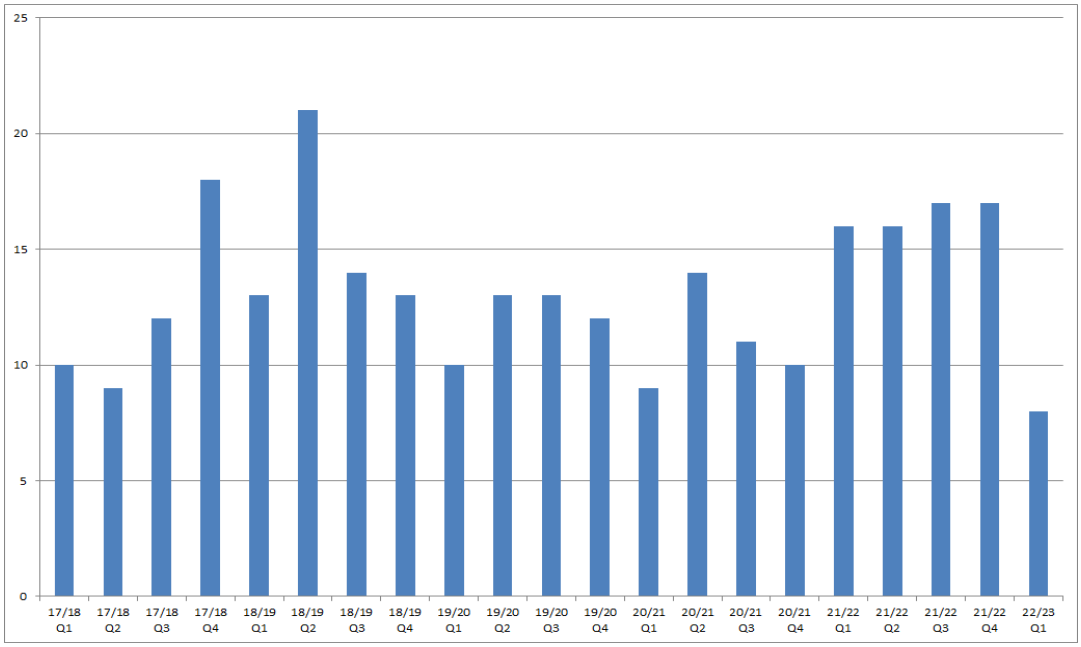


Figure 5

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

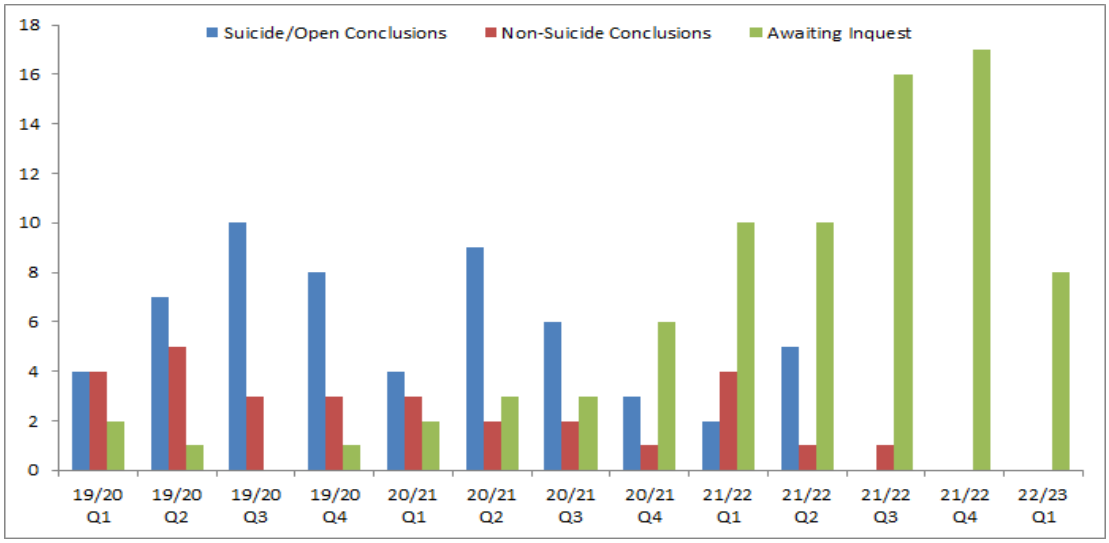


Figure 6

Prevention of Future Deaths

3.12 The Trust was not issued with any Prevention of Future Death (PFD) reports. From the national publications of PFD reports, eight were relevant for the purposes of learning; key areas of learning included:

- Learning around Patient Safety Incident Investigation Report (PSII)
- Failure to carry out an adequate assessment of capacity and resulting failure to administer medication 'in best interest' to alleviate anxiety
- Lack of awareness of autism (and thus risk assessment) by clinicians, that affected the therapeutic relationship
- Safeguarding people who are awaiting Mental Health Act (MHA) assessments in the community
- Processes for accepting referrals, communication and inter agency working, and support for those with addiction problems
- Disclosure made by the perpetrator that he was in possession of a knife not probed and discussed within the multi-disciplinary team (MDT)
- Concerns around Interweave products led to a Safety Alert being issued and an 'Anti-tear clothing and bedding protocol' being produced.

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

4. Least restrictive care

Restraint

4.1 *Figure 7* provides details of reported restraint from quarter 1 2017/18 to this quarter.

4.2 The data shows that the lowest number of physical interventions were reported this quarter since quarter 4 2019/20. This can be attributed to a number of factors including reducing restrictive practice CQI programmes on individual wards. A number of physical interventions can be attributed to a small number of service users with highly complex needs. These increases have been further exacerbated through the lack of specialised services being available nationally. Forest house (62), Astley Court (49) and Robin Ward (49) continue to be the top reporters within quarter 1 accounting for 43% of the total physical interventions across the Trust.

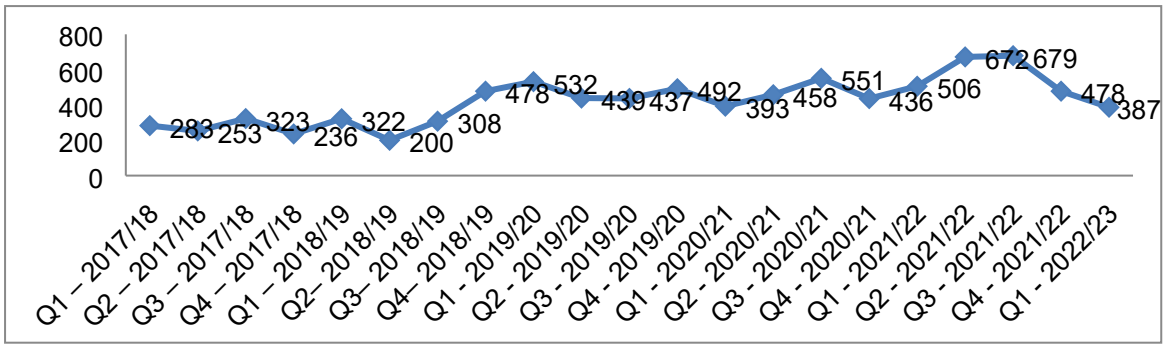


Figure 7

4.2 The Trust's training approach is benchmarked against the current national guidance and standards, evidence-based practices and have been accredited to the British Institute of Learning Disabilities (BILD) Association of Certified Training.

4.3 The Trust developed a recovery RESPECT training plan for 2021/22 which continues to be implemented and revised for 2022/23 considering the challenges with trainer vacancies and Covid-19. The Trust advertised for six fixed term trainers of which one has been recruited to.

4.4 Prone restraint is not taught as part of the restraint teaching methodology, although can happen occasionally. As part of ongoing assurance, each case is subject to a comprehensive review, by a subject matter expert (SME).

4.5 *Figure 8* shows an increase in prone restraint, including the use by police, service users either falling or placing themselves into a prone position before being repositioned into a supine position. Hathor Ward and Forest House both reported two incidents.

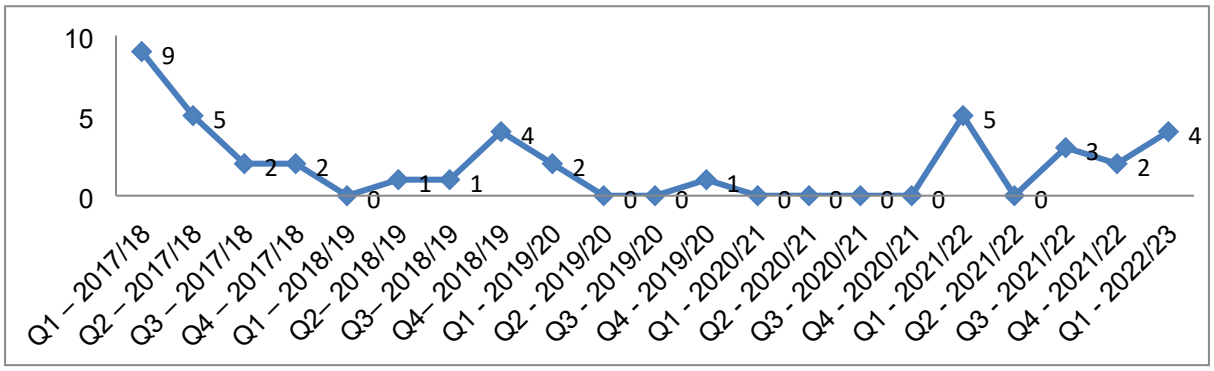


Figure 8

Seclusion

4.6 The Trust ensures it adheres to the Mental Health Act 1983 Code of Practice 2015 (MHA CoP 2015), with the appropriate safeguards being used. The use of seclusion is reviewed daily and audited on a monthly basis, reported both internally and externally through the NHS Digital and the Restraint Reduction Group. These are also reflected in the SBU Flash Reports, and further reviewed and audited on an annual basis, in line with the MHA CoP 2015 and findings are disseminated in the Trust.

4.7 There has been a 15% decrease this quarter from 137 seclusions to 117 (*figure 9*). 86 of the incidents (74%) were attributed to the Learning Disability and Forensic SBU.

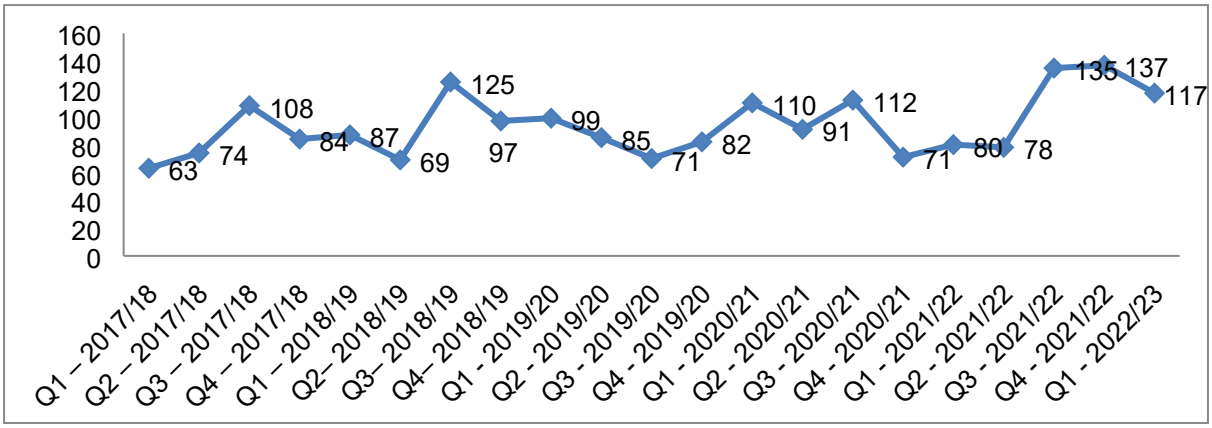


Figure 9

4.8 The mean average time spent in seclusion is 2,060 minutes.

Long term segregation

4.9 All long term segregation (LTS) reviews take place in line with the MHA CoP 2015, including daily medical reviews, weekly MDT reviews, independent clinician reviews, and external hospital reviews as part of agreed procedural safeguards, that up hold Human Rights. As part of the national approach to monitoring the use of LTS within Trusts, each of the service users has a regular external Independent Care and Treatment Review.

4.10 There are 7 individuals being cared for under the LTS framework at the time of this report (*figure 10*) and no applications. Two service users were subject to LTS prior to this period - one within 2 Forest Lane with long term learning disability specialised care and one transferred from Oak to Beech ward. There were two further service users who had two periods of LTS; one following transfer from Forest House to Robin Ward and one in Lambourne Grove. All service users within LTS have regular reviews with independent advocacy. Additional use of the Barriers for Change Check has been used, as part of the HOPE(s) model, with a focus on positive and proactive approaches to reduce the use of LTS.

Unit	Section	Start Date	End Date
2 Forest Lane	3	18 02 2010	
A&T Lexden	3	18 06 2021	
5 Warren Court	37/41	30 09 2021	
Lambourne Grove**	3	09 11 2021	17 05 2022
Beech Ward***	3	25 01 2022	24 06 2022
Forest House	3	26 01 2022	
Robin Ward*	3	17 02 2022	
Astley Court	3	23 02 2022	
Hathor Ward	3	03 03 2022	

Figure 10

Rapid Tranquilisation

4.11 *Figure 11* provides the numbers incidents using rapid tranquilisation. The levels have returned to those previously seen prior to quarter 4 2021/22 due to a change in presentation from an individual service user on Aston Ward. A multi-disciplinary approach involving psychology and Occupational Therapy (OT) led to a significant

reduction in rapid tranquilisation to manage the individuals self harming behaviour. 42/57 (75%) of the incidents were attributed within SBU West and 7/56 (13%) within Forest House.

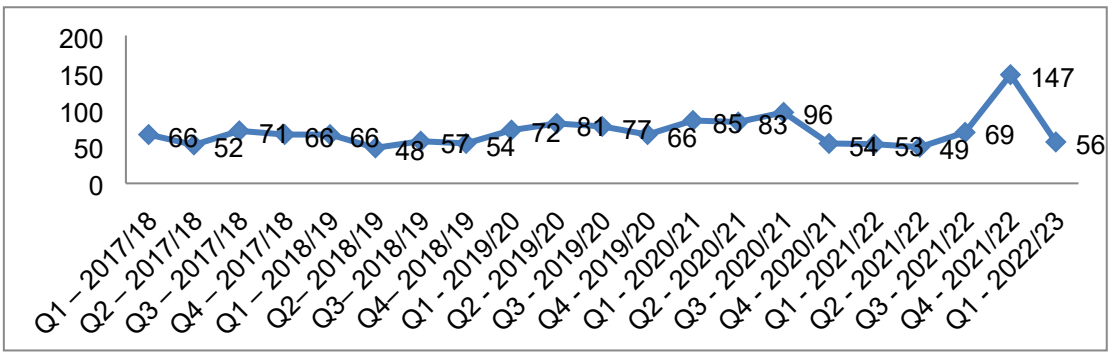


Figure 11

4.12 Associated work relating to the introduction of the National Early Warning Score (NEWS2) and the use of soft measures has supported post incident review after Rapid Tranquilisation.

4.13 There is a difference in the use of Rapid Tranquilisation across the SBUs, in consideration of the different approaches used in terms of Positive Behavioural Support (PBS) and pre-planned interventions undertaken in the Learning Disability and Forensic SBU. Positive Behaviour Support is now being used with individuals with other SBUs.

4.14 Pharmacy monitor Rapid Tranquilisation prescriptions and its use is included in the POMH-UK audit cycle as well the subject of a Practice Audit Implementation Group (PAIG) audit. Changes have been made following the audit including a Rapid Tranquilisation care document on Paris which makes it easier for staff to record the use of Rapid Tranquilisation.

5. Harm free mental health care

Ligature Incidents

5.1 There has been a reduction in reported ligature incidents *(figure 12).* There have been no anchor point ligature incidents reported and 54 non-anchor point incidents.

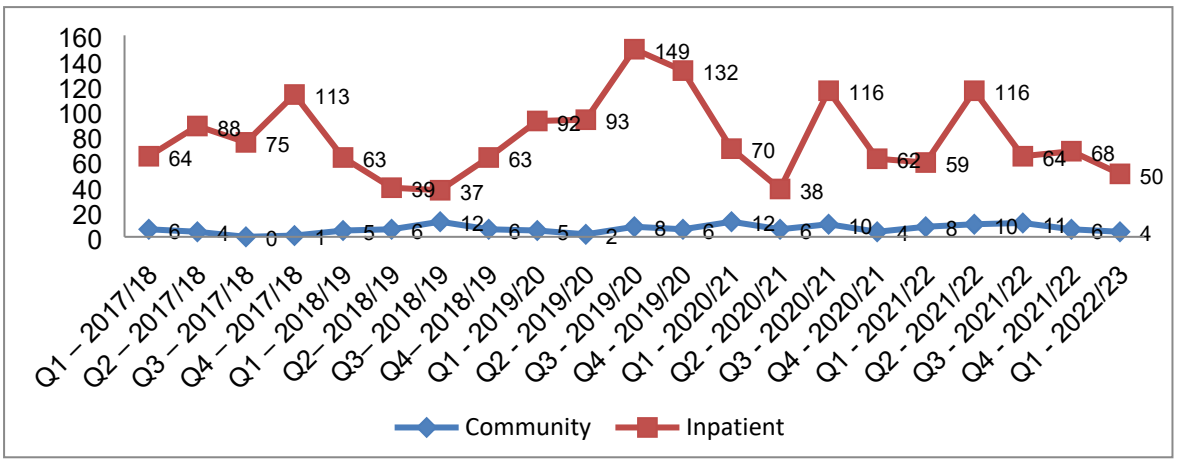


Figure 12

5.3 Ligature incidents using clothing remains the highest category and staff continue to remain vigilant around potential risks in this area. A safety alert has been disseminated following a PFD issued to a manufacturer of anti-tear clothing following a fatality In

another Trust where a service user managed to tie a ligature using the clothing. The alert emphasised the need for observations of service users requiring the need for anti-tear clothing as whilst it reduces the risk, it is not full proof. A review of the Ligature Awareness Training has taken place, which includes additional advice of the use of ligature cutters. The Trust has also received a new supply of ligature cutters which include cordage cutters, wire cutters and cutters for sheets.

5.4 ANT, the review of environmental risk, has developed to improve assurance and evidence of reviews. This includes breaking the weekly audits down by SBU, so each area takes responsibility for their environment, with a lead, overseen by the Health and Safety Manager for the Trust. An electronic form is being introduced that allows storage of all local walk arounds, so evidence of weekly walk around is kept. This process is being applied to community units on a monthly basis.

Absence Without Leave (AWOL) and Missing Persons

5.5 The number of AWOLS and missing persons remains the same as the previous quarter at 37 (figure 13). A task and finish was set up to address AWOLs. Actions form this included the distribution of a safety alert highlighting the risk of service users tailgating staff when leaving units. The Local Security Management Specialist has also been meeting regularly with the police to reduce AWOLs and ensure an appropriate response when they do occur.

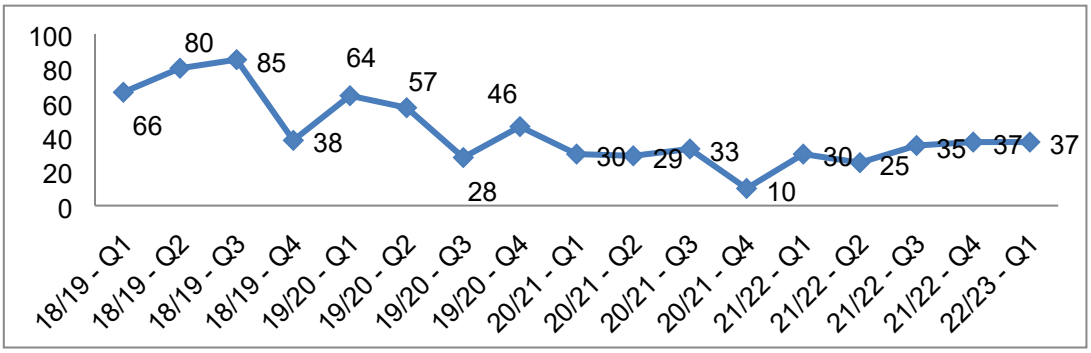


Figure 13

5.6 There were 22 incidents whereby a detained service user under the MHA either absconded or failed to return from section 17 leave, which were reported to NHS Digital as part of the Mental Health Minimum Data Sets (MHMDS).

Service User to Staff Assaults

5.7 The Annual Plan set a target for reducing those that resulted in moderate or severe harm. Work continues to encourage reporting of all incidents of violence and aggression including virtual Datix training sessions for teams emphasising the importance of this.

5.8 *Figure 14* shows there has been a reduction in staff to service user assaults from 254 in quarter 4 to 226 in quarter 1, the lowest number of assaults since quarter 3 2019/20.

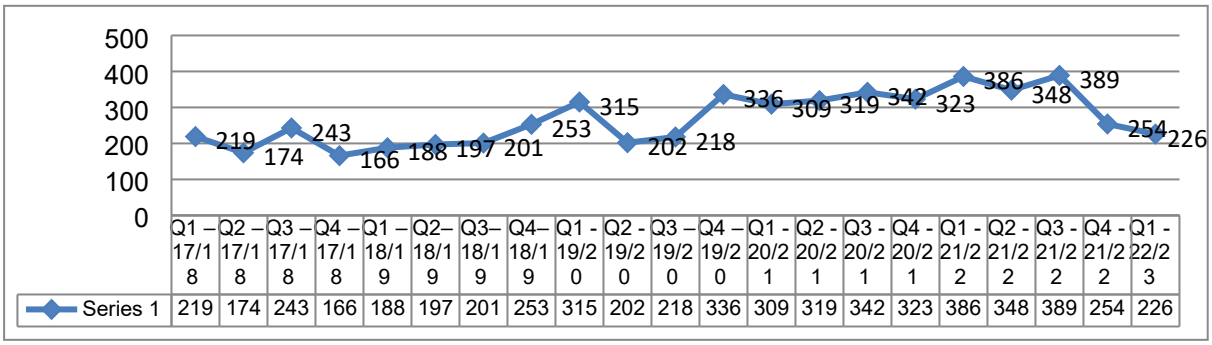


Figure 14

5.9 Four of the service user to staff assaults were categorised as moderate harm and none resulted in severe harm.

Service User to Service User Assault

5.9 Following an increase in service user to service users assaults in quarter 1 2021/22, there has been a steady decline in incidents over the five previous quarters to 85 this quarter. (*figure 15*).

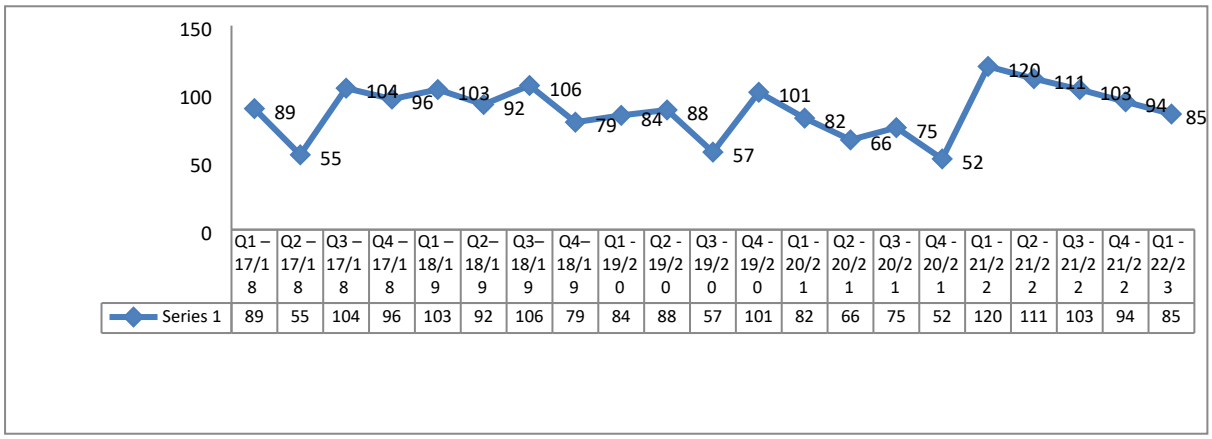


Figure 15

5.10 The Annual Plan sets a target for reducing incidents of violence and aggression incidents that resulted in moderate or severe harm so that people would not be discouraged from reporting. There have been two moderate harm incidents reported this quarter from service user to service user assaults and no severe harm incidents.

Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

5.10 There have been eight incidents reported under RIDDOR, a decrease of five. Five of the incidents were attributable to violence and aggression, two to slips, trips and falls and one occurred during Respect training, as detailed in *figure 16.* Support has been given to all the staff involved in these RIDDORS. LD&F account for the largest number of RIDDORS and these relate to violence and aggression involving service users with complex needs and behaviours that challenge.

	E&N SBU	Essex & IAPT SBU	LD&F SBU	Corporate Services	WSBU	Total
V&A	1		4			5
ST&F	1		1			2
PI training				1		1
Total	2	0	5	1	0	8

Figure 16

Personal accidents

5.11 There have been 19 health and safety related personal accidents to staff. Staff received support following these incidents

Moving and Handling

5.12 There has been one incident in relation to moving and handing involving the moving and handling of an inanimate object.

Needle stick injuries

5.13 There have been no needlestick injuries reported this quarter.

Staff Slips Trips and Falls

5.14 The Trust recorded 18 staff and visitor slips, trips and fall incidents. Seven incidents involved staff falling from a chair or low surface, and, of these, five involved wheeled chairs. A Safety Alert was reissued highlighting the need for the correct castors to be fitted to chairs depending on the floor surface.

5.15 Ten incidents involved a fall on the same level, the incidents occurred both internally and externally and two involved slips on wet or damp floors.

Security Incidents

5.16 The most reported themes were discovering an inappropriate item and a breach of security, see *figure 17*. As a response further training has been delivered to staff re Search procedures and a trial of a new metal detecting screener is underway which can identify where on person a metal object may be secreted.

	Breach of security entrance/exit	Broken item compromising security of building	Discovery of inappropriate item/object on a ward/unit	Inappropriate item brought onto ward by service user	Inappropriate use/access to keys	Item lost/stolen from NHS property	Total
21/22 Q2	14	5	24	8	7	8	87
21/22 Q3	14	4	17	11	5	2	68
21/22 Q4	24	1	14	5	3	5	62
22/23 Q1	23	4	12	9	6	2	73
Total	75	14	67	33	21	17	290

Figure 17

6 Harm Free Physical Health Care

Falls

6.1 The Falls Committee continues to have oversight of falls data Trust wide. A rise in falls reported in West SBU has been noted, particularly at Albany Lodge, resulting in low or no harm *(figure 18)*. Two falls occurred whilst service users were on accompanied leave. Staff have been advised to encourage awareness of surroundings and to support service users to concentrate when walking down steps or on uneven ground.

	21/22 Q4	22/23 Q1
East and North Hertfordshire Strategic Business Unit	109	100
Essex & IAPT SBU	2	1
Learning Disabilities & Forensic Strategic Business Unit	30	54
West Hertfordshire Strategic Business Unit	21	27
Total	162	182

Figure 18

6.2 The Falls Strategy actions are being updated, including:

- analysis of the service users' journey in relation to falls on an older peoples inpatient unit
- creation of a joint community/inpatient process to ensure families provide service users with appropriate footwear
- audit of rooms to assess what personalisation of the environment could be offered in each room when service users are admitted
- simulation training for falls
- consideration of how the team could work with falls specialists in the MDT
- to have 75% of staff on inpatient wards compliant with new falls training.

An action plan for the above agreed priorities will be regularly monitored, updated and be overseen by the Trustwide Falls Committee

6.3 The Trust Falls policy is currently being updated led by the Physical Health team with involvement from East and North SBU. The SBU Falls Groups are to be restarted following a suspension during Covid.

6.4 A Falls Workbook training, developed by Buckinghamshire Community Learning Disability team has been distributed to over 100 staff with over 50% completed and passed the assessment. The next step is to assess the people who have received the workbook but not yet completed the assessment and to retrain and reassess those who failed the assessment.

6.5 Falls training in the Simulation Suite has commenced with learning from serious incidents informing the development of the case scenarios used and incorporated within the facilitated debrief. The Community Falls assessment is now live on PARIS and will be reportable through SPIKE.

Pressure Ulcers

6.6 There were two reported pressure ulcers acquired whilst in Trust care, which were subject to local review (*figure 19*).

	21/22 Q4	22/23 Q1
Category 1 Device Related Pressure Ulcer (Acquired whilst in HPFT Care)	1	1
Category 2 Device Related Pressure Ulcer (Acquired outside HPFT Care)	1	0
Category 2 Device Related Pressure Ulcer (Acquired whilst in HPFT Care)	5	2
Moisture Associated Skin Damage	6	6
Category 1 pressure ulcer (Acquired outside HPFT care)	0	1
Category 1 pressure ulcer (Acquired whilst in HPFT care)	1	0
Category 2 pressure ulcer (Acquired outside HPFT care)	0	1
Unclassified	3	2
Total	17	13

Figure 19

6.7 The Tissue Viability Nurse (TVN) post remains vacant, and the Tissue Viability support worker continues to support the inpatient wards, with support from senior nurses in East and North SBU and the physical health team.

6.8 Issues with correct classification of pressure ulcers were addressed with training delivered by the TVN from East and North Hertfordshire NHS Trust, in partnership with the Trust's physical health team. 36 Trust nursing staff participated in the virtual study day and training slides were made available and will be followed up with a wound care video.

Venous thromboembolism (VTE)

6.9 Suspicion of VTE was investigated promptly and appropriately in two service users by the Trust's physical health team. Digital solution for reporting suspicion and diagnosis of VTE is being sought and junior doctor teaching is planned for the new cohort.

Urinary Tract Infection (UTI)

6.10 The Trust's physical health nurse has joined the Hertfordshire and West Essex (HWE) Integrated Care System (ICS) Infection prevention and Control (IPC) five-year Strategy/UTI Work Stream although this group has yet to meet.

7 Service Users Experience of Feeling Safe

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

7.2 The feeling safe score was 73%, compared to 85% in quarter 4, with the number of responses being 123 which was the same as the previous quarter. Wards are continuing to encourage service users and carers to give feedback about their care and adult acute units are now using iPads alongside paper surveys. A targetted piece of work around service users feeling safe is planned for quarter 3 across all inpatient services to gain an understanding of why service users a feel unsafe and what the Trust can do to address this. A review of the Having Your Say surveys is a major project for the Experience Team this year and the first steering group meeting has taken place. The views of current service users will form part of the codesign and coproduction element of the review to ensure service users and carers can input into the questions being asked and the methods being used.

7.3 One survey was received from Forest House; however, the young person chose not to answer the feeling safe question. The Practice Governance Facilitator is supporting the young people on the unit to give more feedback about their experiences. They are also working with the young people to coproduce a survey for Forest House as part of the HYS review.

7.4 The feeling safe score for the acute 24/7 services was 70% (96 responses) compared to 86% (110 responses) in quarter 4. For the East and North SBU, there were two responses rcompared to 40 responses in quarter 4, with the overall score of 50% for service users feeling safe compared to 83% previously.

7.5 *Figure 20* shows the thematic emotional analysis for all comments given for Having Your Say and compliments for the last three years. Any comment given related to "safety" are mapped as a positive or negative comment and a downward quality trend for the "feeling safe" emotion is noted.

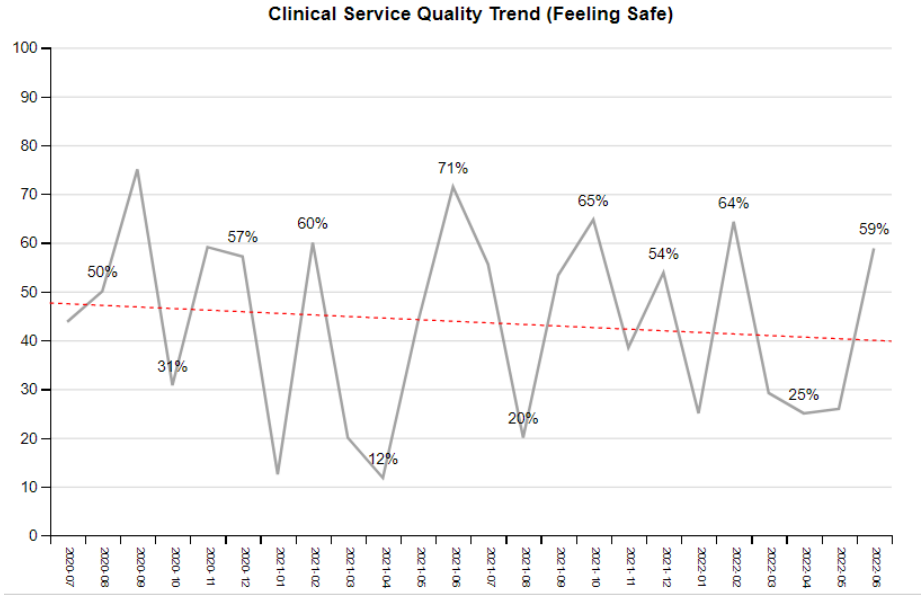


Figure 20

7.7 There were 505 compliments received compared to 439 in the previous quarter; 17 compliments mentioned the word "safe".
"...you worked very hard to keep me safe and alive and I am very grateful for this." (CRHTT Cygnet House)

7.8 113 complaints were received, with seven mentioning the word "safe" relating to Robin ward, the north community mental health services for older people (MHSOP) and Crisis Resolution Home Treatment Team (CRHTT) southeast.

7.9 275 PALS enquiries were received with three mentioning the word "safe", relating to the Single Point of Access (SPA) and CRHTT southwest.

7.10 The Peer Experience Listening and Peer Observation projects continue to progress, and training for the Experts by Experience is being planned for September. The Peer Listening project will listen to service users on medium secure forensic units to understand how safe they feel after witnessing an incident. The Peer Observation Project is the second phase of a project completed in 2020 to understand how safe older people feel in our older peoples' inpatient units.

8 Safeguarding

Safeguarding Children

8.1 Safeguarding children remains a high priority, with clear systems in place for scrutiny and monitoring of safeguarding children incidents reported on Datix. The safeguarding team remains committed in supporting frontline staff on all aspects of child safeguarding concerns and queries.

8.2 *Figure 21* illustrates the number of safeguarding children's incidents by financial quarter. The data shows a decrease of 25 in safeguarding referrals and the evidence tells us that the needs of vulnerable children and their families continues to intensify particularly since the pandemic, for both mental health and social care support.

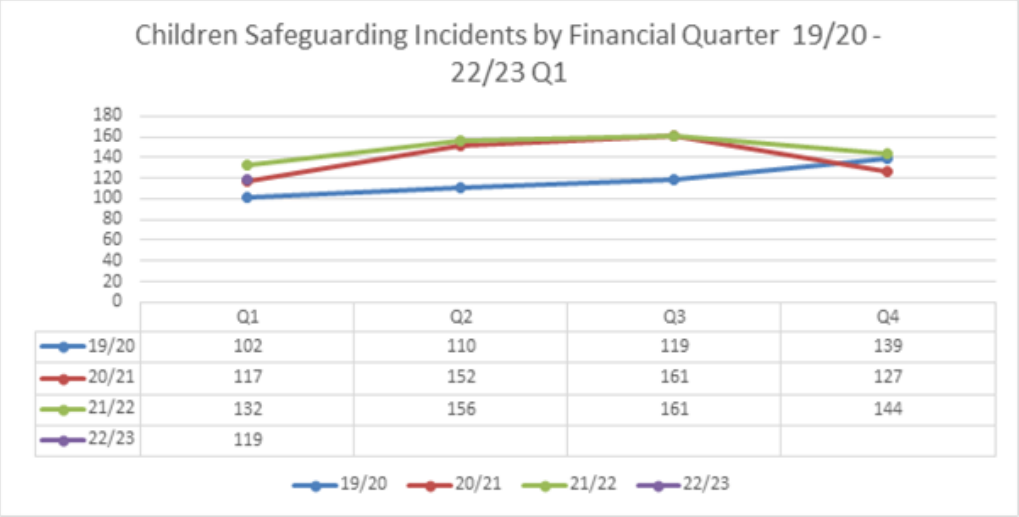


Figure 21

8.3 *Figure 22* illustrates the incidents by categories of abuse; emotional abuse remains the most reported type of child safeguarding incident, which is in line with the demographics of the individuals (and their families) that the Trust supports.

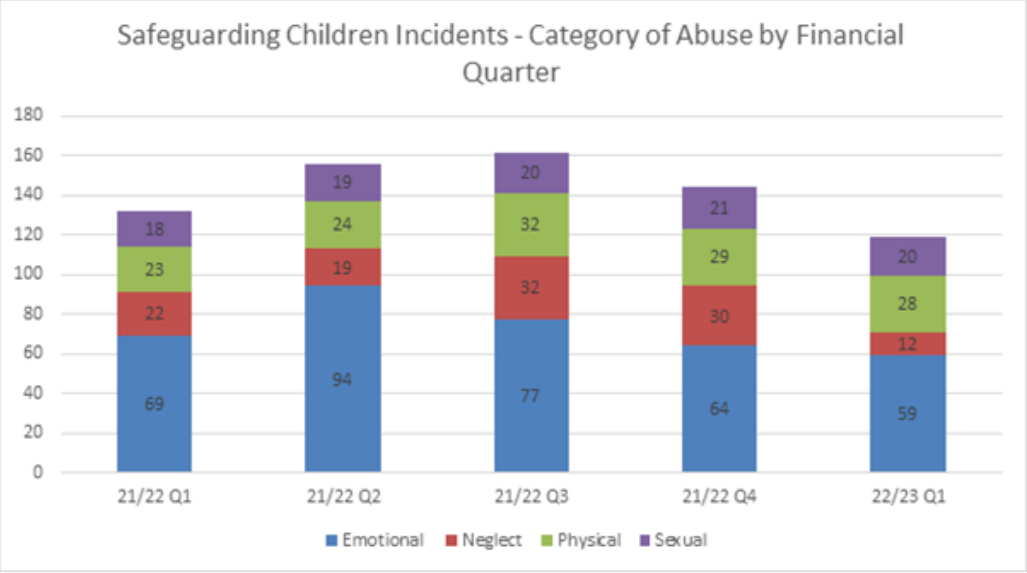


Figure 22

8.4 *Figure 23* illustrates the numbers of incidents reported by specific service areas; as with previous quarters, the Child and Adolescent Mental Health Services (CAMHS) CRHTT have made the most referrals to child safeguarding services, owing to the demographic of their service user group. Adult Services are in blue and CAMHS in red.

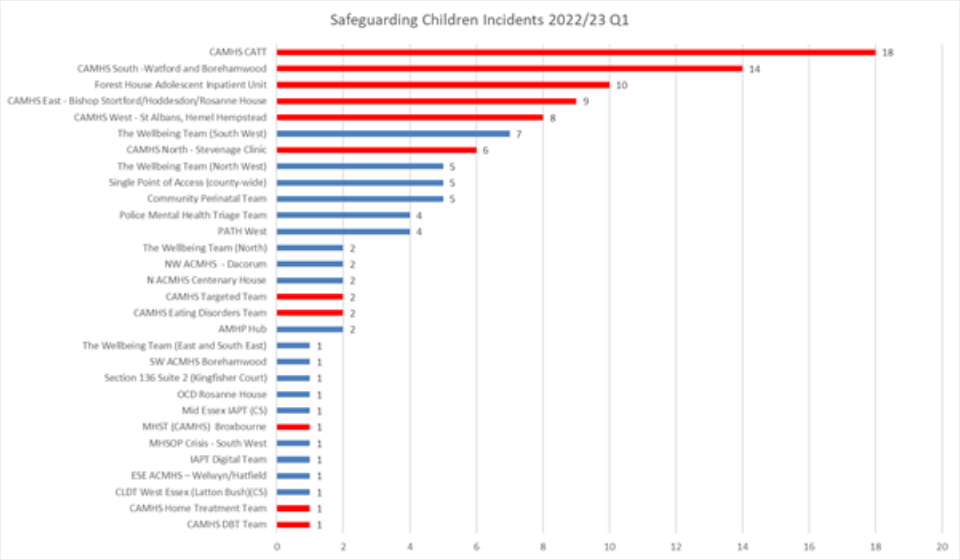
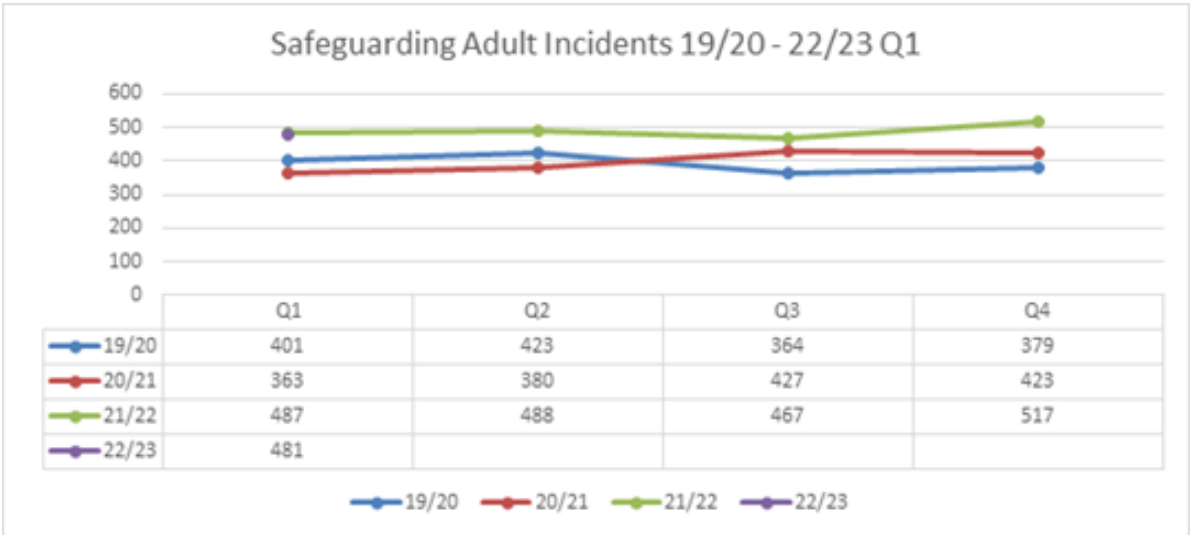


Figure 23

Safeguarding Adults

Safeguarding Activity for Adults

8.5 *Figure 24* illustrates the total number of Adult Safeguarding Adult incidents raised by staff across the Trust from quarter 1 2018 to end of May 2022, drawn from the Datix incident reporting system.



	Q1	Q2	Q3	Q4
19/20	401	423	364	379
20/21	363	380	427	423
21/22	487	488	467	517
22/23	481			

Figure 24

8.6 Rate of referrals illustrate a decrease, bringing the rate back in line with the referral rate for the previous 3 quarters of 2021/22. This continues to be an increase on rates seen in 2020/21 but does not currently project an ongoing upward trend as we head into the new financial year suggesting that rates may be stabilising post-pandemic.

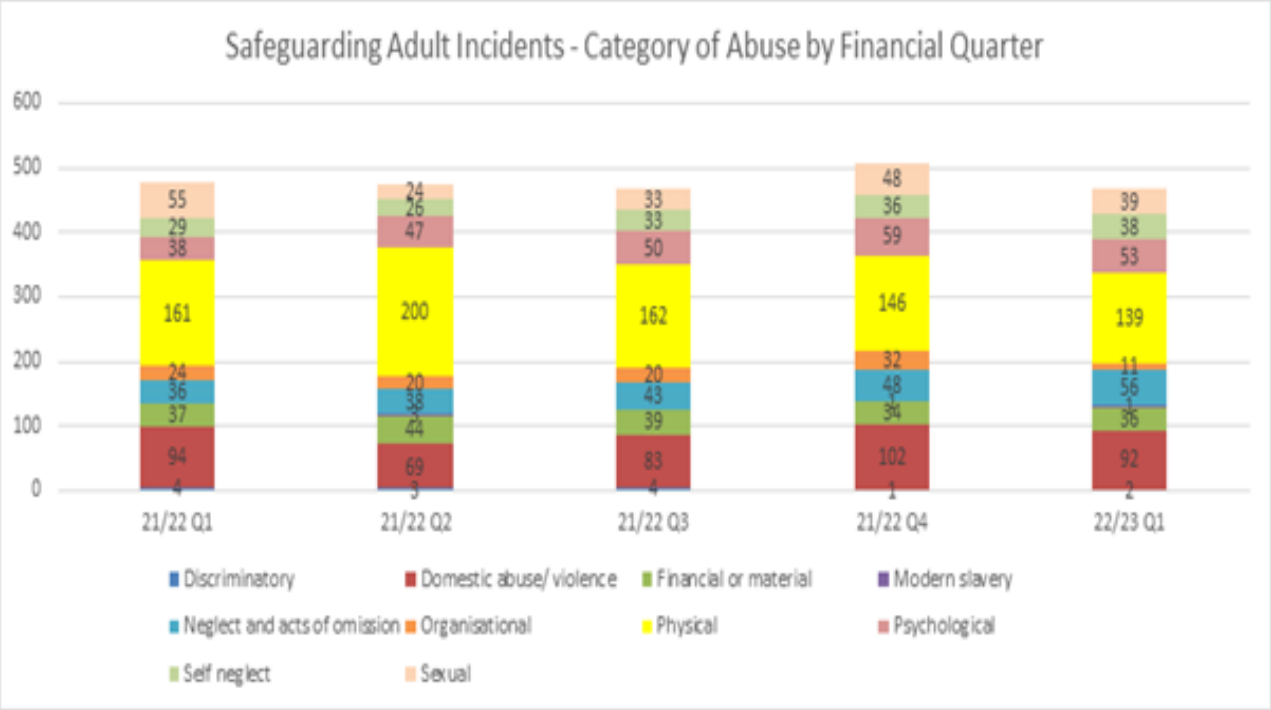


Figure 25

8.7 *Figure 25* demonstrates the breakdown of categories of abuse. Physical abuse remains the highest rated category with domestic abuse second to this. There has been a slight decrease across all categories with the exception of neglect and self-neglect which have seen a very slight increase from the previous quarter. This may be because of increased face to face activity across all services and partner agencies, meaning these types of abuse are more easily identified.

Statutory (Care Act) Safeguarding Adults in Hertfordshire

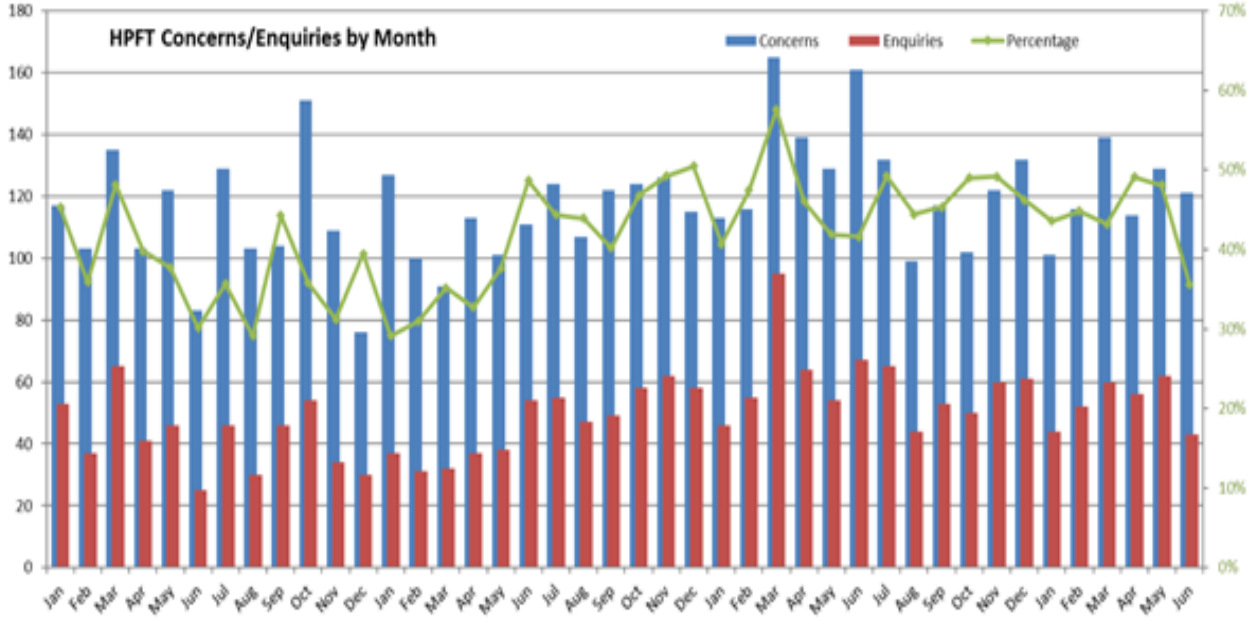


Figure 26

8.8 In Hertfordshire, the Trust carries out investigations into abuse of adults with functional mental disorders on behalf of the local authority (Hertfordshire County Council). Similar to the Safeguarding Datix information, following raised levels of Safeguarding referral

during 2021 and despite a spike in March 2022, rates have stabilised only slightly higher than those seen in the same months during 2019 and in the period leading up to the onset of the Covid Pandemic in 2020

8.9 The Trust conversion rate has remained consistently between 40% to 55%. It should be noted that the conversion rate for June has dipped below this range but is likely to stabilise over coming weeks as outstanding Safeguarding decisions are recorded.

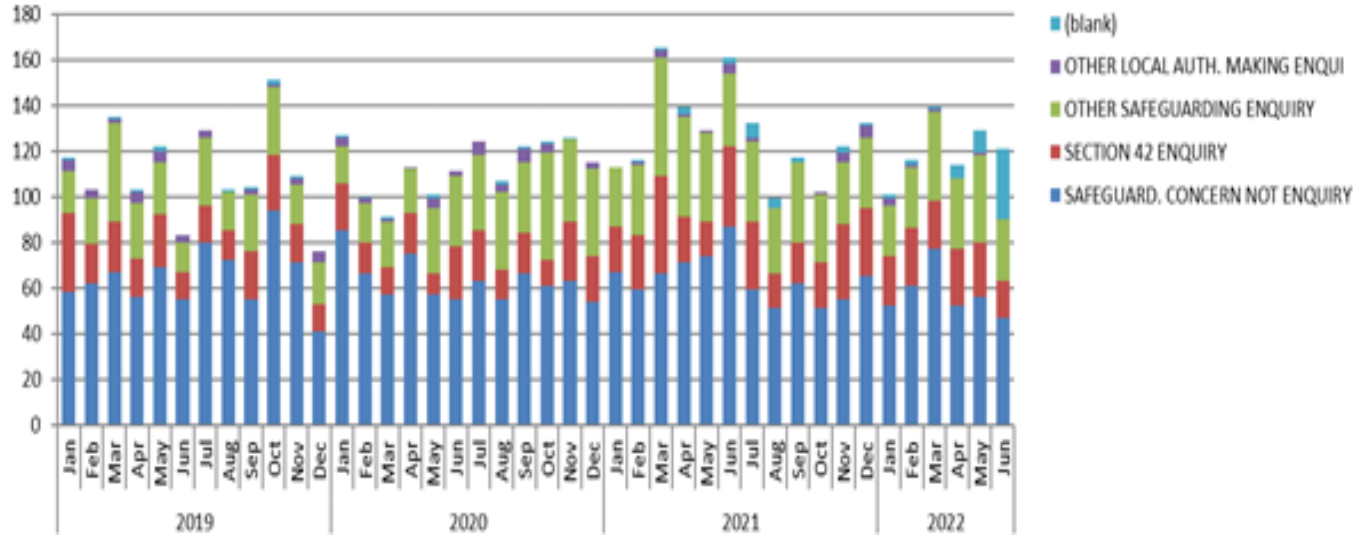


Figure 27

8.10 *Figure 27* shows the differing proportions of types of investigation undertaken in Trust services. Teams continue to favour the 'Other' safeguarding enquiry option. Preliminary findings from a deep dive into this by the Corporate safeguarding team illustrate that whilst the rates of teams using this category have largely decreased countywide, there has been a substantial increase in the use of this category across two of the investigating teams which has resulted in the overall rate of usage remaining largely consistent across each month. This may be linked to a desire to ensure timely decision making when referrals do not contain adequate information around the person's needs for care and support. The Corporate Safeguarding team's audit will be looking at this in more depth to consider whether there is any learning required and ensure consistent decision making across the county.

8.11 Following work done by our Investigating teams, supported by the Corporate Safeguarding team, we have seen an improvement in timeliness around recording of Safeguarding decisions. Whilst we continue to see a need for improvement around this in order to meet statutory timescales, there is no backlog of historic cases open without a recorded decision and the number of 'decision not made' cases continues to decrease. The Corporate Safeguarding Team continue to monitor and support with this.

Hertfordshire Adult Safeguarding Arrangements

8.12 As noted in the Quarter 4 Adult Safeguarding report, the Hertfordshire County Council (HCC) Adult Care Services Management Board (ACSMB) had taken the decision for safeguarding arrangements to stay as stands with the Trust leading on processes for people with functional mental illnesses. As a result, work is under way to build stronger

links between the two services, to ensure that practice aligns across HCC and the Trust services. In the first instance, this involved the Professional Lead for Safeguarding Adults joining the HCC audit group meetings in quarter 1, to discuss and share learning across the agencies. It is hoped that going forwards similar initiatives can take place between front line decision makers across the organisations, to help foster stronger relationships between teams and partnership working.

Trust Safeguarding Leadership

8.13 Following a competitive process, Karen Hastings was appointed to the substantive post of Head of Social Work and Safeguarding. In addition, Kate Johnson has been appointed as the new Professional Lead for Safeguarding Adults in the corporate safeguarding team.

Safety and Improvement Process

8.14 The Trust is responsible for leading on the Safety and Improvement Process (SIP) in Hertfordshire for providers who deliver services for people with functional mental disorders (this includes private hospitals, care homes and similar resources).

8.15 The Trust has led the SIP relating to one private hospital provider. This process commenced in quarter 2 2021, and there were four meetings with the hospital managers and commissioners. This SIP has now concluded. The provider completed a comprehensive action plan and their most recent CQC inspection in February 2022 showed a marked improvement. There will be a bimonthly meeting between the Trust and the provider to review safeguarding concerns and incidents, to continue to support the recovery process.

High Profile Safeguarding Cases: Children and Adults

8.16 High profile cases relate to children or adults who have suffered death or serious injury through suspected abuse or neglect.

Safeguarding Adults Reviews (SAR)

8.17 SAR is a process for all partner agencies to identify the lessons that can be learned from particularly complex or serious safeguarding adult cases, where an adult in vulnerable circumstances has died or been seriously injured and abuse or neglect has been suspected.

8.18 There have been several cases where individuals with alcohol needs have been subject to SAR over a period of two years. The Safeguarding Adults Board have requested a thematic review of these from Alcohol Change UK to facilitate learning across all agencies.

8.19 The Trust is currently involved in one SAR and made one referral for a review. This is still under consideration by the Subgroup panel members.

Child Safeguarding Practice Reviews/Rapid Reviews

8.20 Child R: The publication of the review report has been delayed due to the fact parents are subject to criminal proceedings. Child R had been known to both Community Perinatal Team (CPT) and Wellbeing Services. A learning event was held in September 2021 and actions taken forward, including bolstering the safeguarding supervision for CPT staff, and updating the team's operational policy around supporting families who are subject to Child Protection proceedings.

Safeguarding Training
Safeguarding Children

8.21 Low compliance rates for safeguarding children training levels 2 and 3 were added to the corporate risk register in quarter 4. The decrease was due to the ongoing work to introduce the safeguarding training passport, where the levels of training assigned to staff were amended in the last quarter.

8.22 *Figure 28* illustrates the compliance levels for quarter 1 2022-23 indicating that the Trust is now compliant for Level 2 and Level 3 Safeguarding Children Training.

Training 2022-23	Q1	No. non-compliant	Q4	No. non-compliant
Preventing Radicalisation	96%	109	96%	107
SG Children Level 1	95%	156	97%	106
SG Children Level 2	92%	204	91%	233
SG Children Level 3	94%	60	92%	67

Figure 28

Safeguarding Adults

8.23 *Figure 29* provides percentage compliance for each level of Mandatory Safeguarding Training Trust wide. The percentages for level 2 safeguarding adults compliance continue to increase gradually since the implementation of an action plan around this.

Training	Q1	Q2	Q3	Q4	Q1
Preventing Radicalisation	95%	95%	95%	96%	96%
SG Adults Level 1	96%	96%	96%	96%	98%
SG Adults Level 2	89%	90%	90%	91%	92%
SG Adults Level 3	94%	95%	93%	95%	96%

Figure 29

9. Conclusion

9.1 Part B has provided an overview of incidents reported in the quarter, demonstrating some improvements and areas requiring more increased focus in other areas during quarter 2 as detailed in Part C. There has been continued scrutiny and governance relating to LTS and other restrictive practice and providing increased support and guidance into the SBUs.

9.2 The number of deaths that were thought to be as a result of suicide, was 17 compared to 15 in the previous quarter and 11 in the same reporting period the previous year. Several of these deaths have occurred in the northwest quadrant and a task and finish group has commenced to address this and extra support provided for the teams.

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

9.4 The Trust has made progress with the Serious Incident recovery work with all reports submitted within timescale , with further work required in quarter 2 regarding the outstanding action plans and clarifications

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

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

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

Part C Learning from Incidents and Changing Practice

1. Introduction

1.1. This part of the report summarises key actions and initiatives that have been identified for quarter 1, in consideration of the learning and the detail provided in part B. This is not a full account of the work that has taken place as the Trust's CQI approach supports and has resulted in several local initiatives.

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

2. Learning from Incidents

2.1. Monthly Learning Events facilitated by the Deputy Medical Director, enable learning from SWARMS, incidents and Serious Incidents including positive practice, to be shared and discussed.

Suicide prevention

2.2 Work continues with partner agencies to develop a system wide Suicide Prevention Pathway to support making every contact count with suicide specific brief interventions and timely signposting to support incorporating learning from the work undertaken in Gold Coast mental health services in Australia.

2.3 Work is ongoing with partner agencies supported by Wave 4 national funding on developing system wide suicide awareness/prevention training using the Trust's simulation training facilities. This multi-agency training group is meeting two-weekly and is informed by the existing work of the Training Task and Finish Group as part of the Hertfordshire Suicide Prevention Strategy work streams.

2.4 Suicide risk training continues to be delivered monthly to front line clinicians and teams with a focus on safety planning, dynamic risk formulation and suicide specific interventions. Development and delivery of case scenarios and the facilitated debrief is informed by learning from our serious incidents and the NCISH Annual Report findings and their studies. This has included incorporating anniversaries and significant dates,

access to means, and use of drug and alcohol as part of the risk assessment and safety plan.

2.5 Work is ongoing to commission a Suicide Bereavement Support Service across the West Essex and Hertfordshire Integrated Care System. This work is supported by the Bereavement Task and Finish Group task and co-produced by those bereaved or affected by suicide as part of the Hertfordshire Suicide Prevention Strategy work streams. The service is expected to be in place by year end.

2.6 Work is continuing by the Trust, Public Health and Hertfordshire Constabulary to fully implement Real Time Surveillance (RTS) in Hertfordshire. RTS has proved valuable in other areas of the country to enable monitoring and immediate actions to be taken in response to local suicide data around potential clusters and timely signposting to support for those families bereaved or affected by a suicide.

2.7 Themes from our serious incidents reported in Quarter 1 included support for service users awaiting an initial assessment, timely follow up by teams of service users who do not attend planned appointments, communication and joint working with CGL, importance of face-to-face assessments and safety planning. A learning note on Serious Incident themes and areas for teams to consider was disseminated in May 2022.

Priorities for Quarter 2

Incident management

The Trust is continuing to prepare for the transition to the Patient Safety Incident Response Framework (PSIRF). The guidance is expected to be published in Summer 2022, with full implementation over the following 12 months.

Suicide Prevention

Case scenarios specific to suicide risk in older adults and young people have been developed by the simulation training faculty for use as part of the simulation training programme.

Ligatures

Ligature audits in community hubs to continue in quarter 2. Working with Surrey and Borders Trist to develop a cost-effective app to assess environmental risk.

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

Violence and Aggression

A CQI project group has been formed to address harm from violence and aggression incidents in the Trust. Patient Safety Specialist working with staff side to understand staff experience of violence and aggression and what is needed.
The Police Liaison and Security Group continues to meet and has focused on reviewing and relaunching he joint working protocol and ensuring staff are supported to report assaults and during prosecution if appropriate. A Spitting task force is focusing on reducing risks to staff from service users spitting.

Joint Working with Police

The Joint working Protocol with Hertfordshire Constabulary has been refreshed and a series of launch events are planned for Q2 , to fully embed the protocol and build on existing positive relationships.

Falls prevention
Training on falls risk and prevention using the simulation suite commenced in April 2022. The facilitated debrief session and development of falls specific case scenarios are informed by learning from our incidents including service user and carer experience.

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

The Mental Health Units Use of Force Act 2018 came into force in quarter 1. The Trust's Patient Safety Specialist has led a task and finish group to ensure compliance with the act.

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

A Matron within Learning Disability services commenced a three-year secondment as a Specialist Practitioner to deliver the HOPE(s) model across the region to lead a system change to reduce long term segregation for people with a learning disability and autistic people across the region. All staff within CAMHS inpatient services have been trained in the use of the HOPE(s) model and this will be rolled out to other inpatient services who have utilised Long Term Segregation.

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

Leaflets are available for service users on what to do if they are worried about sexual safety onwards. An Easy Read version of the leaflets will be developed in quarter 2 2022/23. Additionally, work is ongoing to support HPFT wards to co-produce bespoke sexual safety charters which can be displayed in communal areas.

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

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 9b
Subject:	Emergency Preparedness, Resilience and Response (EPRR) Annual assurance process for 2022-23	**For Publication:** Yes
Author:	Caroline Mills, Interim EPRR Lead	**Approved by:** Fiona McMillan Shields, Managing Director E&N SBU
Presented by:	Sandra Brookes, Executive Director of Service Delivery and Experience/Chief Operating Officer	

Purpose of the report:

To give an overview of the Trusts performance in relation to the EPRR Core Standards expected by NHSE/I for 2022/23 and assurance regarding the Trusts annual position statement for EPRR.

Action required:

To receive and discuss the report, noting areas of non-compliance and mitigation in place to ensure full compliance.

To approve the proposed self-assessment of the EPRR Core Standards annual EPRR assessment of conformity, and rating of full compliance

Summary and recommendations:

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

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

All 68 core standards and the 1 deep dive standards have been reviewed. The deep dive standards do not contribute to the overall assurance rating for the trust. This year the deep dive is regarding Evacuation and Shelter. Completions of self-assessment and collation of evidence to support has been completed and the conclusion is that we should declare the Trust as being fully compliant with all systems and processes remaining effective.

After the Accountable Officer's review meeting with Commissioners, NHSE/I will have the opportunity to raise any issues or further clarity around the Trust's submission before it will be formally ratified.

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

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

Relation to the BAF:

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

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

The Civil Contingencies Act 2004 and the NHS Act 2006, as amended by the Health and Social Care Act 2012, underpin EPRR within health. Both Acts place EPRR duties on NHS England and the NHS in England.

Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS funded services to comply with NHS England EPRR guidance.

Equality & Diversity and Public & Patient Involvement Implications:

N/A

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

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

IGC – 15th September 2022

Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2022-23

1. Introduction

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

1.2 The Trust was assessed last year as 'green' and fully compliant in the assurance process of 2021/22 and following local commissioner assurance meetings this final rating was confirmed.

2. Compliance with the Core Standards

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

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

2.2 There are 68 core standards and 55 of those apply to mental health trusts in 2022/23. The table below demonstrates self-assessment of compliance for the Trust for 2022/23. The latest version with the detail for submission is appended to this report.

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

Compliance level	Number of Standards
Not compliant	0
Partially compliant	0
Fully compliant	55

2.4 Each year a deep dive review is conducted to gain additional assurance into a specific area. In 2022/23, the topic is Evacuation and Shelter. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating; these should be reported separately.

The Deep Dive covers the plans for Evacuation and Shelter within the Trust, reflecting the changes to the NHS Evacuation and Shelter Guidance for the NHS, published October 2021. The review looks at planning, activation, triaging, transportation, Service User tracking, partnership working, communications and exercising. HPFT will be submitting a "Fully Compliant" return to the Deep Dive.

2.5 The Core Standards cover 10 Domains

1. Governance
2. Duty to Risk Assess
3. Duty to Maintain Plans
4. Command and Control
5. Training and Exercising
6. Response

7. Warning and Informing
8. Co-operation
9. Business Continuity
10. CBRN

HPFT will submit a Self-Assessment stating that we are “Fully Compliant” in all the Domains

3 EPRR statement

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

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

4 Identification of learning from Covid-19 Pandemic

4.1 Over the past year the Trust has undertaken a series of debriefs regarding the incident management of the Covid19 pandemic. The themes have been considered and incorporated into the Trust EPRR action plan and used to shape the ongoing response. Learning has also fed into other plans, such as the updated Pandemic Preparedness Plan, moving away from preparing only for a Flu Pandemic. During the Pandemic we used a Consolidated Rota with specific Incident Command roles allocated, we will continue to have this rota, in shadow form, to enable a quick incident command response.

4.2 Due to the length and protracted nature of incident some senior staff have changed roles. EPRR training has been completed and further training is booked to better prepare new staff for Incident Management. The current training will be complete by October 2022. As new training dates become available into 2023, we will be booking further staff onto relevant courses.

4.3 The Trust’s incident command (ICC) response has continued to flex up and down, in line with the waves of the pandemic and increased Outbreaks, to meet the needs of the Trust and provide assurance that all actions are being addressed.

5. **Incident Command**

5.1 The Trust’s incident response team has had to address other stressors on the Trust’s business throughout the past year including winter pressures, unprecedented heat alerts and staffing pressures due to sickness and vacancy levels.

5.2 Incident command was stood down at the beginning of May 2022 with the Trust having low covid numbers amongst staff and Service Users and in line with the National Incident Level stepping down to Level 3. We were still required to submit daily, national Covid SitReps and Outbreak data.

5.3 Covid numbers rapidly increased with a new Covid variant, sending several Inpatient Units and Community sites into Outbreak. The ICC was stood up rapidly in July, having kept a shadow rota in place this was achieved quickly and effectively to oversee the impact of increased covid cases on operations. This wave saw 24 different Outbreak areas.

5.4 ICC stood down again in the first week of September. The shadow rota has been kept active and an EPRR weekly meeting takes place to consider if there are any incidents to escalate to the Executive.

6. Working with Partners

6.1 The Trust has continued to be responsive and support local Hertfordshire and wider organisation system calls and meetings. We have responded to the local tactical health response for COVID and more recently for Monkeypox, extreme and unprecedented Heat Alerts and the Ukraine Crisis.

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

6.3 The Trust has offered Mutual Aid to partners, including providing IPC advice to independent providers where HPFT had placed Service Users and providing PPE to partners when requested. We have also benefitted from the Mutual Aid provided by partners, including acquisition of Lateral Flow Devices.

6.4 HPFT participated in an East of England EPRR exercise; "Exercise Walker" - it explored and managed the challenges that are likely to arise for a hospital, the wider health community and multi-agency partners because of a partial or whole site hospital evacuation due to RAAC (Reinforced Autoclaved Aerated Concrete). The exercise considered the operational and practical elements of a regional response to a RAAC plank failure incident, both in the immediate aftermath and in the days following the incident and explored the response of the wider health community and multi-agency partners It also looked at communication with the public and the media. The exercise reinforced the value of multi-agency working and exercising at regional and local level to ensure engagement and the sharing of accurate and timely information between all multi-agency partners during an incident.

6.5 HPFT have joined a regional Resilience Mental health Partnership, working with and supporting regional EPRR leads from other trusts across the East of England.

7. EPRR Group focus

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

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

7.3 "On Call" Training sessions have been run via MSTeams with Service Line Leads sharing information on their specific services, access to admissions and support required from On Call staff.

7.4 The Group has co-ordinated a number of Business Continuity Exercises. Staff discussed Cyber Security and business continuity following the loss of network. Learning included use of mobile phones as Hot Spots to allow access to Electronic Patient Record and this process was highlighted in the weekly staff communications ass it really reduced recovery times significantly. Teams already undertake a local, weekly Patient Record backup download but it's value was highlighted by the exercise. In light of a very recent national system incident, impacting multiple systems, due to a ransom wear attack, the Trust is running exercise to explore loss of Electronic Patient Record and Electronic Prescription Service, supported by CIVICA, for a prolonged time. We will be discussing mitigations and any additional reporting systems that could be created to allow access to records in an emergency.

7.5 The Trust has plans for an Evacuation Exercise with a scenario following a fire on one of the units in quarter 3. This exercise includes standing up of an Incident Command and then a tabletop evacuation and shelter discussion.

8. Winter Planning

8.1 The winter plan supports the Trust approach in terms of support for staff, support for service users and carers and business continuity. Winter planning encompasses support for the system, including response to surges in demand and changes in capacity alongside improved use of technology. The organisation adverse weather policy is also included.

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

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

9. Recommendation

9.1 For the Board to approve IGC's acceptance of the *Statement of EPRR Conformity* and acknowledge the Trust self-assessment of the 2022/23 NHS Core Standards for EPRR.

APPENDIX

Hertfordshire Partnership University NHS Foundation Trust

Emergency Preparedness Resilience Response Policy Statement

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

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

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

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

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

It is vital that the Trust is prepared and can respond to any major incident, providing a coordinated range of emergency, mid and long term services to those involved, including patients, relatives and friends, and our own staff. As such, robust and comprehensive emergency planning is a priority for the trust and compliments the safe and effective governance structures that work 24 hours a day and 7 days a week.

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

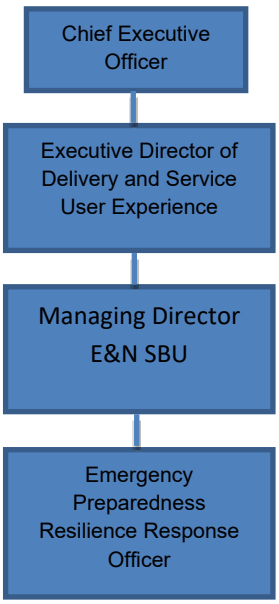
The EPRR groups Terms of Reference ensures accountability by ensuring that the group reports to the Quality and Risk Management Committee (QRMC). One of which will be a yearly report.

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

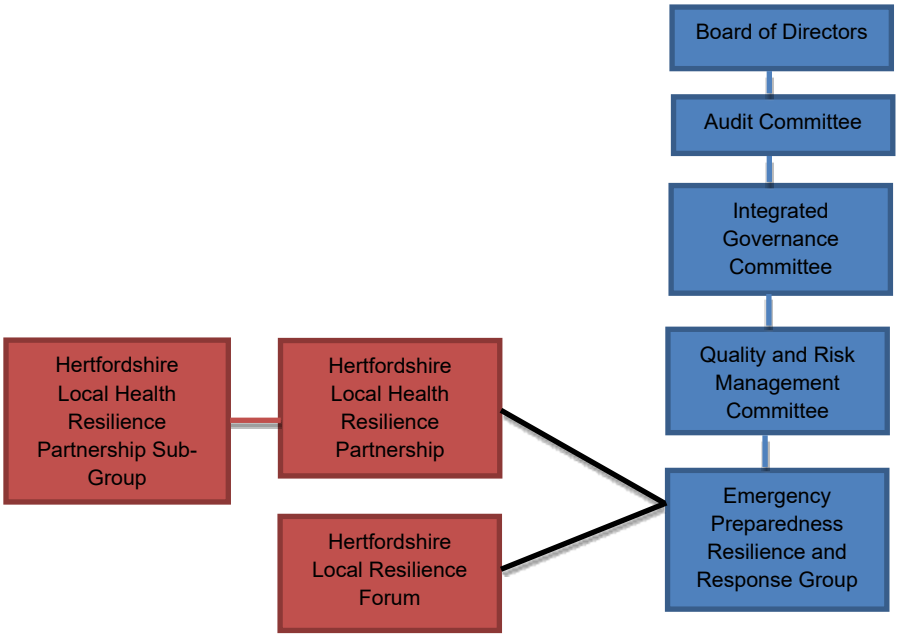
The Trust manages and identifies incidents via Datix and service level risk registers and these are shared within the EPRR group and escalated via the Trust Executive Committee, The Trust Quality and Risk Management Committee or Trust Management Group as

required. This ensures continuous improvement within our services and ensures regular oversight where issues can be worked on and actioned accordingly.

Structure of Roles



Structure of Governance



Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence
Domain 1 - Governance																	
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
Domain 2 - Duty to risk assess																	
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans																	
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Local and Major incidents as defined within the EPRR Framework.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Y	Y	Y			Y					Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Y	Y	Y			Y					Y	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Y	Y	Y			Y					Y		Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control																	

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising																	
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response																	
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Planning arrangements are easily accessible - both electronically and local copies
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for accessing and utilising loggists • Training records
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Y												Guidance is available to appropriate staff either electronically or hard copies
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y													Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing																	
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main point of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
Domain 8 - Cooperation																	
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	Y	Y	Y			Y	Y		Y			Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	Y	Y	Y			Y	Y		Y			Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.			Y					Y	Y	Y			Y	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.									Y					• Detailed documentation on the process for managing the national health aspects of an emergency
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.								Y		Y				• LHRP terms of reference • Meeting minutes • Meeting agendas
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004
Domain 9 - Business Continuity																	

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon			Y											• Exercising Schedule • Evidence of post exercise reports and embedding learning
Domain 10 - CBRN																	
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Y		Y			Y					Y		Staff are aware of the number / process to gain access to advice through appropriate planning arrangements
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Y		Y			Y							Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	Y		Y			Y							• Impact assessment of CBRN decontamination on other key facilities
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y													Rotas of appropriately trained staff availability 24 /7
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/epr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y		Y			Y							Completed equipment inventories; including completion date
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y													Completed equipment inventories; including completion date

Ref	Domain	Standard name	Standard Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Board	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Supporting Information - including examples of evidence
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y													Record of equipment checks, including date completed and by whom.
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y													Completed PPM, including date completed, and by whom
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y													Organisational policy
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y													Maintenance of CPD records
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Y		Y			Y							Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y													Maintenance of CPD records
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Y		Y			Y							Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique
68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	Y		Y			Y							

Over arching changes:	Column previously titled "Standard" has been renamed as "Standard name" Column previously titled "Detail" has been renamed "Standard Detail" Column previously titled "Evidence" has been renamed "Supporting information" Organisation type previously "Clinical Commissioning Group" has been changed to "Integrated Care Board" Remove reference to "effective" arrangements/planning across all standards on the basis that all arrangements should be considered effective in nature. Domain 7 - Warning and Informing - has been reviewed and refreshed to reflect significant lessons in crisis communication identified during recent emergency and incident response. Domain 9 - Business Continuity - was reviewed in collaboration with project team undertaking the review of the Business Continuity toolkit and their associated stakeholder group. The review includes development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard Domain 10 - CBRN - to be reviewed as part of national CBRN work programme 2022-23. Core standards to be updated as part of interim review 2023.

Previous standard detail					New standard detail			
Ref	**Domain**	**Standard**	**Detail**	**2022 Changes**	**Ref**	**Domain**	**Standard name**	**Standard Detail**
Domain 1 - Governance								
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Standard amended to clarify that AEO should be a board level director "within their individual organisation" Removed reference to Non-Executive board member in light of national review of NED Champions. EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met.	**1**	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Previously referred to as EPRR Policy statement, this has been amended to reflect the requirement that an organisation has an "EPRR Policy or statement of intent" Third bullet point under "The policy should" has been updated to include that arrangements are also "exercised" Standard now applicable to Clinical Support Unit and Primary Care Services Moved content requirements of policy to supporting information	**2**	**Governance**	**EPRR Policy**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Removed reference to "Clinical Commissioning Group Accountable Officer" as no longer applicable Removed requirement for EPRR reports to go to "Governing Body" as no longer applicable Added "The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements" Moved content requirements of reports to supporting information	**3**	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Added a new first bullet point to include "Current guidance and good practice" Added: "The work programme should be regularly reported and shared with partners where appropriate"	**4**	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Removed "proportionate to is size" as this is not the only factor for consideration	**5**	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Standard detail wording amended to expand on what is implied by development of EPRR arrangements and specifically reference undertaking a "review and embed" learning into future arrangements	**6**	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
Domain 2 - Duty to risk assess								
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Broadened standard detail to include consideration of all relevant risk registers including community and national risk registers Supporting information updated to address recommendation from the Health and care adaptation reports as part of the Greener NHS programme	**7**	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Added reference to "communicating and escalating EPRR risks internally and externally"	**8**	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
Domain 3 - Duty to maintain plans								
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Standard description amended to encourage greater collaborative working on broader EPRR arrangements and wider stakeholder engagement.	**9**	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Previously separate standards relating to Critical Incident and Major Incident plans have been incorporated into a single standard which requires organisations to have effective plans in place to "define" and respond to "Critical and Major Incidents" as defined in the EPRR Framework	**10**	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Removed this standard as incorporated into the Incident Response standard				
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Previously separate standards relating to Heatwave and Cold Weather Plans have been incorporated into a single standard which requires organisations to have effective arrangements "in place for adverse weather events." Supporting information updated to address recommendation from the Health and care adaptation reports as part of the Greener NHS programme	**11**	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Removed standalone standard as it is incorporated in to the redefined Adverse Weather standard				

15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Sub-section has been renamed "new and emerging pandemic" and reworded to reflect generic pandemic arrangements rather than disease specific (i.e. Influenza) planning, and differentiate separately form current arrangements in place to respond to the COVID-19 pandemic. The revised standard does however include reference to "reflecting recent lessons identified" recognising lessons likely to have been identified during the COVID-19 response and incorporated in to future planning. Revised standard has also been reordered to follow Infectious Diseases standard as these arrangements may be considered as a foundation for Pandemic response.	**13**	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Reference to specific diseases (i.e. VHF) and specific arrangements (i.e. IPC) removed to ensure broader planning considerations are taken in to account. Supporting information updated to include reference to DHSC FFP3 resilience in Acute setting guidance Revised standard has also been reordered to precede New and Emerging Pandemic standard as Infectious Disease arrangements may be considered as a foundation for pandemic response.	**12**	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
17	**Duty to maintain plans**	**Mass-countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Standard has been revised and renamed so not to be specific to Mass Countermeasures but to reflect an incident requiring "countermeasures or a mass countermeasure deployment". All other wording specifically referencing Mass Countermeasures has been removed and moved to supporting information column until national guidance published. Standard is now applicable to Integrated Care Boards and Primary Care Services	**14**	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Standard reworded to reference response to "incidents with mass casualties" rather than "responding to mass casualties". Specific references to freeing up of bed base in acute settings removed as these requirements are included in national guidance. Supporting information updated to reflect that arrangements should include safe patient identification system for unidentified patients in an mass casualty incident.	**15**	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Standard removed and incorporated as a consideration as part of broader Mass Casualty planning.				
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Minor changes to standard name to reflect national guidance title i.e. "Evacuation and Shelter" rather than "Shelter and Evacuation" Removed reference to shelter and evacuation of whole buildings and sites etc. and working with other site users as this is incorporated in national guidance.	**16**	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Standard reworded to reflect different organisations types and any specific regulatory requirements	**17**	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	No change	**18**	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Standard renamed No change to wording of standard	**19**	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
Domain 4 - Command and control								
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Standard reworded to move away from reference to EPRR specific on call, to more broader mechanisms for escalating and responding to incidents 24/7.	**20**	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.
25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Standard reworded to reflect that those staff supporting the 24/7 on call mechanism to respond to incidents (as described above) are appropriately trained in EPRR.	**21**	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
Domain 5 - Training and exercising								
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Reference to training records removed from the standard description, as it is included as evidence.	**22**	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Reference to "minimum standards in line with national guidance" included. Reference to specific exercise and testing requirements moved to supporting information and is included in national guidance. Addition to reiterate that exercise and testing should be undertaken "safely: no undue risk to exercise players or participants, or those patients in your care" "Lessons identified" removed from standard description but incorporated in to supporting information of post exercise	**23**	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)

28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Standard renamed "Responder Training" and reworded to include all responders, and reflect shared responsibility to maintain personal development portfolios with the host organisation. National occupational standards updated to reflect new "Minimum Occupational Standards"	24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
				New standard	25	Training and exercising	Staff Awareness and Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
29	Training and exercising	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	Moved to Domain 9 - Business Continuity	54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon
Domain 6 - Response								
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Standard has been revised to accommodate smarter ways of working and coordinating incident response. This might include physical in addition to virtual arrangements but requires ICC arrangements to be resilient with dedicated BC arrangements. Requirement for equipment testing in line with EPRR Framework.	26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Standard has been revised to accommodate smarter ways of working and coordinating incident response. This might include easily access to digital response plans but requires dedicated business continuity arrangements in place.	27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	No Change	28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Standard description amended in order that there is focus on the importance of maintaining personal records and decision logs and the utilisation of loggists to support this	29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Standard description revised	30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	No change	31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Removed PHE branding from guidance title as this will likely change over time but recognise this has formally been published by PHE previously.	32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)
Domain 7 - Warning and informing								
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Domain 7 - Warning and informing has been reviewed and refreshed to reflect significant lessons in crisis communication identified during recent emergency and incident response. Supporting information has been added to support development of arrangements and future planning	33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.		34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Additional standard with specific requirement for organisations to have incident communication plans in place which can be enacted.	35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.
					36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
Domain 8 - Cooperation								
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Standard name changed to "LHRP engagement". Further clarification of requirement for suitable representation of AEO included in line with EPRR framework. Minimum attendance requirement removed to ensure all efforts are made for organisations to send representation to all meetings.	37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Standard name changed to "LRF/BRF engagement"	38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Added in requirement to adhere to national NHS guidance around MACA etc	39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Changed to reflect that there may be a requirement to plan for *and* respond to multi LHRP/LRF boundary incidents and the resource requirements for this Applicable to ICB	40	Cooperation	Arrangements for multi-area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.	Changed PHE To UKHSA to reflect organisational change	41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.
45	Cooperation	LHRP	Arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	Changed subheading to include Secretariat. Standard applicable ICB to reflect the new statutory responsibilities.	42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.

46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Added into supporting evidence additional legislative requirements	43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.
Domain 9 - Business Continuity								
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	44	Business Continuity	Business Continuity (BC) policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Standard description developed to provide further context regarding the requirement to define scope of the programme. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard.	45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	47	Business Continuity	Data Protection and Security Toolkit (DPST)	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Standard separated into two separate standards to reflect the requirement for a) Business Continuity Plans for the management of incidents and b) testing and exercising of BC Plans. This is extant for the requirement for testing and exercising of other non-BC EPRR and Incident response arrangements	48	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure
					49	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Standard description developed to better define audit cycle and internal and external requirement. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard Supporting information encompasses Monitoring, evaluating, lessons identified and audit cycle findings	52	Business Continuity	BCMS continuous improvement process	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	No change to standard description. Supporting information developed to include support from Procurement and commercial teams at tender stage.	53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.
Domain 10 - CBRN								
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	No substantive change to standard content. Domain 10 - CBRN due to be reviewed as part of national CRBRN work programme and core standards updated as part of interim review. Standards renumbered as necessary	55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.		56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.		57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.		58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/		59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.		60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks		61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment		62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.		63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.		65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.

67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.

67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.

Ref	Domain	Standard	Deep Dive question	Further information	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Boards	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Evacuation and Shelter																						
Domain: Evacuation and Shelter																						
DD1	Evacuation and Shelter	Up to date plans	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	https://www.england.nhs.uk/publication/shelter-and-evacuation-guidance-for-the-nhs-in-england/	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y		Fully compliant			
DD2	Evacuation and Shelter	Activation	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y		Fully compliant			
DD3	Evacuation and Shelter	Incremental planning	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y		Fully compliant			
DD4	Evacuation and Shelter	Evacuation patient triage	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.		Y	Y	Y	Y			Y						Y		Fully compliant			
DD5	Evacuation and Shelter	Patient movement	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.		Y	Y	Y	Y			Y					Y	Y		Fully compliant			
DD6	Evacuation and Shelter	Patient transportation	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.		Y	Y	Y	Y	Y		Y						Y		Fully compliant			
DD7	Evacuation and Shelter	Patient dispersal and tracking	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.		Y	Y	Y	Y	Y		Y						Y		Fully compliant			
DD8	Evacuation and Shelter	Patient receiving	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.		Y	Y		Y			Y						Y		Fully compliant			
DD9	Evacuation and Shelter	Community Evacuation	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Fully compliant			
DD10	Evacuation and Shelter	Partnership working	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.		Y	Y	Y	Y	Y		Y	Y		Y		Y	Y		Fully compliant			
DD11	Evacuation and Shelter	Communications-Warning and informing	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.		Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y		Fully compliant			
DD12	Evacuation and Shelter	Equality and Health Inequalities	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.		Y	Y	Y	Y	Y		Y	Y		Y		Y	Y		Fully compliant			
DD13	Evacuation and Shelter	Exercising	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Fully compliant			

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 9c
Subject:	2022 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data submission	**For Publication:** Yes
Author:	Louise Thomas, Deputy Director of People and OD	**Approved by:** Janet Lynch, Interim Executive Director, People and OD
Presented by:	Janet Lynch, Interim Executive Director, People and OD	

Purpose of the report:

To update the Board on the Trust's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data submission.

Action required:

To receive the report.

Summary and recommendations to the Committee:

The attached presentation sets out this year's WRES and WDES data. Both standards use a combination of locally held workforce data and annual staff survey data to help identify the experience of BAME and disabled staff compared to white and non-disabled staff, in particular any difference in experience and areas for improvement.

Our data was submitted within the deadline of 31 August 2022 and was based on locally held data as at 31 March 2022. All staff survey data relates to the 2021 annual staff survey. Thus, any impact of initiatives to achieve improvement which launched this financial year, such as the inclusion ambassador scheme and the workplace adjustments panel, will not be reflected in the attached data.

The presentation shows the movement since last year's submission, which was based on data as at 31 March 2021 and the 2020 annual staff survey.

Of note is that the data shows that BAME staff this year have been 2.8 times more likely to enter the disciplinary process than white staff. In 2021, we reported a positive position for this indicator, however, it became apparent that the data was incorrect and we should have reported a position of BAME staff being 2.4 times more likely to enter the process.

In future quarterly reports to PODG, the Executive Team and IGC, we will report on all WRES and WDES data on a quarterly basis and this will also inform the inclusion and equalities governance group which is currently being set up.

This report sets out the actions which have been taken thus far and the areas for further work. The data, including the erroneous data submitted last year, is being openly and transparently discussed with staffside colleagues, our staff networks and as part of our engagement to develop our belonging and inclusion strategy, in order to co-produce a comprehensive action plan to

address the areas for improvement.

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 and Public & Patient Involvement Implications:

The WRES and WDES data is intended to ensure that organisations monitor the experience of disabled and BAME staff across a number of key indicators in order to draw up detailed actions to address areas for improvement in order to eradicate discrimination and promote diversity and equality.

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

N/A

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

PODG 7 September 2022
IGC 15 September 2022

WRES & WDES 2022

Overview of WRES & WDES

- The Workforce Race and Disability Equality Standards use a combination of annual staff survey data and local data held by the Trust
- Locally held data is submitted by 31 August 2022
- Our 2021 annual staff survey data is taken directly from the NHS Staff Survey Coordination centre.
- Guidance has been tweaked; most major change this year is exclusion of Bank data and addition of medical education data
- Purpose is to gather key performance metrics with regards workforce race and disability to identify progress and actions to eradicate discrimination and achieve equality

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

WRES Headlines

	2020	2021	2022
Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	1.22	1.26	1.34↑
Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	1.03	2.4 *	2.87↑
Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	1.12	1.35	0.46↓
BAME percentage of VSM staff	25%	12.5%	12.5%↔
BAME Board membership (voting)	12.5%	6.7%	15.4%↑
Percentage of staff experiencing harassment, bullying, abuse from SUs, relatives or public in last 12 months	35.6% (White staff 26.4%)	29% (White staff 24.9%)	30.8%↑ (White staff 22.4%)
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	25% (White staff 20%)	20% (White staff 18.3%)	19.3%↓ (White staff 16%)
Percentage of staff believing that trust provides equal opportunities for career progression or promotion	52.7% (White staff 65%)	45.9% (White staff 67%)	49%↑ (White staff 64.2%)
Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	14% (White staff 6%)	12.1% (White staff 5.6%)	13.2%↑ (White staff 6.8%)

as one

NB: 34% of our staff are BAME people

28% of staff survey responses from BAME staff

Arrow colour & direction compares to last year

* 2021 data submitted on disciplinaries was incorrect; 2.4 is the correct figure.

Our Values
Welcoming Kind Positive Respectful Professional

WDES Headlines – Non-staff survey indicators

	2020	2021	2022
Relative likelihood of non-disabled applicants being appointed from shortlisting across all posts compared to disabled applicants	1.23	0.77	1.13↑
Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff	0	53.28	0↓
Percentage of disabled 8c -VSM staff – non-clinical	0%	5.6%	4.9%↓
Percentage of disabled 8c -VSM staff - clinical	2.94%	5.6%	2.6%↓
Disabled voting Board membership	0%	20%	7.69%↓

WDES Headlines – staff survey indicators

	2020 – with a LTC or illness?		2021 – with a LTC or illness?		2022 - With a LTC or illness?	
	Yes	No	Yes	No	Yes	No
HPFT provides equal opportunities for career progression or promotion	58.8%	62.4%	57.6%	61.8%	55% ↓	61.9%
Experienced harassment, bullying or abuse from service users, relatives or public in last 12 months	35.6%	27%	31.1%	25%	32.2% ↑	22.4%
Experienced harassment, bullying or abuse from manager in last 12 months	14.2%	9.9%	13.3%	8.2%	13.4% ↔	6.7%
Experienced harassment, bullying or abuse from colleagues in last 12 months	20.9%	13.9%	17.8%	12.3%	16.6% ↓	11.6%
They/colleague reported the harassment, bullying or abuse the last time it was experienced	58.4%	59.4%	62.6%	57.3%	57% ↓	64.2%
Felt pressure from manager to come to work when not well enough to perform their duties	18.7%	14.4%	17.6%	16.5%	17% ↓	16.4%
Satisfied with extent the organisation values their work	56.5%	59.9%	51.9%	60.9%	47.6% ↓	58.8%
Employer has made adequate adjustments to enable them to carry out their work	81%	-	86.8%	-	83.5% ↓	-
Staff engagement score	7.3	7.4	7.3	7.5	7.1 ↓	7.4

NB: 27% of survey respondents identified as disabled people or with a LTC/illness; 5.32% recorded on ESR as disabled people (24% disability status unknown)

Arrow colour & direction compares to last year

as one

Our values
Welcoming Kind Positive Respectful Professional

Together we did…

- Reverse mentoring
- Associate NED post created
- Just culture – amended processes & 1st decision making panels
- Staff networks sponsored by Execs
- Diversity events
- Belonging and Inclusion engagement to co-produce strategy and plan
- Career development support for BAME and disabled staff
- Workplace adjustments panel
- Targeted health & wellbeing
- Band 2 to 3 development
- Inclusion ambassadors
- Developed App to improve WDES data quality

More to do together…

- Expanded career development support for BAME staff
- Address experience of racism/B&H from our service users
- Eliminate discrimination/B&H from manager/colleagues
- Better celebrating our valued disabled staff
- Further work on our disciplinary process and closer monitoring
- Reasonable adjustments policy
- More frequent data reporting
- Governance group to be established

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 10
Subject:	Report of the Finance and Investment Committee held on 22 September 2022	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** Anne Barnard, Non-Executive Director
Presented by:	Anne Barnard, Non-Executive Director & Audit Committee Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Finance and Investment Committee at its most recent meeting held on the 22 September 2022.

Action required:

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

Summary and recommendations to the Board:

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

Matters for Escalation to the Board

There were no items for formal escalation to the Board.

Board is asked to note that the Committee formally approved an updated Treasury Investment Policy.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

None

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

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

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

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

Not applicable.

Hertfordshire Partnership University NHS Foundation Trust

Report from Finance and Investment Committee held on 22 September 2022

1. Introduction

1.1 This paper provides the Board with a summarised report highlighting key Committee business and issues arising from the meeting.

1.2 Since the last Finance and Investment Committee report to the Trust Board in Public, the Finance and Investment Committee ["the Committee"] held a meeting on 22 September 2022 in accordance with its terms of reference and was quorate.

1.3 The Committee was chaired for the first time by Anne Barnard, Non-Executive Director.

1.4 The Committee received and considered a number of items, appendix 1 details the agenda items from the meeting. Detailed below are the key areas to be highlighted to the Board and areas that the Committee discussed.

2. Community Transformation

2.1 The Committee received a detailed presentation on the progress with the Community Services Transformation. The Committee were updated on the elements of the programme which was based on the Long Term Plan and Community Mental Health Framework for Adults and Older Adults.

2.2 The Committee were provided with an overview of the whole programme but also the main priority areas of: 'CEN' / Personality Disorder; Community Rehab and Eating Disorders. The Committee noted the funding that had been received in 2021/22 and 2022/23 to support the transformation and discussed progress with implementation of the programme and use of the allocated resources.

2.3 The Committee supported the Trust's vision of the model of there being "no wrong door", it being needs led, focused on improving outcomes and working in an integrated way supported by interoperability.

2.4 The Committee considered the specific priorities in the key areas, noting the progress to date and development of new roles to support the roll out of the model. It was noted that recruitment of workforce remained a challenge. The Committee noted that the transformation programme is supported by a single plan and risk register.

2.5 It was noted that the positive impact of the new models would take some time to be 'felt' as it was linked with confidence of service users, staff and primary care in the new models. It was noted that as an early implementer the Trust was seen as a lead organisation for community transformation both regionally and nationally

3. Finance

3.1 The Committee received a report that detailed the financial position as at end of month 5. The Trust is reporting a break-even position for the year to date and a forecasting a break-even outturn position for year end. The Committee were informed that this is based on current expenditure, reflecting the projected impact of transformation schemes and the delivery of Delivering Value savings schemes.

3.2 The Committee were updated on the performance of the Delivering Value Programme and forecast performance against CQUIN targets. The Committee considered the progress in spending the transformation funds allocated to the Trust. The Committee noted the work underway with commissioners to prepare for year end.

3.3 In response to a question it was reported that the system was aware of the Trust's position. It was noted that the Committee meeting in November would consider an outline financial plan for 2023/24.

4. Female Forensic Business Case

4.1 The Committee considered the proposed Business Case for a female Learning Disability Forensic inpatient service. The Committee noted the aim of the clinical model to provide a 'blended' model in a unit of both low and medium secure services. The Committee were updated on the national context of limited availability of this type of service and that inequity of provision nationally between males and females.

4.2 The Committee welcomed the involvement of clinical and operational teams in the development of the clinical model and business case, coupled with the involvement of service user focus groups and discussion with other female forensic provider organisations. The Committee noted that this proposal aligned with the Trust's role as a national and regional leader of Learning Disability services.

4.3 It was noted that the proposed service would require investment by the East of England Provider Collaborative rather than local commissioners. It was also noted that the proposal required capital investment to upgrade the environment to meet the needs of this cohort of service users.

4.4 The Committee discussed the importance of commissioner support and taking the learning from units who previously provided the service. The Committee supported the business case noting that areas of safety and clinical risk would be carefully considered, and assurance sought. The Committee discussed the need to support male services users in any change to current service.

4.5 The Committee approved the business case in principle noting that it needed to be considered by the East of England Provider Collaborative and that there would be a separate business case for the proposed capital. It was noted that this would be considered by the Committee and Board at a future date.

5. Commercial Strategy

5.1 The Committee considered a proposal with regard to the development of the Trust's commercial strategy. The Committee discussed that the last commercial strategy had been written in 2019 and that the external environment had changed considerably since, in particular with the enacting of the new Health and Social Care Act and changes in commissioning landscape.

5.2 The Committee noted the importance of the commercial strategy being aligned with the Trust's emerging five-year strategy. The Committee stressed the importance of the strategy considering a number of factors such as choosing areas of focus and the commitment to working in partnership. It was noted that the Trust's risk appetite would also need to be considered.

5.3 The Committee supported the approach as outlined and asked that a gap analysis is undertaken to support the development of the strategy and that criteria are developed to assess opportunities. It was noted that the Committee would be updated on the development of the strategy.

6. Matters for Escalation to the Board

6.1 There were no items for formal escalation to the Board.

6.2 The Board is asked to note that the Committee formally approved an updated Treasury Investment Policy.

Appendix One: Finance and Investment Committee 22 September 2022, agenda items

Apologies for Absence
Declarations of Interest
Minutes of meeting held on 21 July 2022
Matters Arising Schedule
DEEP DIVE
Community Transformation
OPERATIONAL
Finance Report Month 5
Performance Report – Quarter One
Contract Update
East of England Provider Collaborative Update
Review of Treasury Investment Policy
Finance Sustainability Audit
STRATEGIC
Female Forensic Business Case
Capital Programme
Commercial Strategy
OTHER BUSINESS
FIC Business Programme
Any Other Business

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Board PUBLIC

Meeting Date:	29th September 2022	**Agenda Item:**	10a
Subject:	Performance Report – Quarter 1 2022-23	**For Publication:**	No Yes
Author:	Hakan Akozek, Director of Innovation and Digital Transformation; Chief Information Officer	**Approved by:**	Hakan Akozek, Director of Innovation and Digital Transformation; Chief Information Officer
Presented by:	Hakan Akozek, Director of Innovation and Digital Transformation; Chief Information Officer		

Purpose of the report:

This report provides an overview of the Trust's performance against both the NHS Single Oversight Framework targets and the Trust Key Performance Indicators (KPIs) for Quarter 1 2022-23 and an update on the actions being taken to improve performance.

Action required:

The Trust Board is recommended to receive the report, discuss key areas of performance and to note actions being taken to improve performance.

Summary:

The first quarter of the 2022-23 has been challenging with more people presenting into our services with a higher level of acuity than before the pandemic.

Despite the high demand on our services, the `number of KPIs meeting the target (33) is similar to Quarter 1 performance in previous years, with strong performance in:

- Access to Adult Crisis services within 4 hours of referral
- Achieving recovery objectives in over 50% of cases after treatment in IAPT
- Mental Health Liaison teams which remained strong for our 1 hour and 24 hour targets
- Feedback from our service users that our services are welcoming and friendly across our services
- Support and follow up for service users discharged from inpatient environments

Our key areas of focus for improvement include:

- Adults and Children and Young People waiting longer than 28 days from referral to assessment
- Service users admitted to out of area placements
- Feedback from our service users about how safe they feel in our inpatient units
- Staff vacancy and turnover rates which remain high, with similar pressures seen across the wider NHS, leading to high levels of temporary staff in teams

We are changing our approach to performance improvement, transitioning to using Statistical Process Control approach in line with NHS best practice. This will allow us to monitor trends and significant variance and as a consequence better direct our resources to address performance.

The Trust's remains committed to meeting all its performance targets. At the end of 2021-22, the Trust established a Recovery Programme that brings together all the performance improvement initiatives under a single governance and support structure with actions we are taking to improve performance in key areas summarised in the report.
The Trust Board is recommended to receive the report, discuss key areas of performance and to note actions being taken to improve performance.

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

The report includes key performance indicators across multiple domains which relate to the Trust's business plan.

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

There are no direct financial, staff, IT or legal implications arising from this report.

Equality & Diversity and Public & Patient Involvement Implications:

Although some of the key performance indicators have equality and diversity dimensions, there are no direct implications arising from this report. The colours and graphics adopted in this report use the standards developed by NHSI/E to make the report more accessible to a wider audience.

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

The report includes all targets reportable in Quarter 1 2022-23.

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

Executive Team – 7th September 2022

Performance Report – Quarter 1 2022-23

1. Background

1.1. This report provides an overview of the Trust's performance against both the NHS Single Oversight Framework targets and the Trust Key Performance Indicators (KPIs) for Quarter 1 2022-23 and an update on the actions being taken to improve performance.

1.2. The Trust continues to innovate in making best use of data to inform our improvement efforts. In line with NHS best practice, we are transitioning to use Statistical Process Control (SPC) techniques offering further insights into our performance by exposing the underlying variation and consistency of our key performance indicators. This approach allows us to better understand what our performance is now, the direction it is going, and provides assurance on how likely the Trust is to meet targets.

1.3. There are two main types of information introduced as part of SPC. The first is Assurance and identifies how consistently our processes are likely to meet the target. The second is Variance which describes the trend for the trajectory over time, including statistically significant variations.

1.4. The following icons are used to represent variance and assurance in this report. Icons are colour coded for easier interpretation with blue for improvement, grey for no significant change and orange for deterioration.

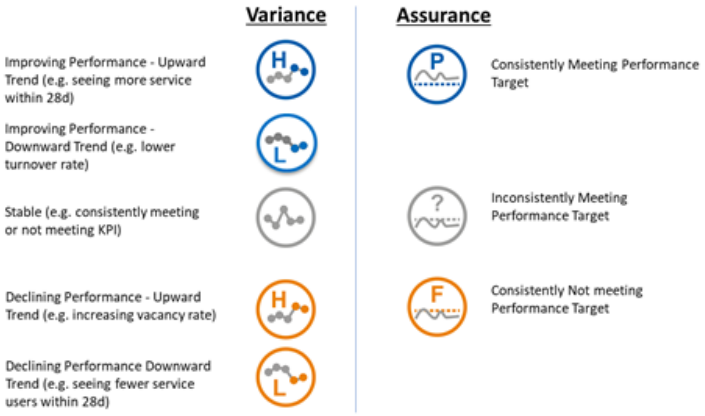


Figure 1 - SPC Icons

1.5. Tables looking at our performance since April 2019 up to end July 2022 using the SPC methodology can be found in Appendix 1. This period is chosen as it encompasses the pre-pandemic, during the pandemic and post-pandemic periods, allowing us to better understand the impact of the changes the health and care system is experiencing.

2 Quarter 1 2022-23 Performance Summary

2.1 High demand levels continued during the first quarter of 2022-23 and into Quarter 2 with significantly increased number of referrals in our Single Point of Access compared to pre-pandemic levels, particularly for Adult Community Mental Health Services. Service users are presenting in inpatient, crisis, and community services with high levels of acuity and complex needs.

2.2 In common with mental health trusts across the country, our local system, and the wider NHS, we are focussing on restoring performance and finding new ways of working to build capacity and resilience in our services to meet the needs of our service users and carers.

2.3 During the pandemic, we embraced new digital solutions, found new flexible ways of working, honed our ability to deliver change at pace, embraced the data culture and practice that directed so much of our pandemic response, and fostered even better relationships with partners across the system. Applying these new skills and relationships has been fundamental to our recovery and transformation in Quarter 1 and into Quarter 2 and sets the agenda and pace for the remainder of the year.

2.4 The overall number of performance indicators that were met in Quarter 1 (33, 51%) is static compared to Quarter 4 of 2021-22 (31, 48%). Despite the pressures we are experiencing, this is similar to historical performance in Quarter 1 periods (34 in 2021/2, 36 in 2020/21, 31 in 2019/20).

2.5 Key areas of strong performance in Quarter 1 are:

- Access to Adult Crisis services within 4 hours of referral
- Achieving recovery objectives in over 50% of cases after treatment in IAPT
- Mental Health Liaison teams which remained strong for our 1 hour and 24 hour targets
- Feedback from our service users that our services are welcoming and friendly across our services
- Support and follow up for service users discharged from inpatient environments

2.6 Focus areas for improvement include:

- Adults and Children and Young People waiting longer than 28 days from referral to assessment
- Service users admitted to out of area placements
- Feedback from our service users about how safe they feel in our inpatient units
- Staff vacancy and turnover rates which remain high, with similar pressures seen across the wider NHS, leading to high levels of temporary staff in teams

2.7 The figure below shows the percentage of KPIs achieved in in each performance domain with green indicating targets met, amber indicating targets almost met and red indicating targets not met.

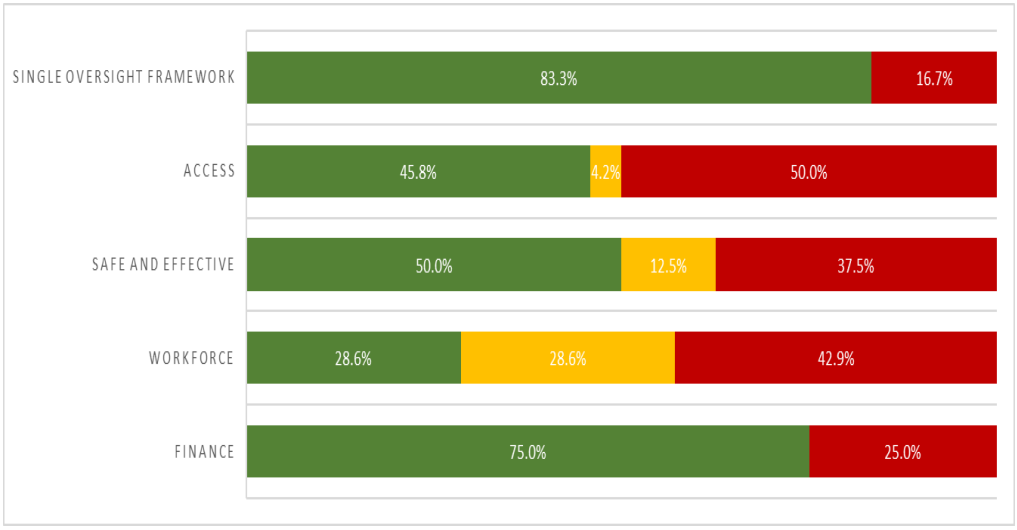


Figure 2 - RAG Breakdown by Performance Domain

3 Single Oversight Framework

3.1 In Quarter 1, the Trust has met five out of six key performance indicators in this domain.

3.2 Our IAPT services typically benchmark in the upper quartile across the UK and have consistently achieved recovery milestones. This means that over 10,000 service users benefit from improvements to their mental health and wellbeing every year.

3.3 Out of area placements occur when people are admitted, often in crisis, and there is no suitable local bed available. Due to increased demand, we used higher number of out of area beds in Quarter 1 than planned.

3.4 The table below summarises the end of quarter position for our single oversight framework key performance indicators.

KPI	Month	Performance	Target
Improving Access to Psychological Therapies (IAPT)/talking therapies Proportion of people completing treatment who move to recovery	Jun-2022	55 %	50 %
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	Jun-2022	94 %	60 %
Improving Access to Psychological Therapies (IAPT)/talking therapies - 18 weeks	Jun-2022	100 %	95 %
Improving Access to Psychological Therapies (IAPT)/talking therapies Waiting time to begin treatment (from IAPT minimum data set) - within 6 weeks	Jun-2022	89 %	75 %
Data Quality Maturity Index (DQMI) – MHSDS dataset score	Mar-22	97 %	95 %
Inappropriate out-of-area placements for adult mental health services	Jun-2022	748	602

Table 1 – Single Oversight Framework KPIs

4 Access

4.1 In Quarter 1, the Trust has met eleven out of the twenty-four access key performance indicators.

4.2 Service users who present in crisis were seen consistently by the Crisis Resolution and Home Treatment Team. We maintained consistently high levels of gatekeeping assessments prior to inpatient admissions to make sure our service users' needs are met in the most appropriate setting and our liaison teams in local hospitals continued to see service users who need our support in line with their needs.

4.3 However, as summarised in the SPC analysis in Appendix 1, performance for most of our access indicators have declined following the pandemic period, with significant challenges in providing timely access to our community services. We are addressing these by a combination of additional staffing to meet the increased demand and introducing new practices to meet the changing needs of our service users as outlined in the Recovery Programme Section.

4.4 The table below summarises end of quarter position for our access key performance indicators.

KPI	Month	Performance	Target
CRHTT referrals meeting 4 hour wait	Jun-2022	100 %	98 %
CAMHS referrals meeting assessment waiting time standards - URGENT (P1 - 7 DAYS)	Jun-2022	83 %	75 %
Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	Jun-2022	96 %	95 %
MHLT Response times: 1 hour wait for A&E referrals	Jun-2022	96 %	90 %
MHLT Response times: 24 hour wait for ward referrals	Jun-2022	95 %	90 %
CAMHS referrals meeting social worker contact waiting time standards - TARGETED SERVICE 14 DAYS	Jun-2022	95 %	85 %
Urgent referrals to community eating disorder services meeting 96 hour wait	Jun-2022	100 %	98 %
Urgent referrals to community mental health team meeting 24 hour wait	Jun-2022	No referrals	95 %
Number of new cases of psychosis	Jun-2022	105	52
Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait	Jun-2022	98 %	98 %
Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait	Jun-2022	No referrals	98 %
Routine referrals to community eating disorder services meeting 28 day wait	Jun-2022	55 %	98 %
EMDASS Diagnosis within 12 weeks	Jun-2022	32 %	80 %
CAMHS referrals meeting assessment waiting time standards - TARGETED SERVICE 28 DAYS	Jun-2022	58 %	85 %
Routine referrals to community mental health team meeting 28 day wait	Jun-2022	50 %	95 %
CAMHS referrals meeting assessment waiting time standards - CRISIS (4 hours)	Jun-2022	90 %	95 %
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS)	Jun-2022	58 %	85 %
CAMHS Eating Disorders - Routine 28 day Waited.	Jun-2022	40 %	95 %
CAMHS Eating Disorders - Urgent referrals seen within 7 Days.	Jun-2022	0 %	95 %

Number of people entering IAPT treatment (ENCCG)	Jun-2022	90 %	100 %
Number of people entering IAPT treatment (HVCCG)	Jun-2022	82 %	100 %
Number of people entering IAPT treatment (Mid Essex)	Jun-2022	69 %	100 %
SPA referrals with an outcome within 14 days (Internal)	Jun-2022	86 %	95 %
Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services	Jun-2022	96 %	98 %

Table 2 - Access KPIs

5 Safe and Effective

5.1 At the end of Quarter 1, the Trust met twelve out of twenty-four key performance indicators in the Safe and Effective domain. Our service users told us that our staff are welcoming and friendly, demonstrated our values and they were involved in discussion about their care. We continued to support our service users transitioning to and from our services and offer evidence-based treatment and care to support recovery.

5.2 However, pressures across the health and care system lead to people staying longer in our in our inpatient facilities as appropriate placements and support packages have been harder to secure. Although the recovery figures met the quarterly 50% target in Mid-Essex IAPT services, this has reduced 49% in June due to higher than usual DNAs and cancellations and larger proportion of service users discharged with recurrent depressive disorder in this area. As demonstrated in the SPC analysis in Appendix 1, there was a decline in recording information to improve our data quality as well as in undertaking some of the routine reviews.

5.3 The Table below summarises end of quarter position for our safe and effective key performance indicators with actions we are taking to improve in key areas summarised in the Recovery Programme Update in Appendix 2.

KPI	Month	Performance	Target
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital:	Jun-2022	100 %	95 %
Care Programme Approach (CPA): The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	Jun-2022	99 %	95 %
Rate of carers that feel valued by staff	Jun-2022	77 %	75 %
IAPT % clients moving towards recovery (ENCCG)	Jun-2022	58 %	50 %
IAPT % clients moving towards recovery (HVCCG)	Jun-2022	57 %	50 %
IAPT % clients moving towards recovery (Mid Essex)	Jun-2022	49 %	50 %

Rate of Service Users saying they have been involved in discussions about their care	Jun-2022	86 %	85 %
Rate of service users saying they are treated in a way that reflects the Trust's values	Jun-2022	82 %	80 %
The percentage of people under adult mental illness specialties who were followed up within 48 hrs of discharge from psychiatric in-patient care	Jun-2022	93 %	80 %
Rate of Service Users Saying staff are welcoming and friendly	Jun-2022	97 %	95 %
Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	Jun-2022	72 %	70 %
Percentage of eligible service users with a PbR cluster	Jun-2022	95 %	95 %
Rate of Service Users saying they know how to get support and advice at a time of crisis	Jun-2022	80 %	83 %
Delayed transfers of care to the maintained at a minimal level	Jun-2022	18 %	3.5 %
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation)	Jun-2022	58 %	85 %
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services	Jun-2022	80 %	90 %
Percentage of eligible service users with a completed PbR cluster review	Jun-2022	71 %	95 %
The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	Jun-2022	76 %	95 %
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment)	Jun-2022	56 %	85 %
Data completeness against minimum dataset for Ethnicity (MHSDS)	Jun-2022	82 %	90 %
Rate of acute Inpatients reporting feeling safe	Jun-2022	70 %	85 %
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services	Jun-2022	82 %	95 %
Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) Seen Only	Jun-2022	92 %	95 %
Rate of service users that would recommend the Trust's services to friends and family if they needed them	Jun-2022	78 %	80 %

Table 3 - Safe and Effective KPIs

6 Workforce

6.1 The Trust met two out of the seven Workforce indicators in the quarter. However, we made significant improvements in our PDP and appraisal rates as well as mandatory training completion in Quarter 1 and our staff tell us that we care and take action to support their wellbeing. We reviewed our RAG rating for the workforce indicators to reflect a more accurate position for this domain. Sickness rates and rate of PDP were rated Amber with mandatory training and staff wellbeing at work indicators rated Green as seen in Figure 2 in performance summary section.

6.2 Following the pandemic, similar to the rest of the NHS, recruiting and retaining the skilled workforce we need remains our biggest challenge in delivering services. Whilst new models of care and ways of working are being developed to help drive efficiency in the medium to long term, we remain critically focussed on recruiting both temporary and permanent staff and ensuring the experience of those already in post is as good as it can be. Actions we are taking to improve our recruitment and retention are summarised in the Recovery Programme Update section.

6.3 The table below summarises Quarter 1 position for our Workforce key performance indicators.

KPI	Period	Performance	Target
Staff wellbeing at work	Q1 2022	87 %	85 %
Rate of staff with a current PDP and appraisal	Jun-2022	85 %	95 %
Sickness rate	Jun-2022	4.7 %	4 %
Turnover rate	Jun-2022	18 %	13.9 %
Mandatory Training	Jun-2022	91 %	92 %
Rate of staff experiencing physical violence from service users	Q1 2022	6.3 %	5 %
Staff saying they would recommend the trust as a place to work	Q1 2022	72 %	80 %

Table 4 - Workforce KPIs

7 Finance

7.1 Underlying financial performance remained strong in Quarter 1, meeting three out of the four Finance indicators. Substantive pay costs were slightly below plan, by £99k. Secondary Commissioning spend was £250k below plan for Quarter 1. This was in line with recovery plans and the delivering value program with reductions in bed usage in both Adult Acute and Older Adult bed placements.

7.2 Provider collaborative activity reported a balanced position for month 3 and non-pay expenditure was below plan by £190k. This reflected a reduction in capital charges and is not forecast to increase further during 2022-23.

7.3 Overheads costs were also below plan, by £292k in Quarter 1. This reflected lower than expected rates of inflation impacting overhead expenditure, delays in implementing new investments and reductions in room hire usage in Essex IAPT services.

7.4 The full year forecast outturn position at the end of the quarter was break-even, with the expectation that transformation schemes deliver, and that associated funding will be fully spent.

7.5 The Trust is having to spend more money on agency workers due to high demand levels in the system. As a result, we have not met our NHS Agency Price Cap limits with 155 breaches in June 2022 against a target of 0.

7.6 We continue to review agency spend regularly. However, we expect this situation to persist across the second quarter as we recover our performance position and develop longer term sustainable models of care.

7.7 However, it should be noted that there are significant ongoing pressures that impact our finances, and this is a key focus for Quarter 2.

8 Recovery Programme Update

3.1 The Trust's remains committed to meeting all its performance targets. At the end of 2021-22, the Trust established a Recovery Programme that brings together all the performance improvement initiatives under a single governance and support structure.

3.2 Each recovery project is led by a member of the senior leadership team and reports to a weekly review meeting. Recovery Programme Board that oversees the entire programme meets monthly and reports to the Executive Team. Initial detailed recovery trajectories and actions were agreed in Quarter 1 based on a number of planning assumptions. These are reviewed regularly and updated where there are significant deviations and actions do not result in the anticipated improvement.

3.3 The recovery programme has also been extended to include the national recovery initiative for planned (elective) appointments in the NHS to provide a strong position to enter the busy winter months.

3.4 In parallel to the recovery programme, the Trust is running a Transformation Programme which takes a longer-term, strategic set of projects with the purpose of creating long-term sustainable services that meet the needs of service users and carers into the future.

3.5 Appendix 2 summarises the steps we are taking in the recovery programme to improve our performance in areas of key concern.

9 Conclusion and Recommendations

4.1 The Trust met 33 (51%) key performance indicators in Quarter 1 2022-23, compared to 31 (48%) in Quarter 4 2021-22.

4.2 A recovery programme has been initiated bringing together all the performance improvement initiatives under a single governance and support structure to improve performance in key areas of concern.

4.3 The Trust has also made significant progress in transitioning to SPC approach for the reporting and analysis of its performance.

4.4 The Trust Board is recommended to receive the report, discuss key areas of performance and to note actions being taken to improve performance.

5 Appendices

APPENDIX 1 – INTRODUCING STATISTICAL PROCESS CONTROL (SPC) ANALYSIS

5.1 This section summarises the performance of the Trust in Single Oversight Framework, Access and Safe and Effective domains from April 2019 up to end July 2022 using the SPC methodology. This period is chosen as it encompasses the period pre-pandemic, during the pandemic and post-pandemic, allowing us to better understand the impact of the changes the health and care system is experiencing.

5.2 Some of our KPIs are difficult to analyse using the standard SPC approach and as a result do not yet have the associated variation and assurance analysis. We are working with NHSIE experts to identify best way of using SPC to analyse these.

Single Oversight Framework

KPI	Month	Performance	Target	Variation	Assurance	Mean
Improving Access to Psychological Therapies (IAPT)/talking therapies Proportion of people completing treatment who move to recovery	Jul-2022	51 %	50 %			51.4%
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	Jul-2022	96 %	60 %			84%
Data Quality Maturity Index (DQMI) – MHSDS dataset score.	Mar-2022	97 %	95 %			96.7%
Improving Access to Psychological Therapies (IAPT)/talking therapies Wiithin 18 weeks (3-Month Rolling)	Jul-2022	100 %	95 %			99.9%
Improving Access to Psychological Therapies (IAPT)/talking therapies Waiting time to begin treatment - within 6 weeks (3-Month Rolling)	Jul-2022	91 %	75 %			89.3%
Inappropriate out-of-area placements for adult mental health services	Jul-2022	757	518			

Access

KPI	Month	Performance	Target	Variation	Assurance	Mean
CAMHS referrals meeting assessment waiting time standards - CRISIS (4 hours)	Jul-2022	96 %	95 %			92%

Number of new cases of psychosis	Jul-2022	77	50			22.7
Routine referrals to Specialist Community Learning Disability Services meeting 28 day wait	Jul-2022	100 %	98 %			98.9%
MHLT Response times: 1 hour wait for A&E referrals (Lister & Watford combined)	Jul-2022	92 %	90 %			95.8%
CAMHS referrals meeting social worker contact waiting time standards - TARGETED SERVICE 14 DAYS	Jul-2022	95 %	75 %			88.8%
CRHTT referrals meeting 4 hour wait	Jul-2022	100 %	98 %			100%
MHLT Response times: 24 hour wait for ward referrals (Lister & Watford combined)	Jul-2022	94 %	90 %			98.8%
Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	Jul-2022	95 %	95 %			96.8%
Urgent referrals to Specialist Community Learning Disability Services meeting 24 hour wait	Jul-2022	No referrals	98 %			
CAMHS Eating Disorders - Urgent referrals seen within 7 Days	Jul-2022	0 %	95 %			24.2%
Rate of referrals meeting maximum 18 week wait time from referral to treatment for all mental health and learning disability services	Jul-2022	95 %	98 %			97.9%
Routine referrals to community mental health team meeting 28 day wait	Jul-2022	52 %	95 %			82.7%
CAMHS referrals meeting assessment waiting time standards - ROUTINE (28 DAYS)	Jul-2022	56 %	95 %			79.1%

Routine referrals to community eating disorder services meeting 28 day wait	Jul-2022	56%	98 %			93.7%
EMDASS Diagnosis within 12 weeks	Jul-2022	33 %	80 %			69.5%
Number of people entering IAPT treatment (Mid Essex)	Jul-2022	75 %	100 %			83.2%
SPA referrals with an outcome within 14 days (Internal)	Jul-2022	86 %	95 %			95.1%
CAMHS referrals meeting assessment waiting time standards - TARGETED SERVICE 28 DAYS	Jul-2022	56 %	85 %			90.6%
CAMHS Eating Disorders - Routine 28 day Waited	Jul-2022	12 %	95 %			28.7%
CAMHS referrals meeting assessment waiting time standards - URGENT (P1 - 7 DAYS)	Jul-2022	63 %	75 %			85%
Number of people entering IAPT treatment (ENCCG)	Jul-2022	93 %	100 %			91.6%
Number of people entering IAPT treatment (HVCCG)	Jul-2022	76 %	100 %			90.4%
Urgent referrals to community mental health team meeting 24 hour wait	Jul-2022	No referrals	95 %			
Urgent referrals to community eating disorder services meeting 96 hour wait	Jul-2022	100 %	98 %			

Safe and Effective

KPI	Month	Performance	Target	Variation	Assurance	Mean
The percentage of people under adult mental illness specialties who were followed up within 48 hrs of discharge from psychiatric in-patient care	Jul-2022	80 %	80 %			88.2%

Care Programme Approach (CPA): The percentage of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	Jul-2022	99 %	95 %			96.9%
Rate of carers that feel valued by staff (rolling 3 month basis)	Jul-2022	77 %	75 %			78.2%
IAPT % clients moving towards recovery (ENCCG)	Jul-2022	54 %	50 %			51.4%
Rate of Service Users saying they have been involved in discussions about their care (Rolling 3 months)	Jul-2022	86 %	85 %			86.6%
Rate of service users saying they are treated in a way that reflects the Trust's values	Jul-2022	82 %	80 %			82%
Rate of Service Users Saying staff are welcoming and friendly	Jul-2022	97 %	95 %			92.9%
IAPT % clients moving towards recovery (HVCCG)	Jul-2022	53 %	50 %			52.4%
Data completeness against minimum dataset for Ethnicity (MHSDS)	Jul-2022	87 %	90 %			89.8%
Identifier metrics	Jul-2022	100 %	95 %			99.7%
Delayed transfers of care to the maintained at a minimal level	Jul-2022	16 %	3.5 %			8.1%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Accommodation)	Jul-2022	60 %	85 %			67.9%
Percentage of eligible service users with a completed PbR cluster review	Jul-2022	70 %	95 %			82.3%

The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	Jul-2022	73 %	95 %			87.2%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to NHS Digital (Employment)	Jul-2022	59 %	85 %			67.4%
Rate of service users with a completed up to date risk assessment (inc LD&F & CAMHS from Apr 2015) Seen Only	Jul-2022	93 %	95 %			91.8%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services	Jul-2022	77 %	90 %			61.8%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on Care Programme Approach)	Jul-2022	80 %	95 %			63.5%
Rate of service users that would recommend the Trust's services to friends and family if they needed them	Jul-2022	77 %	80 %			86.2%
IAPT % clients moving towards recovery (Mid Essex)	Jul-2022	42 %	50 %			50.1%
Rate of acute Inpatients reporting feeling safe (rolling 3 month basis)	Jul-2022	70 %	85 %			80%
Percentage of eligible service users with a PbR cluster	Jul-2022	95%	95 %			95.6%
Rate of Service Users saying they know how to get support and advice at a time of crisis (Rolling 3 months)	Jul-2022	80 %	83 %			86.6%
Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	Q1 2022	72 %	70 %			

Workforce

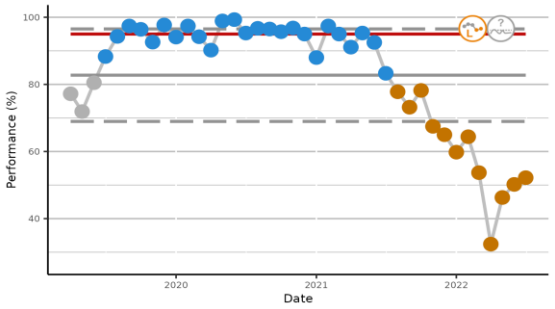
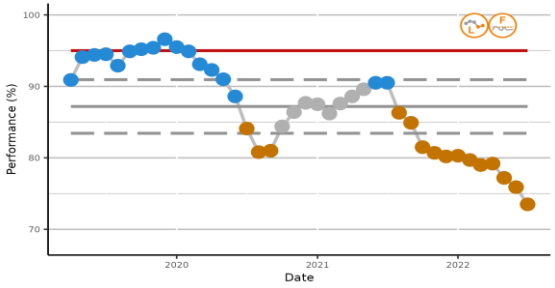
KPI	Month	Performance	Target	Variation	Assurance	Mean
Turnover rate	Jul-2022	19 %	13.9%			16.4%
Sickness rate	Jul-2022	5.2 %	4 %			4.7%
Rate of staff with a current PDP and appraisal	Jul-2022	85 %	95 %			81.9%
Mandatory Training	Jul-2022	92 %	92 %			90.2%
Rate of staff experiencing physical violence from service users	Q1 2022	6 %	5 %			
Staff saying they would recommend the trust as a place to work	Q1 2022	72 %	80 %			
Staff wellbeing at work	Q1 2022	87 %	75 %			

APPENDIX 2 – RECOVERY PROGRAMME UPDATE

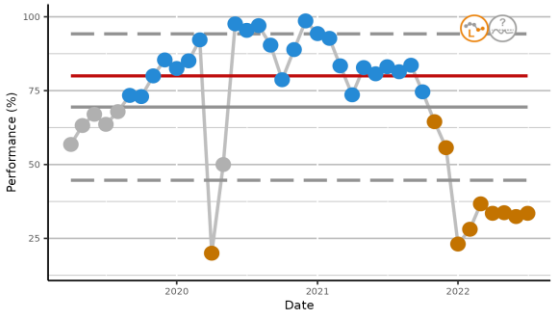
5.3 This section summarises the steps we are taking to improve performance in areas of key concern. It is organised into logical groups (Inpatient, Adults, CAMHS etc) for ease of reference with:

- Statistical Process Control Chart showing the target (red line), trend line (grey / blue / orange dots joined by a grey line), and normal variance levels (dotted grey lines)
- An explanation of what the data is telling us
- A summary of the underlying cause of the issue
- Key actions we are taking to address the issue

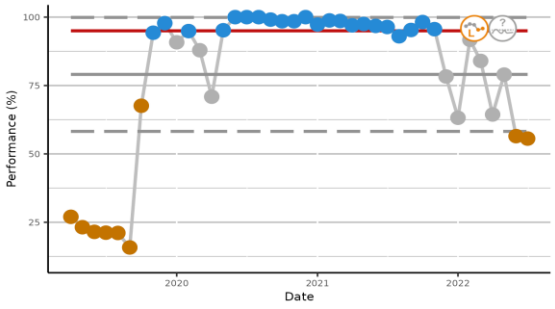
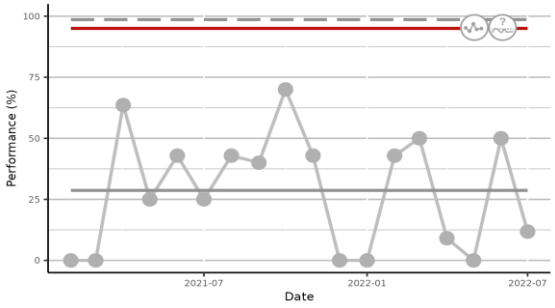
Adult Community MH Services

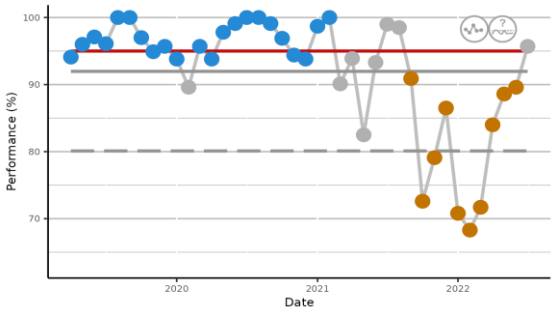
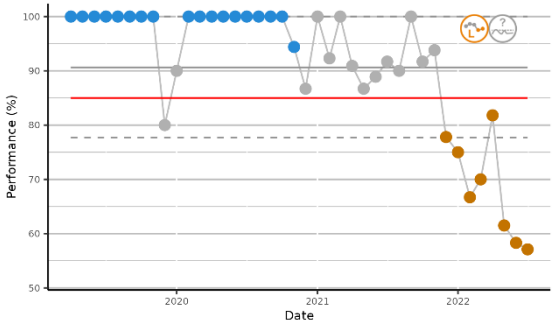
KPI	Chart	What the data is telling us	Summary	Key Actions
Adult 28 Days		**Jul-2022** 52.2% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean **Latest Target** 95% **Assurance** Inconsistently meeting performance target	Sustained high demand has resulted in a waiting list for initial assessments, with high levels of vacancies in some teams, where recruitment is particularly challenging.	• Additional staff recruited on a temporary basis to cover large demand increase and recover backlog with eight currently in post • Agency rate reviewed to remain competitive and secure staffing • Electronic referral and digital assessment support offers in development for medium to longer term improvement • Long term plans to improve recruitment and retention in place
CPA Reviews		**Jul-2022** 73.5% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean **Latest Target** 95% **Assurance** Consistently not meeting performance target	Pressures during COVID and increased caseloads, compounded staffing challenges resulted in people waiting longer for a multidisciplinary review.	• Case review and re-allocation for large care co-ordinator case loads • Weekly agency and bank recruitment review with Service Line Leads and Team leaders to target support to high vacancy areas

Older Adults Services

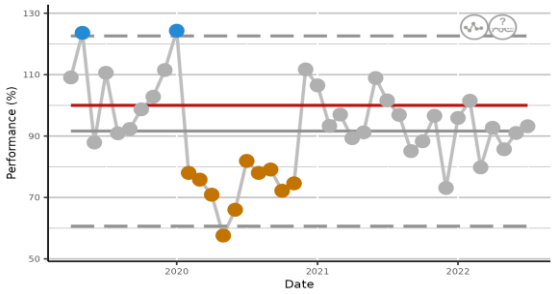
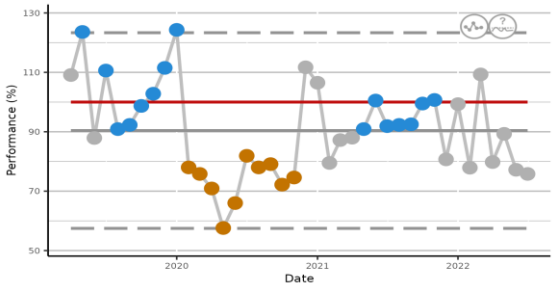
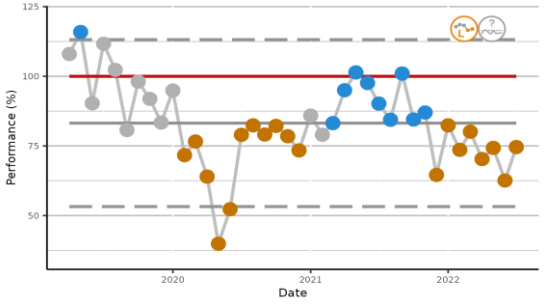
KPI	Chart	What the data is telling us	Summary	Key Actions
EMDASS 12 Weeks		**Jul-2022** 33.5% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean **Latest Target** 80% **Assurance** Inconsistently meeting performance target	Period over winter 2021 COVID wave EMDASS staff were required to support inpatient units, which resulted in an increase in people waiting for diagnosis	• EMDASS nurse deployed to SPA to signpost inappropriate referrals and reduce unnecessary wait for service users • County wide model for diagnosis to pool resources and strengthen MDT • Additional clinics for evening and weekends to see service users on waiting list

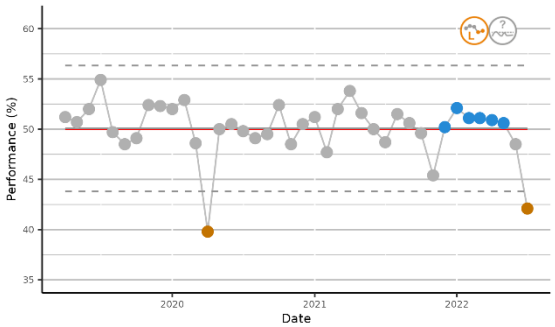
Children and Adolescent MH Services

KPI	Chart	What the data is telling us	Summary	Key Actions
CAMHS 28 Day		**Jul-2022** 55.6% **Variance Type** Special Cause Variation: Latest value below lower control limit **Latest Target** 95% **Assurance** Inconsistently meeting performance target	An increase in demand, combined with capacity issues in our Single Point of Access (SPA) Service resulted in an increased number of children and young people waiting for an initial assessment	• SPA Triage Tool improved to meet 5 day pass on to teams • Additional agency staff being recruited to address short term capacity • New reporting solution in development to assist monitoring of 1st contacts • Job planning to continue in all quadrants to ensure qualitative approach
CAMHS Eating Disorders		**Jul-2022** 11.8% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Inconsistently meeting performance target	Increase in demand by 47% nationally and challenges in recruitment resulted in an increased number of children and young people waiting for treatment.	• Caseload acuity review and transition support for Tier 2 CAMHS and primary care • Additional two Eating Disorder Specialists being recruited • Additional clinics supported by bank and agency staff to address increased demand and waiting list

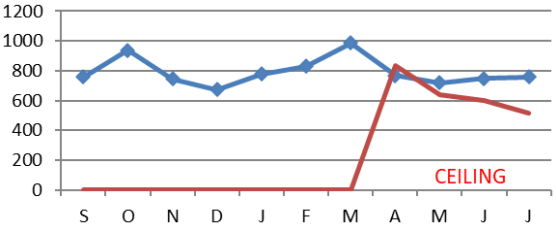
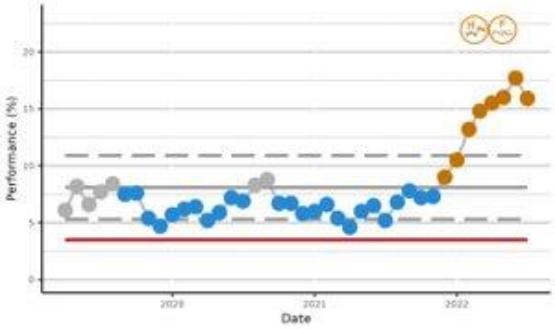
KPI	Chart	What the data is telling us	Summary	Key Actions
CAMHS Crisis		**Jul-2022** 95.7% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Inconsistently meeting performance target	An increase in demand and children and young people presenting with more complex issues after COVID, combined with challenges in recruiting staff have resulted in more children and young people waiting longer than 4 hours to be seen when they are in crisis	• Additional two staff recruited to cover extra demand presenting in A&E during busy periods. • Remodelling work to take place to design future model for delivery • Electronic patient record and reporting functions to be enhanced to better monitor 4-hour breaches
CAMHS Looked After CYP 28 Days		**Jul-2022** 57.1% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean **Latest Target** 85% **Assurance** Inconsistently meeting performance target	An increase in demand combined with recruitment challenges resulted in longer waits to make contact with the social workers of children who are looked after.	• Active recruitment drive has taken place to fill vacancies • Review of current systems & processes; adjusting variances & congestion points which has improved flow and performance • Improving efficiency including job planning and focused clinical support • Protocol in place with Social Care to improve availability of social workers to undertake joint assessment.

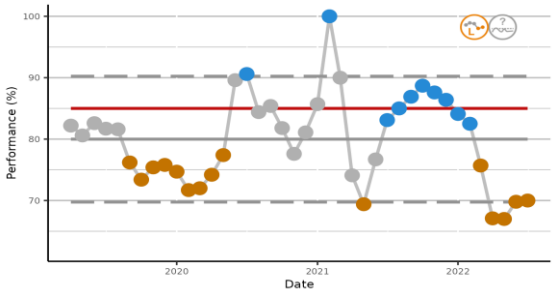
IAPT Services

KPI	Chart	What the data is telling us	Summary	Key Actions
IAPT Referrals ENCCG		**Jul-2022** 93.2% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 100% **Assurance** Inconsistently meeting performance target	The expected increase in referrals to IAPT services post-COVID has not materialised and despite benchmarking well nationally we need more referrals to the service in order to meet our monthly contracted activity levels	• Updated online campaign for direct referrals • Updated offer and marketing to GPs (key referrers) • Outreach workshops for older people • Updating comms and engagement for people with long-term conditions • Requests to system partners to increase referral rates
IAPT Referrals HVCCG		**Jul-2022** 75.8% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 100% **Assurance** Inconsistently meeting performance target		
IAPT Referrals Mid Essex CCG		**Jul-2022** 74.6% **Variance Type** Special Cause Variation: Latest 6 data points are below mean **Latest Target** 100% **Assurance** Inconsistently meeting performance target		

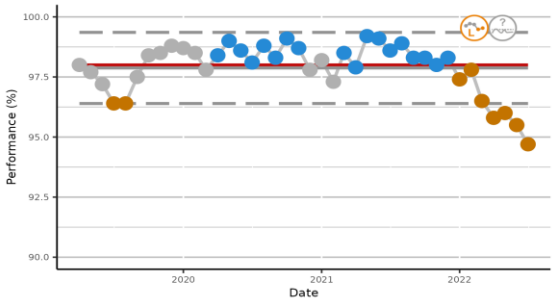
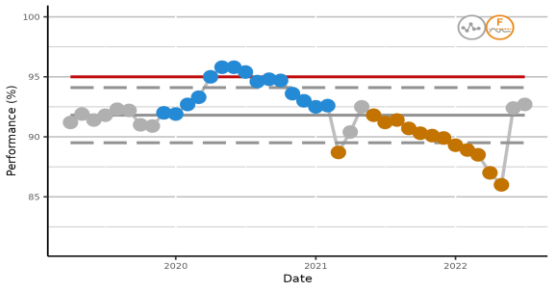
KPI	Chart	What the data is telling us	Summary	Key Actions
IAPT Recovery Mid Essex CCG		**Jul-2022** 42.1% **Variance Type** Special Cause Variation: Latest value below lower control limit **Latest Target** 50% **Assurance** Inconsistently meeting performance target	Low recovery rates in July due to higher than usual severity presentation, higher than usual DNAs and cancellations and larger proportion of service users discharged with recurrent depressive disorder	• Contacting service users who didn't complete treatment to identify reasons • Recovery Outcomes project commencing with electronic patient record supplier. This uses an algorithm based on historical data to track recovery trajectories for individual service users to predict if they are showing a positive impact of their treatment. • Two additional staff recruited for counselling for depression intervention to increase capacity for this area

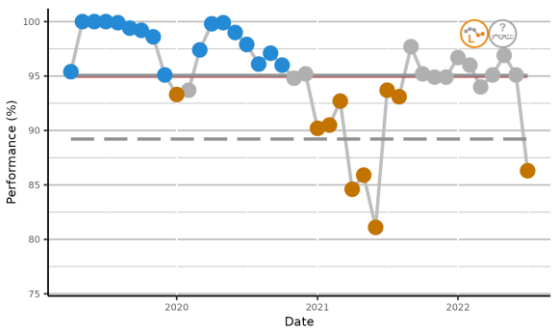
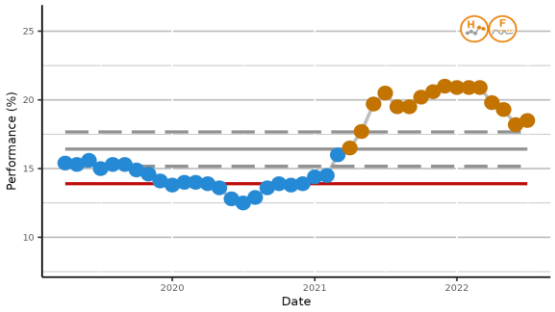
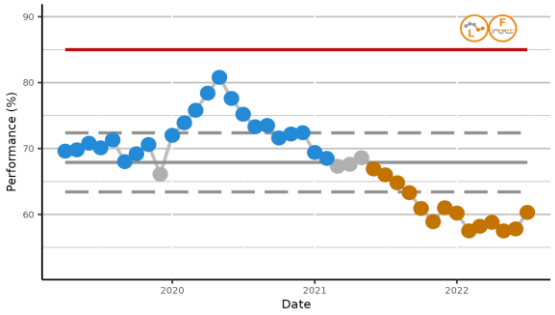
Inpatient Services

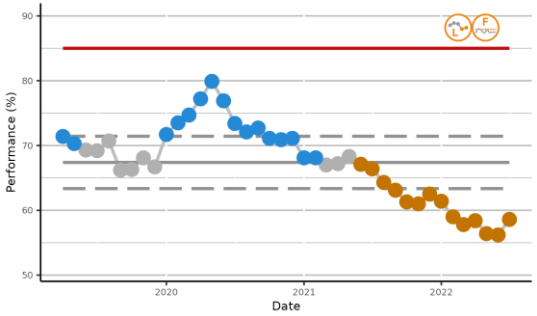
KPI	Chart	What the data is telling us	Summary	Key Actions
Out of Area Placements		**Jul-2022** 757 **Variance Type** N/A **Latest Target** 518 **Assurance** N/A	Out of area placements (OAPs) have increased, reflecting the national picture of increased demand and acuity within mental health services. The Trust also benchmarks at the lower end for number of inpatient beds per population.	• Working with NHSI/E to identify other localities with evidence of good practice. • Engaging with additional expertise as part of the national Getting It Right First Time programme to identify areas of improvement • Review and standardisation of community processes by external expert to identify opportunities for additional capacity • Review of community caseloads • Weekly meeting focusing on service users who have been in an OAP for a long time
Delayed Transfers of Care		**Jul-2022** 15.9% **Variance Type** Special Cause Variation: Latest value above upper control limit Latest 6 data points are above mean **Latest Target** 3.5% **Assurance** Consistently not meeting performance target	The number of people who are ready to move on from our inpatient services but are delayed has increased. This is due to a number of complex factors, including suitable placements being available for service users with complex needs and increased demand on community services.	• Joint Adult Services (HCC) & Placement team (HPFT) weekly placement review • Multi-agency focus on discharge plans for people with complex needs. • Dedicated discharge coordinator • Ongoing planning of discharge from the point of admission • Joint market development with Hertfordshire County Council identifying current and future needs gaps

KPI	Chart	What the data is telling us	Summary	Key Actions
Inpatient Feeling Safe		**Jul-2022** 70% **Variance Type** Special Cause Variation: Two of three data points within zone A (LCL) **Latest Target** 85% **Assurance** Inconsistently meeting performance target	The number of people saying that they feel safe in our inpatient units has decreased, but the number of people completing the survey is low, making the results less reliable.	• Focused survey on safety in inpatient units to ensure that we understand and address the reasons for service users not feeling safe. • A review of our current survey is taking place to identify ways to improve number of feedback surveys received from service users.

Trust-wide Indicators

KPI	Chart	What the data is telling us	Summary	Key Actions
18 Week Wait to Treatment		**Jul-2022** 94.7% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean **Latest Target** 98% **Assurance** Inconsistently meeting performance target	Sustained high demand in our services is impacting on our 18 week wait to treatment times, particularly in hard to recruit areas. Recording of start of treatment in electronic records also needs improvement.	• Recovery in adult community waiting times will impact positively on our 18 week wait times. • Caseload review and development of caseload management tool to increase capacity overall and improve time to treatment. • Data quality project in place as part of Recovery Programme with additional support to services to address potential data quality issues
Risk Assessments		**Jul-2022** 92.7% **Variance Type** The KPI is currently undergoing common cause variation **Latest Target** 95% **Assurance** Consistently not meeting performance target	Pressures during COVID and increased caseloads, compounded by time consuming recording methods, resulted in people waiting longer for a review of their risk assessment.	• Improvements on electronic patient record to ensure risk is assessed at each clinical contact • Simulation suite training rollout to teams with low assessment compliance • Case review and re-allocation for large psychiatry case loads • Data quality review and deep dive on data

SPA 14 Days to Outcome		**Jul-2022** 86.3% **Variance Type** Special Cause Variation: Latest value below lower control limit **Latest Target** 95% **Assurance** Inconsistently meeting performance target	Increased referral volume and capacity issues in SPA adversely affected performance, particularly in older people's services.	• Strengthening of the triage team for older people to improve capacity and throughput • Daily monitoring of waits, using an updated waiting time report that gives greater visibility of any backlog that may be building
Turnover		**Jul-2022** 18.5% **Variance Type** Special Cause Variation: Latest value above upper control limit Latest 6 data points are above mean **Latest Target** 13.9% **Assurance** Consistently not meeting performance target	The largest group of leavers are within our registered and unregistered nursing workforce. An increase in people leaving is usually seen over holiday periods, reflected in June and July figures.	• Wellbeing and benefits offer refresh, including financial wellbeing • Specific retention plans for nursing staff, including enhanced development offer • International recruitment and UK recruitment campaigns with new recruitment partner • Skill mix review and workforce transformation, including new roles and enhanced career pathways • Staff engagement, including 'you said, together we did' • Engagement to develop our belonging and inclusion strategy
Accommodation Recording		**Jul-2022** 60.3% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean **Latest Target** 85% **Assurance** Consistently not meeting performance target	Recording of accommodation and employment status decreased during the COVID period, as staff focused on areas of greatest risk for our service users.	• Data quality campaign with information team working with services to record status for initial improvement • Longer term solution to simplify recording in our electronic patient record and ensure that staff understand the importance of recording demographic data and how it is used.

Employment Recording		**Jul-2022** 58.6% **Variance Type** Special Cause Variation: Latest value below lower control limit Latest 6 data points are below mean **Latest Target** 85% **Assurance** Consistently not meeting performance target	Recording of accommodation and employment status decreased during the COVID period, as staff focused on areas of greatest risk for our service users.	• Data quality campaign with information team working with services to record status for initial improvement • Longer term solution to simplify recording in our electronic patient record and ensure that staff understand the importance of recording demographic data and how it is used.

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 11
Subject:	Financial Position – Month 5	**For Publication:** Yes
Author:	David Flint, Head of Financial Performance & Reporting	**Approved by:** Maria Wheeler, Executive Director, Finance & Estates
Presented by:	Paul Ronald, Interim Director of Finance& Estates	

Purpose of the report:

This paper presents the financial position to the Trust Board for the five months to 31 August 2022 and the forecast year-end outturn.

Action required:

To note the financial position as at 31st August 2022.

Summary and recommendations

Summary

The month 5 position has deteriorated by a further £327k, in addition to the £105k that had been projected. The drivers of this deterioration remain as at month 4, agency staff usage and demand for OOA beds.

Further detail on the month 5 and forecast outturn positions is set out below.

Financial position for the 5 months to 31 August

The financial position for month 5 and for the year to date is on plan, (break-even). However, this position reflects the *unplanned* release of an additional £432k from Trust reserves.

	Month 5			Year to Date		
Financial Position to 31 August 2022	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
Income incl. COVID-19	28,774	28,908	134	144,809	144,770	(39)
Pay	16,828	17,593	(765)	84,308	86,185	(1,877)
Secondary Commissioning	3,559	3,851	(292)	18,375	18,607	(232)
Provider Collaborative	3,624	3,624	0	18,164	18,164	0
Non Pay	1,999	1,958	41	10,117	10,069	48
Overheads & Reserves	2,765	1,882	883	13,846	11,745	2,101
Surplus / (Deficit)	-	-	-	-	-	-

In month 5 **income** is above plan, reflecting the full value of the HWE ICB contract. Year to date income is however, slightly below plan due to slippage in implementing SDF funded transformation schemes.

Pay costs have increased in month and are above plan by £765k and by £1,877k for the year to date, reflecting increased bank and agency costs. The costs of temporary staffing are offset by underspends from substantive vacancies.

Of this overspend, £279k in month and £514k for the year to date, relates to pro-active investments, including bank incentives and 28-day initial assessment recovery work.

The *unplanned* year to date overspend on pay costs is therefore £1,363k. This overspend reflects high levels of temporary staffing, the cost of which exceeds the value of substantive vacancies.

Secondary commissioning spend is £292k above plan in Month 5 and £232k above plan for the year to 31 August. The month 5 position reflects a deterioration from previous months as a consequence of sustained demand for inpatient services, with an increase in acute OOA placements.

Provider collaborative activity reports a balanced position for month 5 and the year to date. This continues to be monitored closely by the TACT team, due to the number of beds currently closed in the EoE region. Plans are in place to reopen beds, including within HPFT, during 2022/23.

Non-Pay costs are in line with plan for the year to date.

Overhead costs & Reserves are below plan, by £2.1m for the year to date. This category reflects actual overhead costs incurred, which are below plan due to delays to the commencement of transformation schemes, less the total value released from reserves. See below for the detail of reserves.

Year to date performance reflects CQUIN achievement at 73%, equal to £1.683m, with a level of risk associated with the achievement of the national target for staff flu vaccinations. See further detail below.

Forecast Outturn
The break-even forecast outturn shown below has been projected based on current expenditure, adjusted to reflect the projected impact of transformation schemes and the delivery of DV savings over the remaining months of the year.

Financial Position to 31 August 2022	Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast Outturn £'000	Variance £'000
Income incl. COVID-19	144,809	144,770	(39)	347,117	346,808	(309)
Pay	84,308	86,185	(1,877)	203,847	208,444	(4,597)
Secondary Commissioning	18,375	18,607	(232)	43,287	43,557	(270)
Provider Collaborative	18,164	18,164	0	42,319	42,319	0
Non Pay	10,117	10,069	48	24,111	24,656	(545)
Overheads & Reserves	13,846	11,745	2,101	33,553	27,833	5,720
Surplus / (Deficit)	-	-	-	-	-	-

Following a full review of the DV programme, savings of £6.4m are now estimated for the full year 2022/23. This incorporates expected additional savings from OOA placement reductions, a reduction in observations in the second half of the year.

The forecast full year *unplanned* overspend is currently £1.983m. Trust reserves are sufficient to mitigate this overspending in year, but this overspending is not sustainable for future years.

	Year to M4	M5	M6	M7	M8	M9	M10	M11	M12	FY23
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(116,789)	(29,935)	(29,547)	(29,547)	(29,547)	(29,547)	(29,547)	(29,547)	(29,547)	**(353,555)**
Pay	68,444	17,314	17,691	17,433	17,400	17,400	17,406	17,406	17,406	**207,899**
Non Pay	38,836	10,394	9,861	9,896	9,831	9,631	9,502	9,315	9,294	**116,564**
Overheads	10,303	2,654	2,474	2,563	2,626	2,601	2,495	2,702	2,659	**31,076**
***Unplanned* overspend**	**793**	**428**	**480**	**345**	**310**	**85**	**(144)**	**(124)**	**(188)**	**1,983**

Use of Trust reserves

The financial plan for 2022/23 is balanced by the application of £3.1m from Trust reserves. In addition to this, a number of investments have been made during the year, to be funded by the planned release of Trust reserves.

For the 5 months to 31 August, a total of £3.9m has been released from reserves. This includes the release of £2.7m in line with the Trust's *planned* release of reserves, and a further £1.2m to cover additional cost pressures in year so far.

The table below shows the forecast release of reserves of £6.6m for the year.

	Year to M4	M5	M6	M7	M8	M9	M10	M11	M12	FY23
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
£3.1m	1,867	191	256	141	143	168	220	13	66	3,065
Planned	300	344	172	146	71	114	108	108	181	1,544
Unplanned	793	428	480	343	310	85	(144)	(124)	(188)	1,983
Release from reserves	2,960	963	908	630	524	367	184	(3)	59	6,592

The Trust has sufficient reserves to cover this forecast position in 2022/23, but this level of spend cannot be sustained beyond March 2023.

Delivering Value

In the five months to 31 August 2022, savings of £2.11m have been realised against a plan of £3.67m. The forecast outturn is £6.4m for the full year. The schemes target a reduction in SU observations and in the number of OOA placements.

Transformation

The Financial plan for 2022/23 includes non-recurrent transformation funding of £13m from HWE ICB. The profile of plan and actual investment is summarised below:

Scheme name	Value allocated on contract as new funding in 22/23	Prior year projects	Value already spent to M4	Forecast for remainder of 22/23	Total forecast 22/23 spend	Forecast under/ (over) spend
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Adult Community	4,694	2,930	1,176	4,780	5,956	1,668
Staff Wellbeing Hub	711	344	179	511	690	365
Adult MH Crisis Liaison	208	0	0	0	0	208
Suicide Prevention	50	0	0	0	0	50
Perinatal Maternity MHS	65	0	0	0	0	65
MHSTs	2,165	516	497	1,610	2,107	574
Adult Mental Health Crisis	0	480	167	286	453	27
Winter Pressures	0	891	203	221	424	467
Total	**7,893**	**5,161**	**2,222**	**7,408**	**9,630**	**3,424**
Total Funding Available		**13,054**			**9,630**	**3,424**

An underspend of £3.4m is currently forecast, however work continues to accelerate schemes where possible in order to utilise available funding in year.

CQUIN
The Trust's HWE ICB contract includes a quality incentive of £2.3m or 1.25% of the contract value. This funding is conditional and dependent upon the Trust meeting six distinct quality performance targets. These targets and the Trust's estimated full year achievement are set out below.

Indicator No	Indicator	Each worth 20% - Value £000	Projected Achievement £000
CCG1	Staff flu vaccinations *	461	226
CCG9	Cirrhosis & Fibrosis tests for alcohol dependent patients	461	400
CCG10a	Outcome measurement ACMH	231	154
CCG10b	Outcome measurement ACMH	231	0
CCG11	Use of anxiety specific measures in IAPT	461	452
CCG12	Biopsychosocial Assessments by MH Liaison	461	452
Total		**2,305**	**1,683**

*** - assumes flu vaccinations at 80%**

The forecast outturn position reflects the projected achievement set out above.

Financial risks
The financial position includes a number of key risks including the following:

- High demand for the Trust's services
- Inflationary pressures rising above levels funded
- Challenges in recruitment and retention
- Shortfall on DV savings
- CQUIN levels are not attained, particularly associated with the Flu programme

The Board are asked to note the finance report for month 5.

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

Delivery of Financial Plan

Summary of Financial, IT, Staffing & Legal Implications:

Delivery of financial control total

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

All DV schemes in excess of £300k are subject to both QIAs and EIAs

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

Financial Management

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

Executive Team 14 September 2022
Finance and Investment Committee 22 September 2022

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 12
Subject:	Month 4 People & OD Report	**For Publication:** Yes
Author:	Louise Thomas, Deputy Director of People and OD	**Approved by:** Janet Lynch, Interim Executive Director, People and OD
Presented by:	Janet Lynch, Interim Executive Director, People and OD	

Purpose of the report:

To update the Board on progress against the People and OD KPIs for Month 4 (July) of 2022/23.

Action required:

To receive the report.

Summary and recommendations to the Executive Team:

The attached report sets out the Trust's month four performance in relation to key People and OD metrics that support our annual plan.

The format of the report was revised at the end of Q1 and feedback on the format is being incorporated, although this will evolve in coming months. The report aims to be clear and concise and to state the actions being taken to address performance issues.

The key headlines from month four are as follows:

- Our unplanned turnover rate has slightly worsened, although our vacancy rate has remained stable. As with the same time last year, we recruited fewer staff than left us in July.
- Our nurse vacancy rates are of most significant concern and a specific action plan has been put in place to address these. There have been some improvements in HSCSW and AHP vacancy rates.
- Our agency spend remains high, however, this has meant a continued high temporary staff shift fill rate.
- Sickness absence rates increased as result of a significant spike in Covid-19 absence, whilst mental ill health related absence remains lower than historically.
- Our mandatory training and appraisal rates have continued to improve, albeit that appraisal compliance remains below target and therefore remains an area of focus. Mandatory training is just under target at over 91%.
- Belonging and inclusion continues to form a major element of our approach to improving staff experience, with engagement and co-production at the heart, and data will be woven into other aspects of this report in due course.

A number of key performance indicators are showing a positive improvement, however, recruitment and retention are particular areas of focus, for which there are detailed action plans to achieve recovery, due to be reviewed at September PODG.

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

Summary of Implications for:

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

Equality, diversity and inclusion plays a major role in our plans to recruit and retain staff and improve wellbeing and morale and the report includes a new section on EDI.

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 g/Board / Audit

IGC 15 September 2022

Hertfordshire Partnership University NHS Foundation Trust

Trust People and OD Report
Month Four - July 2022

as one

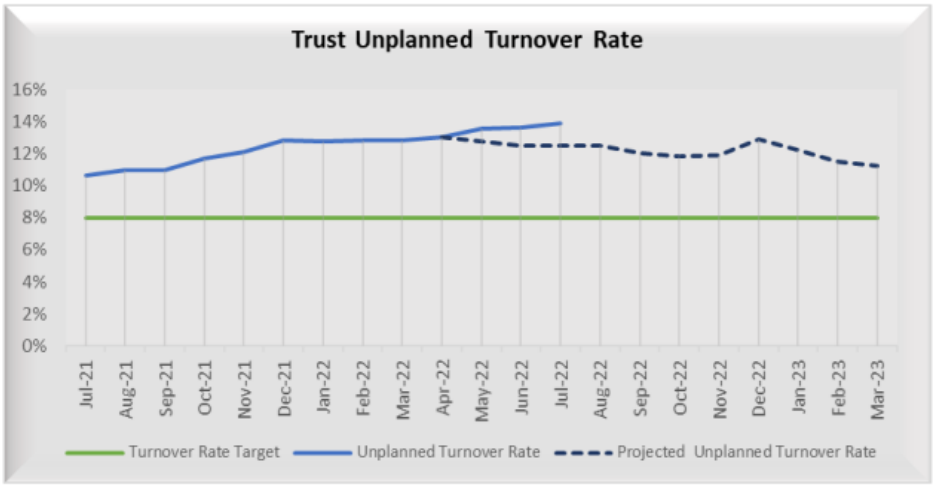
Our values
Welcoming Kind Positive Respectful Professional

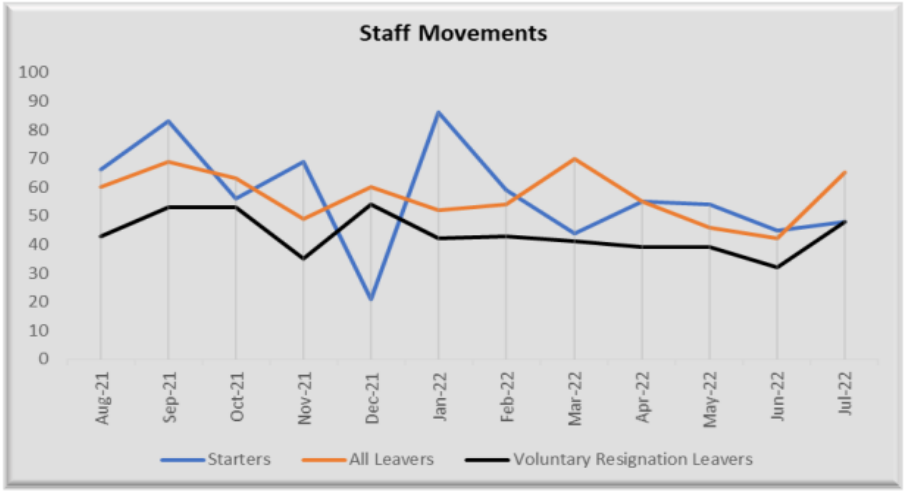
Contents

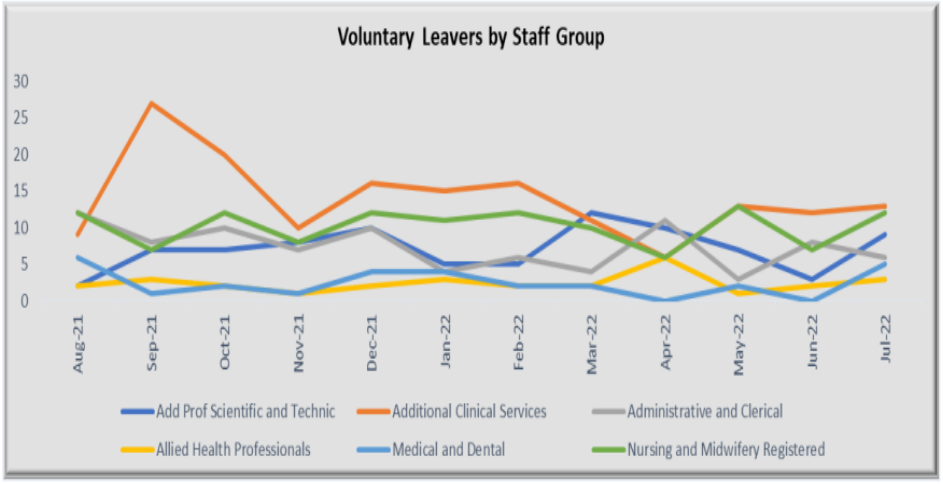
1. Overview

Metric	Previous Months											Current Month	Trend
	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	
Staff in Post - Headcount	3673	3699	3695	3722	3703	3730	3747	3757	3744	3758	3763	3730	
Staff in post - FTE	3317.59	3342.17	3339.67	3365.63	3340.76	3363.01	3384.26	3396.34	3383.30	3386.26	3392.34	3387.33	
Budgeted Establishment FTE	3838.62	3855.05	3876.49	3894.69	3907.63	3943.42	3952.30	3955.74	3946.14	3945.14	3945.14	3941.89	
Vacant FTE	521.03	512.88	536.82	529.06	566.86	580.41	568.04	559.39	562.84	558.88	552.80	554.56	
Vacancy Rate	13.6%	13.3%	13.8%	13.6%	14.5%	14.7%	14.4%	14.1%	14.3%	14.2%	14.0%	14.1%	
Total Turnover Rate	19.5%	19.5%	20.2%	20.6%	21.0%	20.9%	20.9%	19.4%	19.8%	19.3%	18.2%	18.5%	
Unplanned Turnover Rate	11.0%	11.0%	11.7%	12.1%	12.8%	12.8%	12.8%	12.8%	13.0%	13.6%	13.6%	13.9%	
Starters Heacount	66	83	56	69	21	86	59	44	54	54	45	48	
Leavers Headcount	60	69	63	49	60	52	54	70	58	49	42	65	
Stability Rate	84.4%	83.9%	82.4%	82.8%	83.2%	82.0%	82.2%	83.7%	79.8%	82.4%	83.6%	82.9%	
Sickness Rate	4.9%	4.9%	5.2%	5.8%	6.0%	6.2%	5.3%	5.1%	4.9%	4.5%	4.7%	5.2%	
Training Compliance Rate	90.4%	90.5%	89.8%	89.4%	89.1%	88.8%	88.8%	88.7%	89.6%	90.4%	91.2%	91.2%	
Appraisal Rate	87.7%	86.6%	84.8%	82.6%	78.7%	75.6%	70.6%	72.3%	76.4%	83.2%	84.5%	85.3%	
Bank Spend	£2,012,730	£2,170,643	£2,056,040	£2,138,089	£2,022,177	£2,025,119	£1,991,660	£2,085,542	£2,142,297	£2,142,297	£2,009,843		
Agency Spend	£718,303	£853,672	£841,510	£845,438	£957,992	£934,878	£810,429	£1,277,588	£1,027,222	£1,027,222	£1,139,239		

2. Retention

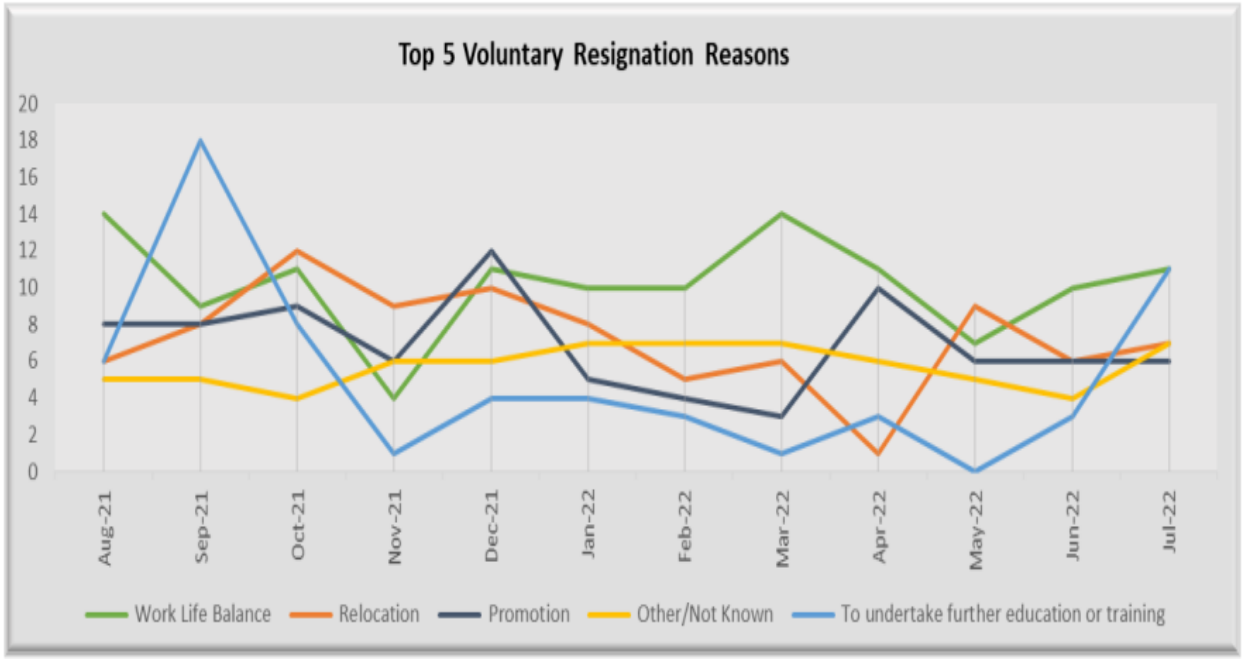






Our unplanned turnover increased slightly from 13.6% in June to 13.9% in July, significantly above the target of 9%. Turnover had previously risen since the start of 2021/22 and then stabilised since December 2021. The increase this month is as a direct result of more staff leaving than joining in July. We experienced this same pattern in July 2021, potentially as a result of fewer people starting roles in school holiday periods. However, the number of leavers also spiked, as they did last July and as they appear to do around other holiday periods. The largest group of leavers are within the registered and unregistered nursing workforce, which has led to a deep dive into nurse recruitment and retention and a detailed action plan to address the current vacancy and turnover rates within nursing.

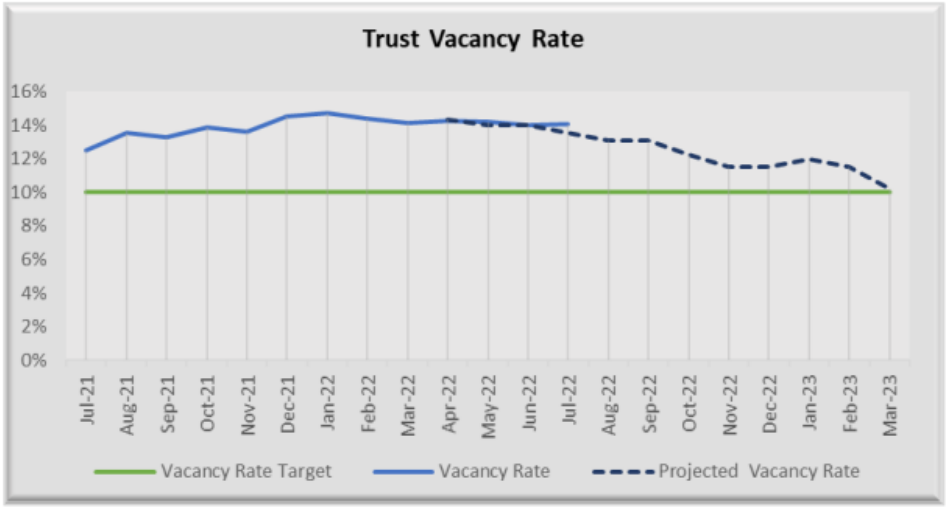
2. Retention

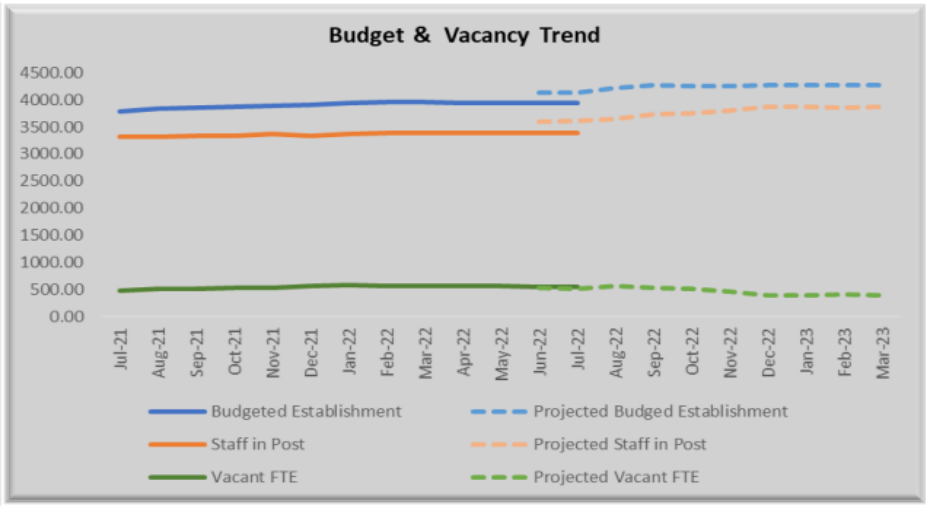


The key actions being taken to address retention are designed to address the top five reasons that people leave us and are as follows:

- Continued engagement with staff to act on feedback and improve experience, including implementation of our co-produced staff survey action plan to continue to make HPFT the best place to work.
- Implementation of our flexible working Flex for the Future action plan and rolling our team based rostering across the Trust
- Enhancing our talent management and career development offer, with a specific focus on inclusion and diversity and increasing use of apprenticeships, particular for unregistered nursing roles and routes into nursing.
- Redesigning our workforce structures to enable us to tap into novel talent pools, enhance career development opportunities and enable teams to better meet the heightened levels of activity we anticipate.
- Developing our existing Band 2 HCSW staff into Band 3 roles.
- Developing legacy nurse support to new staff
- Refreshing and extending our benefits offer, in particular responding to cost of living pressures
- Undertaking a review of recruitment and retention premia to propose future actions

3. Recruitment



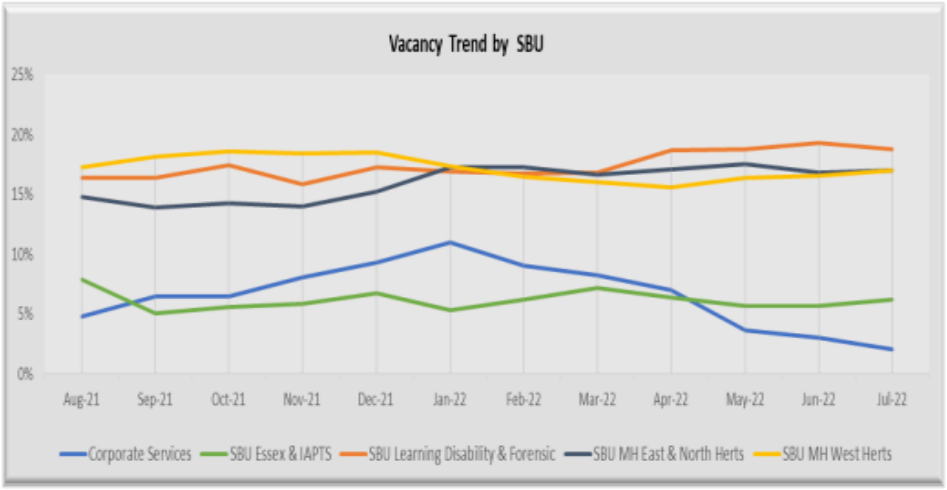


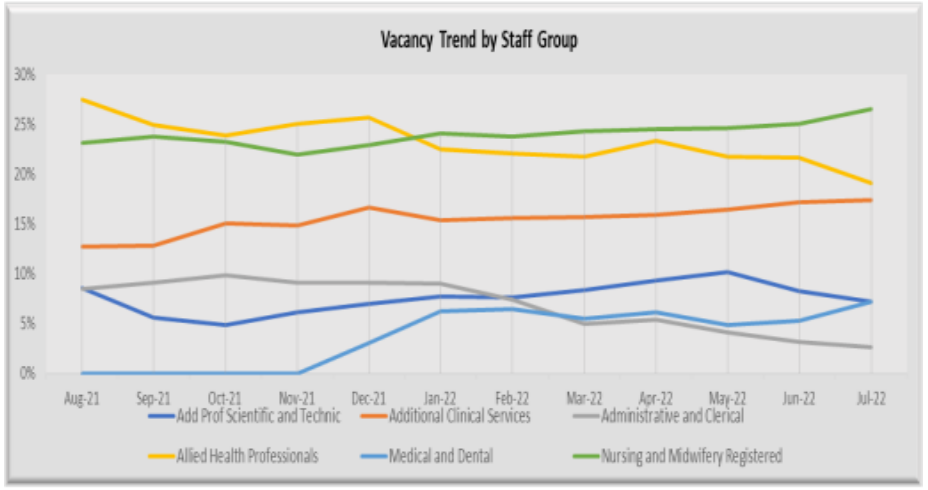
The overall vacancy rate has remained around the same since March 2022 and was 14.01% in July. However, this remains higher than our target of 10% and equates to 554.56 FTE vacancies. Our workforce plan for the year predicted that our budgeted establishment and our staff in post would be slightly higher at this point in the year. However, there is work being undertaken to realign ESR and the financial ledger in September 2022, which is likely to lead to a higher budgeted establishment being reflected in the data. Further detail on this work will be brought to the Executive Team in a detailed paper, together with assurance regarding maintaining this level of reconciliation in future.

Our projected actual number of vacancies have remained close to those predicted in this year's workforce plan, however, our vacancy rate remains slightly higher than our predictions.

The September meeting of PODG will review the updated Recruitment and Retention action plan, developed through the R&R sub group.

3. Recruitment

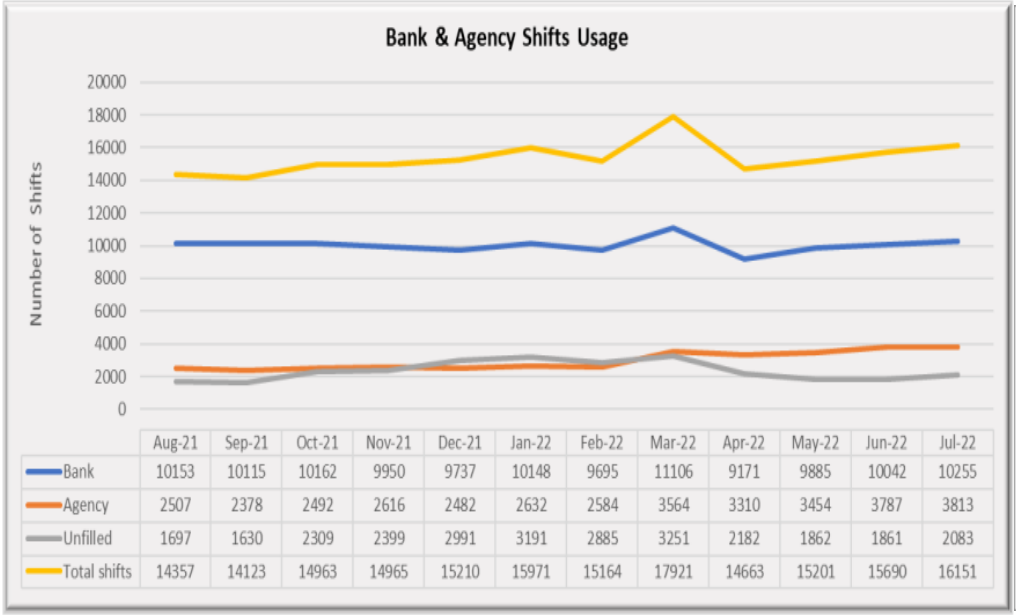




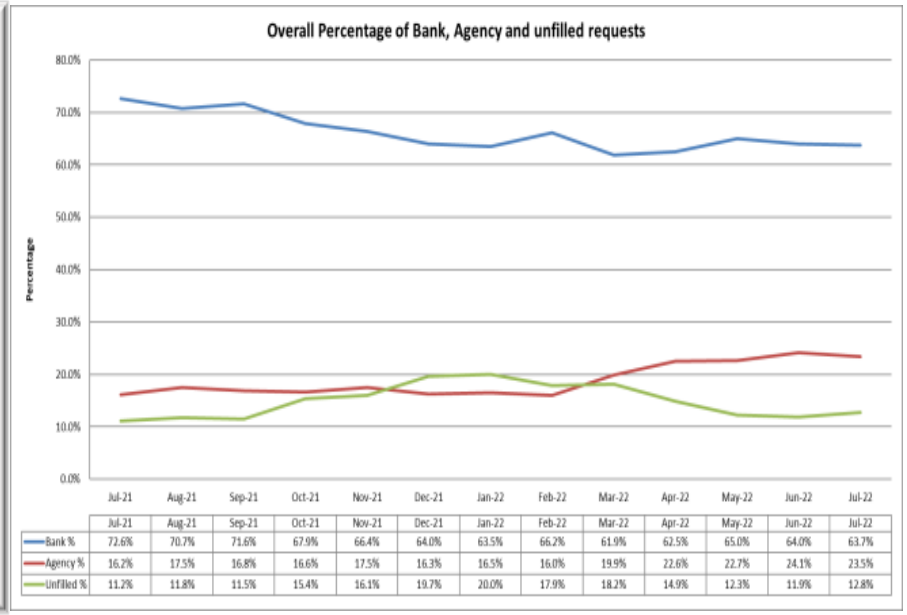
Our registered nurse vacancy rate increased significantly from 25.07% in June (233.71 FTE) to 26.5% in July (246.5 FTE), whilst our HCSW rate reduced slightly from 19.15% (123.83 FTE) to 18.75% (120.7 FTE). Our AHP vacancy rate reduced significantly from 21.6% (41.09 FTE) to 19.05% (36.23 FTE). Rates are similarly high across the three SBUs. The key actions being taken to address recruitment are as follows:

- Appointment of TMP Wordwide as our marketing and attraction partner to overhaul our social media presence, landing pages, adverts, campaigns, internet search optimisation and advertising intelligence
- Reviewing the attraction and retention offer for Bank staff
- Reviewing our recruitment and retention payments
- Onboarding this year's cohort of newly qualified nurses
- Enhancing and streamlining our onboarding, including digitisation of people processes and reviewing our policies for new starter annual leave and salaries
- Further embedding the Inclusion Ambassador scheme
- Creating novel pathways into HPFT, e.g. through a full work experience offer
- Establishing international recruitment pathways into HPFT
- Expanding our apprenticeship offer as a route into HPFT, including converting all new Band 2 HCSW posts to apprenticeships
- Implementing the Recruitment Partner model to support services with recruitment activity.

4. Temporary Staffing



	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Bank	10153	10115	10162	9950	9737	10148	9695	11106	9171	9885	10042	10255
Agency	2507	2378	2492	2616	2482	2632	2584	3564	3310	3454	3787	3813
Unfilled	1697	1630	2309	2399	2991	3191	2885	3251	2182	1862	1861	2083
Total shifts	14357	14123	14963	14965	15210	15971	15164	17921	14663	15201	15690	16151

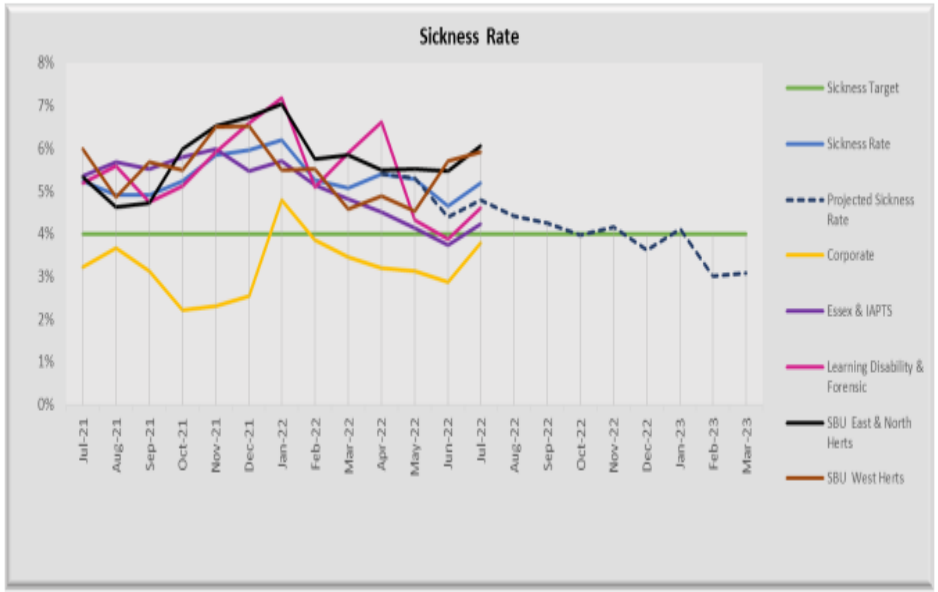


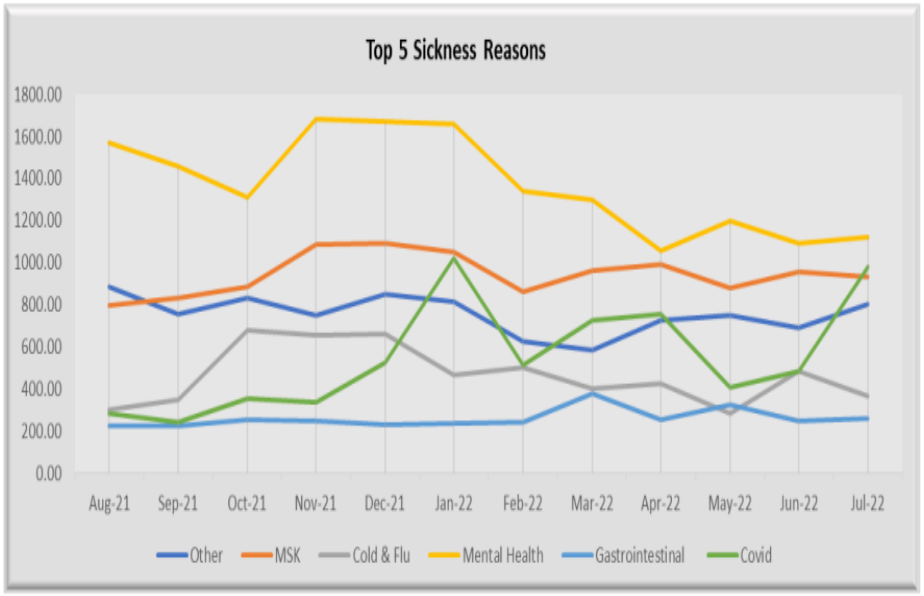
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Bank %	72.6%	70.7%	71.6%	67.9%	66.4%	64.0%	63.5%	66.2%	61.9%	62.5%	65.0%	64.0%	63.7%
Agency %	16.2%	17.5%	16.8%	16.6%	17.5%	16.3%	16.5%	16.0%	19.9%	22.6%	22.7%	24.1%	23.5%
Unfilled %	11.2%	11.8%	11.5%	15.4%	16.1%	19.7%	20.0%	17.9%	18.2%	14.9%	12.3%	11.9%	12.8%

Demand for temporary staffing has remained high and the percentage of temporary staffing shifts filled with Bank staff has remained lower than historically, whilst our agency use has remained higher than previously. However, this has meant that we have maintained our relatively high shift fill rates for temporary staff. In order to expand our Bank pool and better recruit and retain our temporary workforce and ensure safe staffing levels, a number of actions are being taken forward:

a) Proactive Bank recruitment campaigns, including converting agency staff to Bank and reviewing the starting salary policy as it relates to agency staff
b) Reviewing our Bank recruitment and retention plans, including our pay rates, for example, the payment of Fringe Allowance, incremental progression, incentive bonus payments and weekly pay
c) Reviewing our Agency pay rates, whilst maintaining the agency cap rates
d) Temporarily reinstating the extension of the Bank bonus payment to inpatient services
e) Retaining the 'pay to grade' arrangement for substantive staff undertaking Bank shifts
f) Temporarily reinstating the over-booking of Bank staff to create roaming temporary staffing teams to be deployed as required across our larger sites.

5. Health and Wellbeing



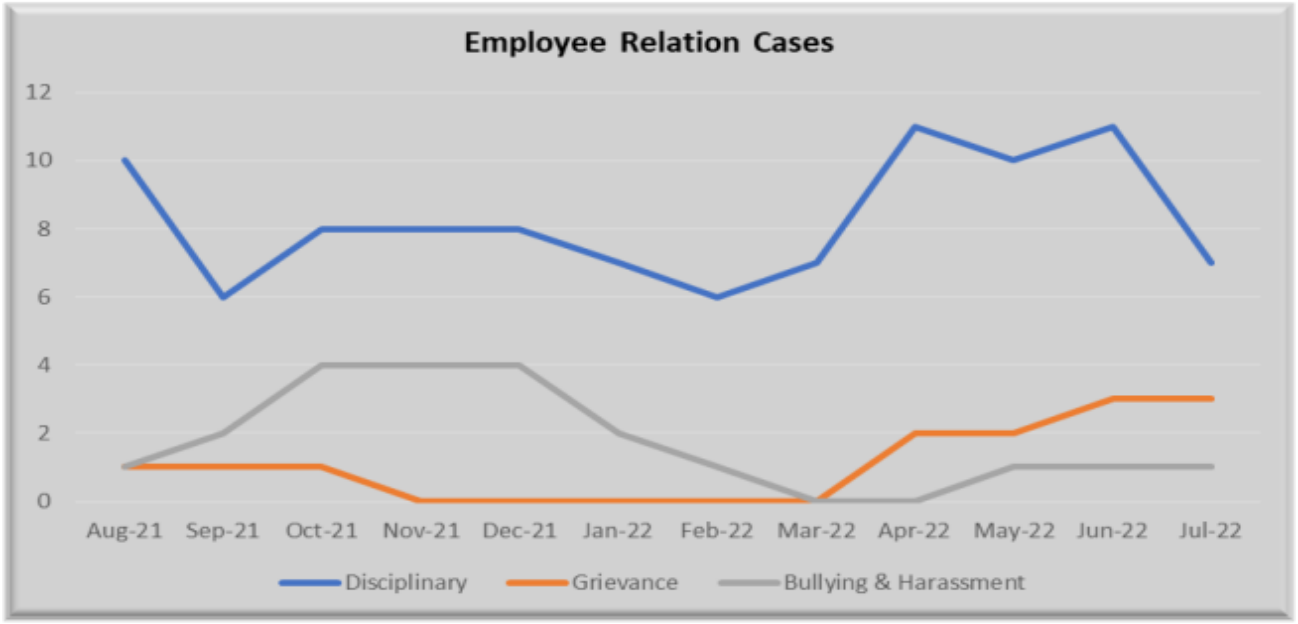


Sickness absence increased slightly from 4.65% in June to 5.2% in July. The increase is as a result of the spike in Covid-19 related sickness absence, which became the second highest reason for absence in July, overtaking musculoskeletal related absence. Whilst this spike in absence was predicted in our workforce plan, the extent of the spike was not predicted. Mental ill health related absence has remained at a relatively lower level, whilst continuing to be the highest reason for absence amongst our people.

The key actions being taken forward to address staff wellbeing are as follows:

- Continuing our regular health and wellbeing offer to staff and adapting this in line with feedback and engagement with staff to ensure it remains relevant and supportive
- Pursuing accreditation as a menopause friendly organisation and the actions to help us achieve this
- Expanding our pool of health and wellbeing champions and mental health first aiders
- Offering on-site mini health checks and using the themes arising from these to adapt our wellbeing offer to staff
- Repeating our wellbeing festivals, aligned to the issues staff are currently facing, with our next events taking place in September

6. Employee Relations

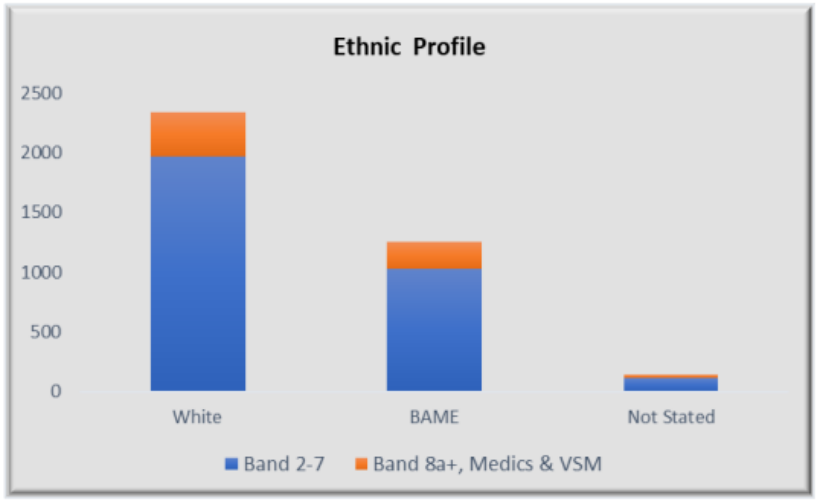


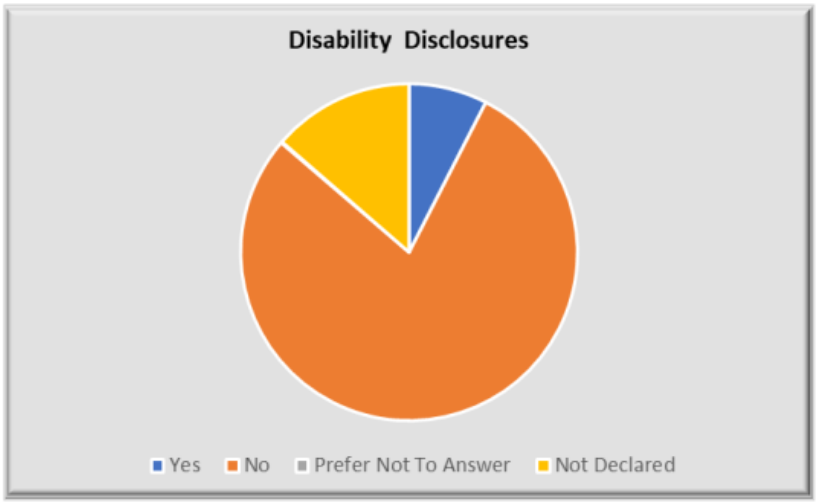
Our formal disciplinary cases reduced significantly from 11 in June to 7 in July, whilst the number of grievances remained at 3 and the number of harassment and bullying cases remained at 1.

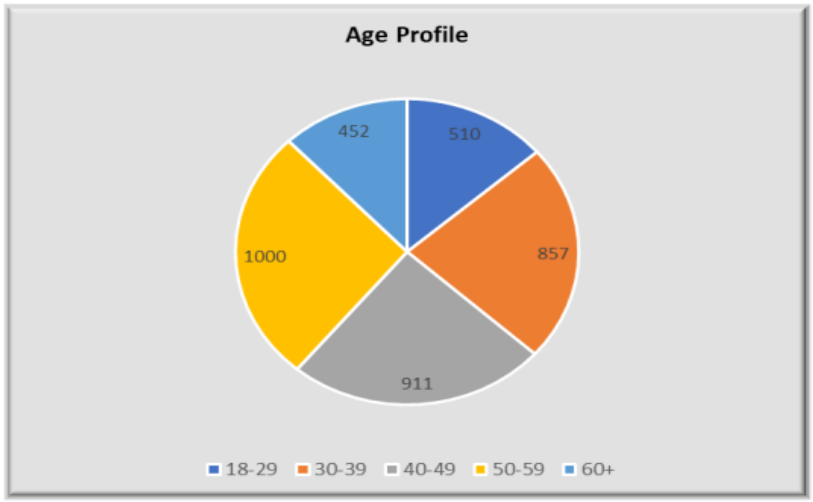
Our decision making panel continues to consider fact finding cases in order to sift cases for formal disciplinary proceedings. Analysis of our themes and learning from cases has taken place highlighting the need for action to be taken to make improvements in the areas of disability discrimination and reasonable adjustment s and inappropriate behaviour, particular amongst the unregistered nursing workforce in relation to conduct towards service users and boundary issues.

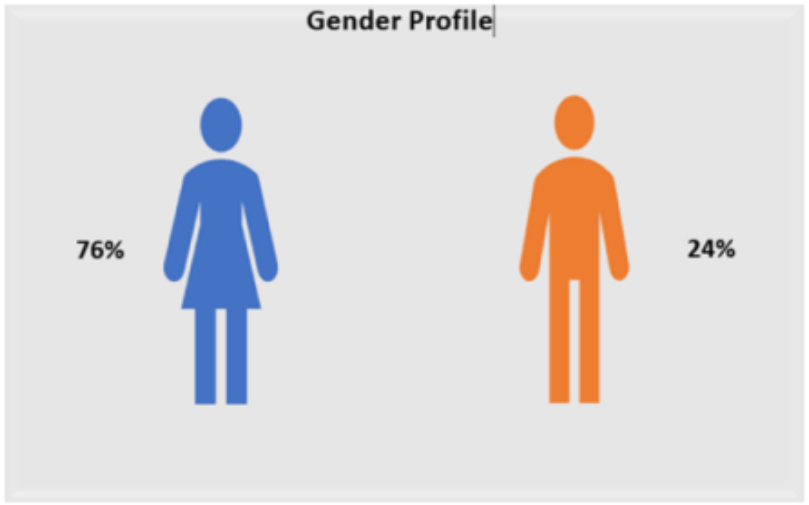
New policies are being developed in the areas of Sickness Absence, Reasonable Adjustments and Grievance which will support improvements.

7. Equality and Inclusion









7. Equality and Inclusion

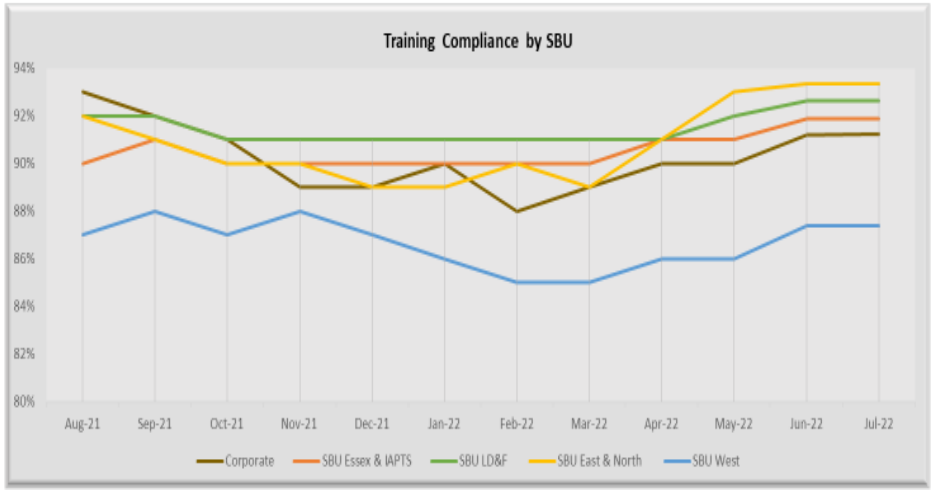
In conjunction with our WRES and WDES indicators and our staff surveys, our workforce profile identifies a number of areas for particular focus in relation to equality, diversity and inclusion as follows:

- There is a common theme with regards inclusion and achieving a consistently great experience across all groups.
- The representation of BAME staff at more senior levels is disproportionately low compared to the rest of the workforce where there is 36% representation
- We have a low rate of self declaration with regards disability/long term ill health status, which means that we have low confidence in some of our WRES data and monitoring metrics to identify and address inequalities
- There is a gender pay gap between men and women, whilst 76% of our workforce are women

The key actions being taken forward in order to address these challenges are as follows:

a) Launch of the Staff Details App to improve the quality of equalities data, in particular disability/long term ill health status
b) Talent management and leadership development prioritising BAME staff
c) Launch of our Inclusion Ambassador programme in Band 8a+ appointments
d) Maintaining and further developing our decision making panel in considering whether to enter the formal disciplinary process
e) Launch of our belonging and inclusion work to achieve a cultural reset, with our Big and Local Listen events focussing on belonging and inclusion and taking place in October, to coincide with Black History Month

8. Staff Development

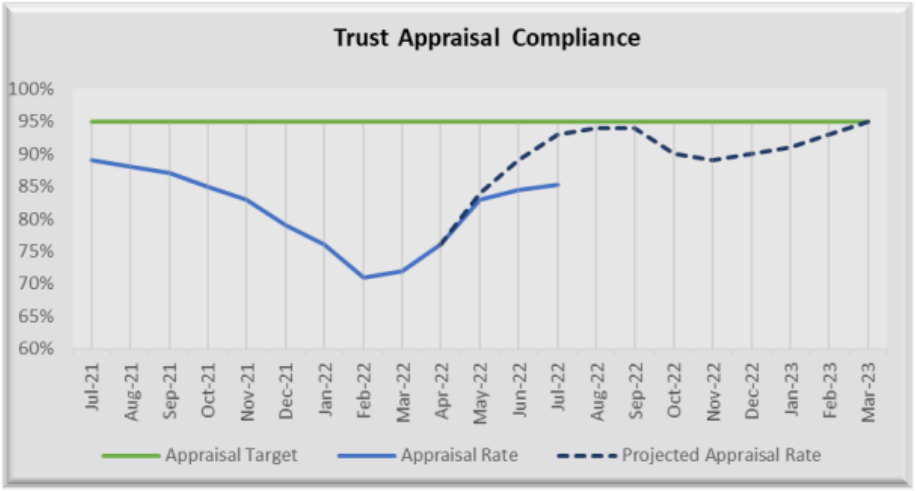


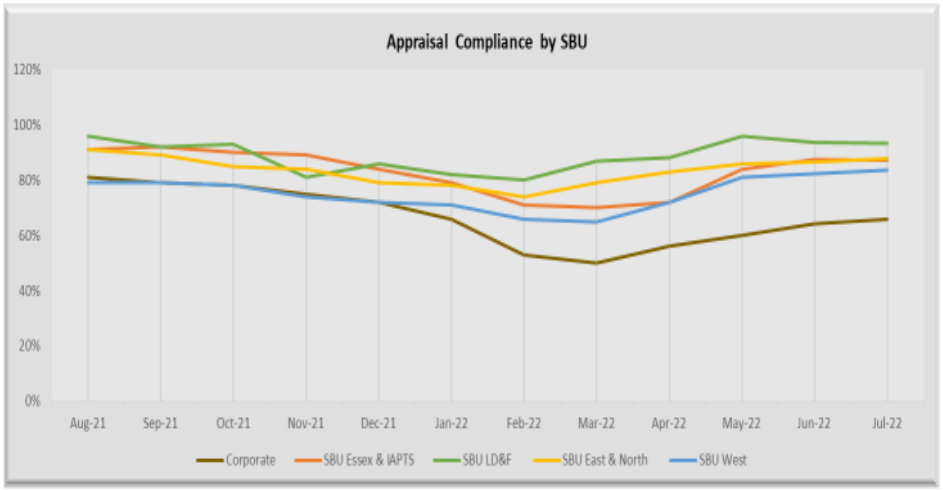
Mandatory training compliance increased from 91.2% in June to 92% in July, reaching our target compliance rate for the first time since the Covid-19 pandemic commenced. However, compliance within West SBU remains a particular focus.

The actions being taken to continue to drive up compliance include:

a) Weekly compliance reporting via HR Business Partners and the L&D team
b) Monthly reporting to the Executive Team and People and OD Group
c) Weekly reporting of face to face courses with available spaces together with details of staff who require the training.
d) Scrutiny at the weekly Providing Safe, Effective and Quality Services meetings
e) Increased training capacity for 22/23, including more trainers, weekend training, use of external training companies and external training venues
f) Review of Respect training model to ensure fitness for purpose
g) Undertaking a CQI project to review our learning management system and address short notice training withdrawals/non-attendance and failure to achieve the maximum training course capacity on every course

8. Staff Development – Appraisals





Appraisal compliance continued to increase from 84.5% in June to 85.3% in July. This remains lower than our target rate of 95% and our predicted recovery trajectory. All corporate areas have been asked to ensure that outstanding appraisals are arranged and undertaken rapidly.

The actions being taken to continue to drive up compliance include:

a) Weekly compliance reporting via HR Business Partners and the L&D team
b) Monthly reporting to the Executive Team and People and OD Group
c) Launch of the new Appraisal App
d) Scrutiny at the weekly Providing Safe, Effective and Quality Services meetings

9. Conclusion

The key headlines from July (Month 4) are as follows:

- Our unplanned turnover rate has slightly worsened, although our vacancy rate has remained stable. As with the same time last year, we recruited fewer staff than left us in July.
- Our nurse vacancy rates are of most significant concern and a specific action plan has been put in place to address these.
- Our agency spend remains high, however, this has meant a continued high temporary staff shift fill rate.
- Sickness absence rates increased as result of a significant spike in Covid-19 absence, whilst mental ill health related absence remains lower than historically.
- Our mandatory training and appraisal rates have continued to improve, albeit that appraisal compliance remains below target and therefore remains an area of focus.
- Belonging and inclusion continues to form a major element of our approach to improving staff experience, with engagement and co-production at the heart.

A number of key performance indicators are showing a positive improvement, however, recruitment and retention are particular areas of focus, for which there are detailed action plans to achieve recovery.

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 13
Subject:	EoE Provider Collaborative Update	**For Publication:** Yes
Author:	Andrew Godfrey, Managing Director Learning Disabilities and Forensics SBU	**Approved by:** Sandra Brookes, Executive Director of Service Delivery and Experience/COO
Presented by:	Sandra Brookes, Executive Director of Service Delivery and Experience/COO	

Purpose of the report:

The report provides an update to the Trust Board on the progress of the operational, financial and contractual aspects of the East of England Provider Collaborative.

Action required:

The Trust Board is requested to note:

1. The progress made by the Provider Collaborative;
2. Continued challenges in the delivery of CAMHS transformation;
3. Overall financial position
4. The progress in delivering the Patient Flow Hub, Adult Eating Disorder transformation and LD Secure transformation
5. Seek any additional information required

Summary and recommendations

The paper provides an update on the progress to date around the Provider Collaborative. It provides a breakdown by areas of responsibility, which are:

1. Lead provider for Child & Adolescent Tier 4 (T4) Services
2. Host of the Patient Flow Hub (bed management) for all service lines
3. As a provider of Secure/Forensic, CAMHS and Adult Eating Disorder services.

This paper provides a brief update on the progress to date in the following areas:

- Lead provider for Child & Adolescent Tier 4 Services
- General provider update
- Whole Provider Collaborative Finance Position
- Key Risks & Mitigations

Lead provider for Child & Adolescent Tier 4 Services

There has been a significant improvement in the care, quality and experience across CAMHS T4 services. At the time of writing, the number of Children and Young People (CYP) waiting for a bed is 18, which compares favourably to the 51 who were waiting at the point of the Provider Collaborative taking on responsibility. Of those waiting, most are service users requiring specialist eating disorder or beds for services user aged under 13.

Whilst there has been excellent progress in reducing the waiting list, there remain 38 closed CYP Mental Health (CYPMH) beds across the region. This is an improvement from the peak of 57 closed beds. But as a result, a number of children and young people have been placed in the independent sector and in out of area NHS providers which has led to a significant cost pressure on the CYPMH clinical stream.

General provider update

Good progress has been made in both secure and adult eating disorder services in the mobilisation of their transformation initiatives. Both services went live in Q1.

The Patient Flow Hub launched on 15 November for HPFT and NSFT CAMHS and has now expanded to all other providers and streams in the region. The Hub is fully staffed and now shifting focus onto supporting discharges in CYPMH.

The Women's Forensic LD Inpatient business case has been developed and has been considered by Finance and Investment Committee.

Whole provider Collaborative Finance Position

The provider collaborative position continues to be under pressure. Whilst it was expected that the CYPMH position would take some time to recover, pressures in adult secure are now placing pressure on the overall position. Adult eating disorders continues to make a surplus, which will offset the other deficits. TACT are still modelling a break even position by March 2023.

The CYPMH M4 Year to Date position is a deficit of £691k against plan with a total Year to Date deficit of £1,086k.This is being driven by the out of area and independent sector bed usage.

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

Relation to the Trust Risk Register:

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

Relation to the BAF:

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

Summary of Financial, IT, Staffing & Legal Implications:

N/A

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

N/A

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

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

Finance and Investment Committee – 22nd September 2022

1. Lead provider for Child & Adolescent Tier 4 Services

HPFT is the Lead Provider for CAMHS in the Provider Collaborative. Since taking on responsibility for the Tier 4 services in 2021, the Provider Collaborative has been under significant pressure regarding the availability of beds. This has had a significant impact on both patient care and costs.

At the point the Provider Collaborative went live, there were 51 Children and Young People (CYP) waiting for a bed. This peaked at 55, in March was 37 and as of the week commencing 5 September, was down to 18. At times it has gone below 10. Of those waiting, 10 have been waiting longer than 10 days. All 10 require specialist services – eating disorder, under 13s or PICU.

There remains a large number of block contracted NHS beds closed across the region. This peaked at 57 in 2021 and was 43 in March 2022; it has now dropped to 38. Most of the closed beds are general adolescent beds where there is no significant challenge in terms of patients waiting, however, this has led to cost pressures. HPFT currently has 8 beds closed on Forest House Assessment Unit.

On 1 September, the Forensic CAMHS service transferred to the Provider Collaborative. This is a small service provided by Cambridge and Peterborough Foundation Trust (CPFT). The annual value is £892k.

1.1 Transformation

Three core CYPMH transformation schemes have been identified for roll out across the region:

- Home Treatment Team (HTT)
- Red to Green
- 72 Hour Admissions.

All providers continue to make progress against the key transformation areas, with some local variation, for example, eating disorder specific HTT in BLMK. Similarly, investment in community services in Norfolk is showing good impact. However, the scale and pace has been limited.

The clinical lead for CYPMH has been leading on the development of a new eating disorders pathway in partnership with the wider CYPMH clinical body. Further work and engagement is underway to refine the proposed model.

A CYPMH programme manager has been appointed by TACT to support transformation across all CYPMH services.

1.2 Governance

The CYPMH governance structures introduced in 2022 have continued. This consists of the CYPMH Operational Oversight Group, Clinical Oversight Group and Clinical Scrutiny Panel. The latter can meet weekly but only goes ahead if there are cases to discuss.

Additionally, HPFT and TACT meet on a quarterly basis to review and oversee CYPMH performance across all the providers.

1.3 Finance

An update on the wider Provider Collaborative finances, including the CYPMH position, can be found in the Whole Provider Collaborative Finance Position below.

1.4 Contracting arrangements

Together with the other Lead Providers within the East of England Provider Collaborative (EoEPC) the Trust has delegated responsibility for the negotiation and management of its lead provider contract and associated sub-contracts to the EoEPC TACT.

As described in more detail in the separate contracts update report on the agenda, we have now signed the majority of the regional provider collaborative contracts for 2021/22.

The process for 22/23 has now started and should be faster than the 21/22 process as the majority of the contracts will just require a small amount of updating for 2022/23.

2. General provider update

2.1 Secure services

HPFT was allocated £761k to support the development of specialist community learning disability services in Norfolk.

The Norfolk Forensic Community Learning Disability Service launched in April 2022. The service was fully recruited at the time of launch. A launch event, which was attended by over 150 people, was held in Norfolk on 12 May 2022. HPFT has received praise and recognition from both the Provider Collaborative and NHSE for the speed at which the service was mobilised. The service is supporting both the prevention of admissions and expediting discharges across Norfolk.

HPFT has supported the region-wide work on identifying service users for repatriation into Provider Collaborative beds. There are currently challenges with assessor capacity to support this work. This has been escalated to the clinical lead for secure.

HPFT has developed a business case for a Women's LD secure inpatient service. This will be considered separately on the FIC agenda.

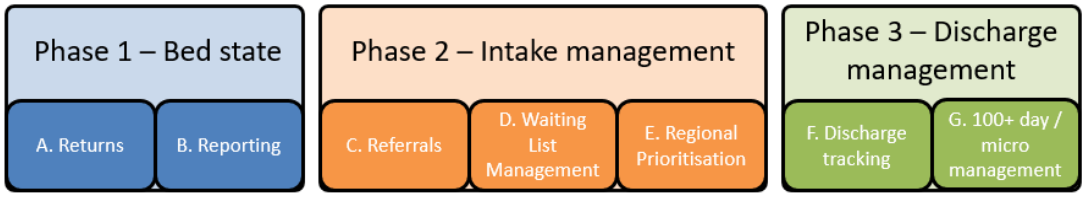
2.2 Adult Eating Disorder Services

Our Adult Eating Disorder Services were allocated transformation funding to support the roll out of an Intensive Community Service. The service has launched but still only has two staff, despite numerous rounds of recruitment. The service is looking at whether they can recruit different roles or posts to meet the need. Despite the recruitment challenges, the service has prevented at least one admission.

HPFT worked with partners across the Collaborative to develop a region-wide Virtual Intensive Team model. HPFT have successfully bid for an been appointed as the provider for the service. Contracts and finance are still being finalised and a mobilisation plan is being developed with the intention of rolling out the new service by Q4.

2.3 Patient Flow Hub

HPFT agreed to host the Patient Flow Hub on behalf of the Provider Collaborative. These functions are outlined in the diagram below.



The service has now taken on responsibility for all functions in phases 1 and 2 for the three clinical streams. Further refinement of the processes for the secure and adult eating disorder services is underway, including data reporting and dashboards.

A clear development plan has been shared with commissioners as the service moves from project to business as usual. This includes a shifting focus of attention onto supporting discharges and flow through CYPMH.

A bed management system for the Hub has been included in scope for the Trust wide bed management system. The service is currently out to tender with four providers being shortlisted for demonstrations and is expected to go live in Q4.

3. Whole Provider Collaborative Finance Position

3.1 *CYPMH*

As at month 4 the Provider Collaborative are reporting a year-to-date deficit position of £0.7m for CYPMH, against income of £21.1m. There continues to be a significant number of Out of Area (OOA) bed placements with circa £1.1m with other NHS Providers outside of the East of England and £11.4m with Independent Sector Providers YTD. This is driven by the continued closure of a number of in region provider beds.

As outlined above, HPFT currently has 8 beds closed due to challenges around safely staffing the wards. A number of other NHS Providers within the East of England are in a similar situation and operating a phased reopening of the beds to meet demand levels.

Plans are in place to recover the position and the Provider Collaborative are still forecasting a break-even position at 31 March 2023. This will be supported by underspends across the other service streams within the collaborative.

3.2 *Provider Collaborative*

The consolidated position of the three service streams within the Provider Collaborative are reporting a deficit position as at month 4. This is broken down across the service streams as below.

	East of England Provider Collaborative		
	YTD Plan	YTD Actual	YTD Variance fav/(adv)
	£000	£000	£000
Adult Secure	(230)	(365)	(135)
Children and Young People	(395)	(1,086)	(691)
Adult Eating Disorders	0	615	615
Net Surplus / (Deficit)	**(625)**	**(837)**	**(211)**

The continued overspend within CYPMH services is offset by underspends within Adult Eating disorders, however emerging pressures within Adult Secure services have increased the financial risk of not breaking even. This increased Adult Secure spend has come through the use of Independent Sector providers.

There is a potential financial risk to HPFT from the deterioration of the Provider Collaborative financial position and a potential deficit across the three service streams at the end of the financial year. This could be mitigated against within the Provider Collaborative by implementing the contracting option of reducing expenditure within region providers where beds have been closed. This is constantly under review by Directors of Finance within the East of England region and is the least palatable option. Work continues across the system to recover the financial position and avoid using this option.

3.3 *Transformation spend*

Transformation spend has been slow across the region and its utilisation to transform the way Tier 4 services are provided. To month 4, £1.9m of transformation funding has been allocated to partner providers and a total of £47k has been spent (excluding HPFT). The TACT team are working with providers to accelerate these schemes and a programme manager within TACT has now been brought in to support this. KPI's are being developed to monitor progress and the impact of the transformation schemes on service provision.

HPFT were allocated £230k for Adult eating disorder services and £731k for an Adult Secure service. As at month 5 HPFT have spent £48k of the Adult Eating Disorders funding and £215k of Adult Secure transformation funding, with expectations that this funding will be exhausted during 22/23 and require recurrent funding through the Provider Collaborative and local ICBs.

The above risks are mitigated, in part, by the agreement between partner organisations to pool financial risk. HPFT are not currently providing for any final deficit position at 31 March.

4. Key Risks & Mitigations

There are a number of key risks which have been identified as part of the development of the Provider Collaborative. A number of these are outlined in the table below. Whilst these risks remain, there is a clear mitigation and risk management strategy in place. Actions are in place to either resolve these risks entirely or mitigate them sufficiently to avoid significant issue.

Key risks and mitigations are summarised as:

Risks	Mitigations	Risk trend
CYPMH bed closures and pressures result in inability to deliver wider CYPMH transformation outcomes.	Working closely with providers and TACT on plans to reopen beds and maintain existing beds through mutual aid and support. Potential move towards aligned payment incentive approach.	Reducing
Risk that service users (CYPMH and AED) remain in hospital treatment outside of their local area	Transformation plans in place to offer alternatives to admission delivered locally. Effective controls will also be in place through single point of access, effective bed management, clinical scrutiny of admissions and a focus on repatriation.	Reducing
Activity growth above long term planning assumptions	'Hard' review of activity and associated funding with NHSEI at end of year. Current analysis suggests no significant increase in demand growth, however, there may be suppressed demand in CYPMH.	No change
Ability to recruit workforce to achieve the pace of transformation that is required	The collaborative is working with HEE as well as together across partners to develop innovative workforce solutions	No change
Investment in New Care Model unaffordable due to delayed transformation delivery	c. £4.7m non-recurrent funding from NHSEI for 21/22 to pump-prime community team development. As lead provider for CYPMH we are focusing on how we influence other providers to mobilise transformational change at pace.	No change
Transformation Schemes deliver efficiencies below plan	Transformation schemes are based on an evidenced approach and have been discounted in part either by an efficacy factor or prudently profiled	No change
Quality risk arising from activity growth above funded levels e.g. COVID impact where appropriate settings, particularly inpatient admission, are temporarily unavailable due to demand.	Effective mitigations are through investment in patient flow management, clinical scrutiny and the planned development of viable alternatives to admission.	No change

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 14
Subject:	Development of a new 5-year Strategy for the Trust	**For Publication:** Yes
Author:	Simon Pattison, Deputy Director of Strategy and Development	**Approved by:** David Evans, Executive Director, Strategy and Partnerships
Presented by:	David Evans, Executive Director, Strategy and Partnerships	

Purpose of the report:

The presentation accompanying this front sheet sets out the proposed approach to developing a new overarching 5 year strategy for the Trust to replace the existing Good to Great strategy which expired in 2021.

Action required:

Board are asked to consider the attached presentation and recommendations set out below.

Summary and recommendations

The Trust's existing strategy (Good to Great) covers the period 2016 – 2021. Work on developing a new strategy did not start during 2020 or 2021 as a result of the Covid pandemic. Therefore the purpose of this report is to recommend to Board that we launch the process of developing a new strategy. The strategy will set out the direction for the organisation for the next 5 years, building on the excellent progress that the Trust has made during the period of the existing Good to Great Strategy.

The accompanying presentation sets out the approach and the journey that we are proposing to take in developing this.

It is recommended that the Board:

- Agree the proposed approach for the creation of a new strategy

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

Setting a corporate strategy is a key responsibility of the Trust Board and underpins the delivery of Annual Plans

Summary of Financial, IT, Staffing & Legal Implications:

The costs of consultation and engagement in the development of the new strategy will be met within existing budgets

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

In the development of the strategy we are proposing to engage widely with patients and the public. As we develop the strategy, we will consider equality and diversity implications of the proposed priorities and these implications will inform the development of the final strategy

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

Not applicable

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

Not applicable

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Looking Forward Together, a new HPFT 5 Year Strategy

Board presentation

29th September 2022

as one

Our values
Welcoming Kind Positive Respectful Professional

Outline of the session

- A reminder of where we have come from
- Proposed approach to developing a new strategy
- Proposed Timeline

Vision: Delivering Great Care, Achieving Great Outcomes - Together

Hertfordshire Partnership University NHS Foundation Trust

The current 'Good to Great' Strategy: 2016 - 2021

Mission Statement:
We help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well.

Strategic Objectives

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

Our Values

We are **welcoming** so you feel *valued as an individual*

We are **positive** so you can feel *supported and included*

We are **professional** so you can feel *safe and confident*

We are **kind** so you can feel *cared for*

We are **respectful** so you can feel *listened to and heard*

Our Values
Welcoming Kind Positive Respectful Professional

Good to Great has served us well

Since 2016 we have (amongst many other things):

- Expanded services outside Herts – in Norfolk, Bucks, Essex and through the regional Provider Collaborative
- Developed new services such as the community perinatal mental health team and Mental Health Support Teams in Schools and significantly expanded others like IAPT
- Dramatically developed our digital offer
- Delivered great outcomes for many thousands of people

This is our opportunity to set the direction for the next 5 years

Issues we've considered in developing our approach

Hertfordshire Partnership University NHS Foundation Trust

How radical do we want to be?

Do we want to change the vision, values and mission statement?

Do we need to change the strategic objectives?

Is the Good to Great triangle still a good way of summarising our approach?

How does this link with other HPFT strategies?

What level of engagement do we want in the development of the strategy?

What is the audience for the strategy?

How does this link to the development of other local system strategies?

What type / style of strategy document should we produce?

How does this link to broader system strategies?

How much time, energy and money do we want to put into developing the new strategy?

as One

Our Values
Welcoming Kind Positive Respectful Professional

Our Engagement Journey

From the outset, CWPT leaders were clear that the vision, core purpose and values for the Trust should not be developed 'in a darkened room', but should reflect the voices of those who need or use our services, as well as the people who work here. We started by holding focus groups with members of the leadership team and with staff, patient and carer representatives. This initial phase presented the first opportunity to consider what we wanted to achieve, what was important to people, and what success might look like.

The ideas flowed, and we captured a wealth of suggestions and feedback. They were developed into themes and thereafter crafted into draft statements for further discussion. These were shared with even more groups, and developed on an iterative basis meaning that the statements evolved from one discussion to the next to reflect the latest feedback and thinking.

After around four weeks, the themes and statements required fewer and fewer changes between sessions. Participants began to more on from 'what' we wanted to achieve, to how we would achieve it. Once there was widespread support for the draft statements, we developed an engagement pack to share thinking and gain feedback on the emerging direction.

In Summer 2021, we embarked on a programme of 'Big Conversations', where we used the engagement pack to involve hundreds of people in shaping a meaningful vision, core purpose and strategic pr
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Despite being in the midst of a pandemic, we were successful in having individuals, including representatives who were targeted to ensure we those who find it 'harder to be heard'. We spoke to:

- CWPT Volunteers
- Staffside/staff representatives
- BAME, LGBTQ+, disabilities groups
- Clinical leaders
- Directorate management teams
- Prograr
- Front-li
- Volunta
- Patient,
- Health

as one

better lives, together

Our strategic framework 2019-23

NHS
Bradford District Care
NHS Foundation Trust

What will we do to achieve our vision

Our goals

Our services
To provide seamless access to the best care

To provide excellent quality services

Our community
To provide our staff with the best places to work

We will do this by:

Improving

Innovating

For services and communities...

We are a partner of choice and service users' first point of call

We are well led and well managed

Work is meaningful

Our workplace is fit for purpose

With great ....

Service user experience and outcomes

Staff satisfaction

Regulator ratings

External recognition

Bringing it all together

Everything we do over the next five years will contribute to one or more of these four goals to achieve our vision of connecting people to the best quality care, when and where they need it, and be the best place to work

QUALITY AND SAFETY AT THE FOUNDATION OF EVERYTHING WE DO

WORKING TOGETHER TO IMPROVE PATIENT SAFETY, QUALITY AND OUTCOMES FOR OUR NHFT COMMUNITY.

Quality and Safety at the foundation of everything we do means we are making sure we remain focused on delivering positive outcomes for our population by delivering services that are safe, effective, caring, responsive and well-led.

Quality and safety are the foundation of our DIGBQ strategy framework and run through everything we do to achieve our vision; to be a leading provider of outstanding, compassionate care.

Our vision
Achieving local excellence and global reach through compassionate and innovative healthcare, education and research.

OUR QUALITY & SAFETY PRIORITIES

- We will work together with our service users, staff and carers using a model of co-production to strive to achieve a CQC Outstanding rating for all our services individually, and for the safety domain overall
- We will strive to improve patient safety across the organisation and across our ICS for the population we serve
- In line with our quality framework and the ICS Quality Strategy, we will use quality imp to ensure continuous systematic change for the benefit of patients and staff
- We will participate in all relevant ICS work streams, working collaboratively to deliver quality improvements
- Improve outcomes for our patients.

The 5 'p's of our strategic framework	Our 2019/2020 breakthrough objectives:
1. Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality	1. Deliver oustanding care 2. Reduce avoidable harm 3. Excellent patient experience and engagement
2. People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential	4. Excellence in training and education 5. Sustainable workforce planning 6. #FlourishAtNewcastleHospitals
3. Partnerships – We will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national and international programmes	7.Integrating services across Newcastle city 8. Acute collaboration across the ICP/ICS
4. Pioneers – Ensuring that we are at the forefront of health innovation and research	9. Becoming truly digital (GDE) 10. Develop a commercial unit
5. Performance – Being outstanding, now and in the future	11. Improve cancer performance and outcomes 12. Ongoing sustainability and quality improvements

Various Hypothesis Considered

Option One: minimal update

- Vision, values, mission and objectives unchanged
- Would be just a restatement of Good to Great with some update for the current environment
- Limited engagement –a small number of meetings with staff, NEDs and governors
- Document would again look like a Board report
- Wouldn't need much time or effort – probably equivalent to Annual Plan update process
- Could be done in 3 months
- Reflects continuation of strategic direction given the success of the organisation under Good to Great

Option Four: change everything

- Vision, values and mission all changed
- Strategic Objectives radically amended
- Good to Great triangle replaced
- Would reference Good to Great but with fundamental change in direction given impact of all the changes over the past 6 years
- Detailed and comprehensive engagement
- Would need significant dedicated staff time and external input
- Estimate of about 9-12 months
- Entirely new direction of travel

Vision, Values and Mission Statement

- We think the vision remains relevant but we will consult on the exact wording during the journey
- The values will not change
- We believe the “Mission Statement” is outdated and no longer reflects our “Purpose”

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Mission Statement:
We help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well.

as one

Vision: Delivering Great Care, Achieving Great Outcomes - Together

Our Values
Welcoming Kind Positive Respectful Professional

Consultation – Strategic Objectives

1. We will provide safe services, so that people feel safe and are protected from avoidable harm
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7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

We believe the Strategic Objectives require a refresh. There will be areas we will need to consider with the Board:

- Increased inequalities due to the pandemic. Specifically, the disproportionate impact on people from Black, Asian and other minority ethnic groups, older people and disadvantaged communities.
- Collaboration – how do partners help us and how do we help them
- New models of care
- Carer and service user co-production and engagement
- Community impact outside of organisational boundaries – system leadership
- Inclusion and Belonging
- Trauma Informed Care
- Social Care values driven organisation
- Digital Innovation

as one

Our Values
Welcoming Kind Positive Respectful Professional

Our proposed journey ahead

Discovery Phase – October and November

Playback Phase - December

Co-design Phase – January and February

Launch – April

as one

Our values
Welcoming Kind Positive Respectful Professional

Discussion

- Does the Board agree with the proposed approach?
- Is there anything else we need to consider?

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 15
Subject:	System Update	**For Publication:** Yes
Author:	David Evans, Executive Director, Strategy and Partnerships	**Approved by:** David Evans, Executive Director, Strategy and Partnerships
Presented by:	David Evans, Executive Director, Strategy and Partnerships	

Purpose of the report:

This report provides the Board with a range of system updates within the Herts and West Essex Integrated Care System.

Action required:

To discuss the update provided, noting implications for HPFT.

Summary and recommendations to the Board:

Summary

The NHS continues to go through significant transformation both nationally and locally since the launch of the Integrated Care Boards (ICBs) on 1st July

This report provides an update on:

- Herts and West Essex ICB
- Integrated Care System Strategy
- Update on the Mental Health, Learning Disability and Autism Health and Care Partnership (MHLD&A)
- Place based updates on Health and Care Partnerships in Hertfordshire
- Review of Section 75 Commissioning Arrangements

Recommendation

The Board is asked to:

- Note the content of this report and discuss implications for the Trust

Relationship with the Annual Plan & Assurance Framework:

Strategic Objective 7: Partnerships and Collaboration – the development of the ICB/P and MHLDA Collaborative have been a key factor in the approach and strategy of the Trust.

Summary of Implications for:

- Changes in the local system will impact on our partnerships

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

N/A

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

N/A

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

Regular updates and discussions have taken place at Executive Committee and Trust Board on the development of the Integrated Care System.

1. Hertfordshire and West Essex Integrated Care System Update (H&WEICB):

1.1 The H&WEICB formally met for its inaugural public meeting on 1st and held a second 27th July. Main areas of focus have been on approving the constitution and confirming governance arrangements.

1.2 In the months since the establishment of the Integrated Care Board (ICB) at the start of July, the organisation has been focussed on key areas with system partners to further strengthen the joint approach to tackling the ongoing unprecedented demand on Urgent and Emergency Care, to reduce the elective waiting lists, improve performance against our cancer targets, coordinate delivery of the autumn booster programme and improve access to Primary Care.

1.3 In the coming months the ICB will continue to focus on putting in place some of the key building blocks as a system, finalising ICB structures, making significant progress with the development of the Integrated Care Strategy (ICS) strategy, progressing plans for a system elective hub, holding an event on the 4th of October to bring system leaders together to agree an approach to place based partnerships (including the mental health and learning disability and autism collaborative – MHLD&A) and implementing the winter plans to support what will be a difficult period for the entire NHS.

2. Integrated Care System Strategy

2.1 The Health and Care Act 2022 requires Integrated Care Partnerships (ICPs) to write an Integrated Care Strategy to set out how the assessed needs (from the JSNA) of local people of all ages can be met through the exercise of the functions of the Integrated Care Board, partner local authorities.

2.2 The strategy is an opportunity to improve people's health and wellbeing, by encouraging collaboration, joint working, and integration.

2.3 ICPs have a statutory duty to create an integrated care strategy to address the needs, such as health and care needs of the population within the ICB's area, including determinants of health and wellbeing such as employment, environment, and housing.

2.4 CBs and Local Authorities (LA) will be required by law to have regard to the integrated care strategy when exercising any of their functions. NHSE must have regard to the integrated care strategy when 'exercising any functions in arranging for the provision of health services in relation to the area of a responsible LA. Through being involved in the development of the ICS strategy, providers will be able to shape, influence and support the strategic direction of the ICS.

3. Herts and west Essex Integrated Care Strategy:

3.1 The Hertfordshire and West Essex Integrated Care Partnership (ICP) has commenced the development of the Integrated Care Strategy for our 'system', with two workshops being held to date to begin developing the ICS priorities. The Hertfordshire and West Essex Integrated Care Partnership (ICP) is an equal partnership between the NHS and local government set up under the new NHS arrangements. It is a statutory requirement for each ICP to develop a strategy for the ICP area and for this to be published by December 2022.

3.2 Working through their ICB and ICP, ICSs have four key aims:

- Improving outcomes in population health and care.
- Tackling inequalities in outcomes, experience, and access.
- Enhancing productivity and value for money.
- Helping the NHS to support broader social and economic development.

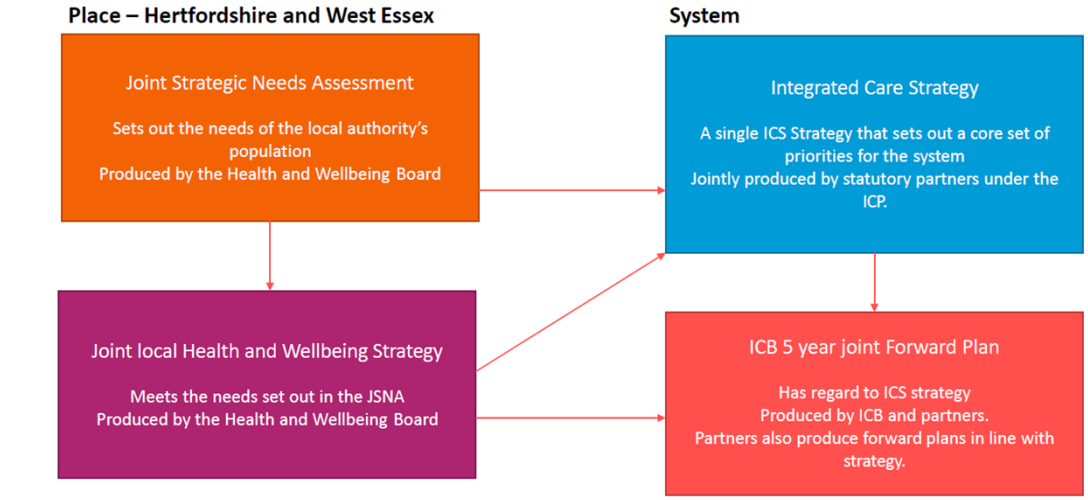
The ICS Strategy must:

- Have regard to the NHS mandate
- Involve the people who live and work in their area
- Involve the local Healthwatch organisations whose areas coincide with, or fall wholly or partly the Integrated Care Partnership
- Consider if the needs could be met more effectively using the partnership arrangements under Section 75 of the National Health Service Act 2006
- Be published, and shared with the relevant local authorities and Integrated Care Board

3.3 The approach will focus on ambitions over a ten-year time horizon, will ensure it dovetails with the Health and Wellbeing Strategy, and will seek to address system-level challenges focussing on prevention, wellbeing, and tackling pervasive health inequalities.

3.4 The strategy will be developed for December 2022, and with a corresponding five-year Joint Forward Plan to be agreed by March 2023.

Relationships between different system-level plans and strategies



Hertfordshire and West Essex Integrated Care Partnership

3.5 HPFT and the MHLDA Collaborative are supporting the development of the ICS Strategy ensuring all plans are inclusive of and ensuring all the needs of people living with mental health, learning disability and autism needs supported as part of the plan.

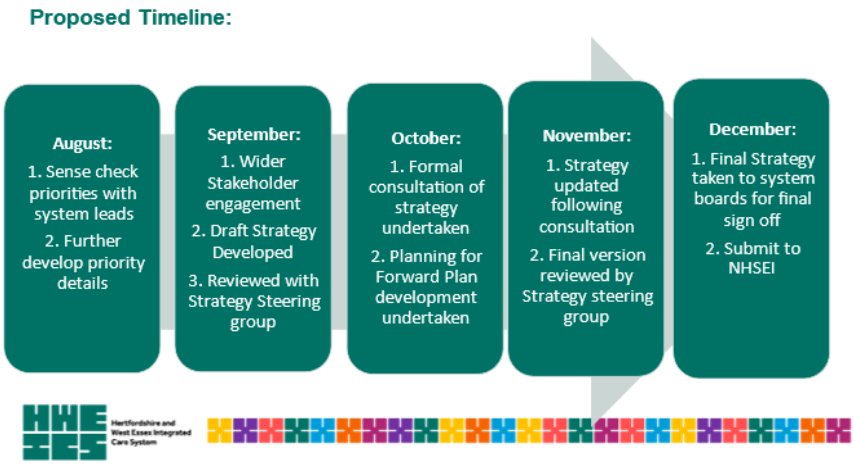
3.6 Whilst there is a specific ambition related to mental health and learning disabilities, we are also looking to weave mental health and learning disabilities throughout the different ambitions. This would include actions like reducing smoking rates for people with mental ill health and improving the accessibility of physical health services for people with learning disabilities.

3.7 The draft strategy has 10 proposed ambitions:

1. To collectively address the health and care workforce challenges across Hertfordshire and West Essex
2. To reduce health inequalities
3. Prevention and Early Intervention
4. Every child has the best start in life
5. Healthy and sustainable communities
6. To enable a healthy standard of living
7. To reduce the number of people developing long-term health conditions and improve support for those living with these conditions
8. Improve our resident's mental health and outcomes for those with Learning Disabilities and Autism
9. Improve accessibility to services for our residents
10. Reduce substance misuse, smoking & alcohol consumption

3.8 The current timeline for finalising the ICP strategy is as follows:

- September – stakeholder engagement and development of a draft strategy
- October – formal consultation undertaken
- November – strategy updated following consultation
- December – strategy agreed by system



4. Mental Health, Learning Disability and Autism Collaborative Update:

4.1 Over the summer, the Collaborative has continued to develop its capacity to both influence and direct system-wide activity, resulting in tangible progress in improving local services and outcomes. There has been a significant and sustained improvement in supporting children and young people who need access to specialist inpatient beds.

4.2 Over the last month the Collaborative has:

- Successfully secured a system investment of £1.4m to deliver a Collaborative model to address the backlog of children and young people waiting for an ADHD assessment in south and west Hertfordshire.

- Secured over £1.4m investment to strengthen our Urgent and Emergency Care support for people with mental health support needs including investment in both Hertfordshire Hospital Trusts and with our local MIND organisations.

- Progressed system work around tackling inequalities.

- Develop with the Collaborative Board the agenda and outcomes for a Collaborative Board development day, currently scheduled for November 2022.

- Alongside the geographical Health and Care Partnerships, define a trajectory and timeframe for further development of place and Collaborative arrangements with ICB Executive and system leaders.

4.2 ASD/ADHD for Children and Young People

- The business case to address the backlog of children and young people waiting for an ADHD assessment, developed through the Collaborative, was approved by the Herts and West Essex Integrated Care Board (ICB). The Collaborative has secured £1.4m of investment to both increase the number of assessments but also to provide ongoing management of monitoring through an innovative model with GP surgeries. The ICB welcomed the partnership working that informed the business case and encouraged the Collaborative to continue to focus on developing a single strategic approach to better supporting neurodiverse young people across the County.

- Next steps for the Trust will be to finalise the contracting requirements, recruit and mobilise the new service. It is currently envisaged that the ICB will contract directly with the Trust for this service with a view to developing the future commissioning model for the wider neurodiversity pathway across Hertfordshire.

4.3 Hertfordshire's Children's Emotional and Mental Wellbeing Board:

- As part of the collaborative, a multi-disciplinary Children and Young People's Emotional and Mental Wellbeing Board provides leadership, oversight, and strategy to improve the outcomes and effectiveness of transformational activity across the continuum of emotional wellbeing and mental health services for children and young people (CYP) in Hertfordshire.

  These include:
  - Understanding our progress and direction of travel against our local and national CAMHS priorities, including the anticipated/achieved benefits.
  - Understanding demand and capacity across the continuum of emotional and mental wellbeing needs and the impact on access targets
  - Understanding, considering, and agreeing actions to address challenges/barriers to success
  - Agreeing strategic objectives/plan, including our response to addressing inequalities across the CAMHS system
  - Considering, agreeing, and allocating financial investment against transformational priorities

- The board has enabled the delivery of significant transformational activity across the emotional and mental wellbeing system including:
  - £1.3M additional investment to increase service provision at earliest level, ensuring CYP have improved access to support and are able to achieve improved outcomes as soon as possible. This additional investment has enabled the following

- An early help eating disorder service delivered though First Steps, who will support CYP with lower-level eating disorder concerns. They will also provide support/training to professionals to identify potential eating disorder (ED) issues and provide appropriate support CYP within their care

- An early help Digital Intervention Service delivered through Hertfordshire MIND Network (HMN) in partnership with BfB Labs, providers of digital therapeutics for children and young people's mental health

- Parental Support Programmes

- £1.4M additional Investment to deliver a 24/7 integrated crisis support offer for CYP in line with the long-term plan. This service is delivered primarily through our Children's Crisis Assessment and Treatment Team service with additional support from HCC Children's Service's and HCT's **P**ositive behaviour, **A**utism, **L**earning disability and **M**ental health **S**ervice (PALMS).

- £440K to develop a Paediatric Liaison Service to work within our acute trusts to provide support to both staff and CYP with co-morbid mental and physical health needs

- Financial agreement to progress to the design/development stage to develop a digital gateway and front door for the emotional and mental wellbeing system.

4.4 Drugs & Alcohol and Mental Health

- Following its inaugural meeting in July, the Substance Misuse and Mental Health Pathway Task & Finish group reconvened on 01 September. The group continued to refine its terms of reference and considered how best to ensure that it could focus both on prevention and earlier intervention but also on helping to address the specific demands currently being experienced by the system, specifically the need for more joined-up provision for people in crisis and for people who don't engage with the commissioned drug & alcohol services

- The Task and Finish Group also considered how best to integrate data across the Integrated Care System to best support and evidence activity.

  The Task and Finish Group also considered how best to integrate data across the Integrated Care System to best support and evidence activity.

  At its next meeting, the Task and Finish Group will identify workstreams and how it will provide oversight, direction, and pace to deliver improved outcomes.

5. Place Based – Health and Care Partnerships (HCP)

5.1 South and West Herts Health Care Partnership (S&WHHCP)

Over the summer the S&WHHCP has confirmed its transformation programme priorities which includes a range of different projects aligned with the agreed strategy at place.

Two key pilot programmes are launching in the autumn: a system approach to advanced care planning and a pilot of a proactive programme of managing care needs for people with multiple long-term conditions.

5.2 East and North Herts Health Care Partnership (ENHHCP):
ENHHCP has agreed a series of high-impact priorities with the MHLD&A collaborative to focus on two key areas.

- Improving integration of services for people who are frail, and particularly those who have SMI and LD.
- Improving the recognition of common mental health conditions in discrete physical specialties with an initial focus on, diabetes, heart failure, respiratory pathways.

A monthly working group has been established which HPFT is a member to oversee the work, the MHLD&AC have a slot on the ENH HCP's Transformation Group, and a session is being planned to scope a wider programme of work.

6. Section 75 Review
As part of the new system arrangements the Herts and West Essex Integrated Care Board (H&WEICB) and Hertfordshire County Council have requested a review of the current section 75 arrangements between the two organisations.

The Section 75 is a legal agreement that enables the pooling of resources and delegating of certain local authority and health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

The review will look at the current arrangements for the pooling of funding for mental health, learning disability and autism provision, the Better Care Fund and equipment services.

Areas that will be considered as part of the review include the new NHS provider selection regime and its potential impact on joint commissioning, alongside other areas in which joint commissioning arrangements between H&WEICB and HCC can be improved.

The Trust is engaged as a partner in the review and the Board will be kept updated on progress, including any risks or opportunities as it develops.

7. Recommendation
Note the content of this report and discuss implications for the Trust

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 16
Subject:	Report of the Audit Committee held on 8 September 2022	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs & Company Secretary	**Approved by:** David Atkinson, Non-Executive Director and Audit Committee Chair
Presented by:	David Atkinson, Non-Executive Director and Audit Committee Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Audit Committee at its most recent meeting held on the 8 September 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.

One item was agreed to be highlighted for the Board of Trustees namely the recommendation for them to approve the Charitable Accounts for 2021/22.

Matters of Escalation

There were no matters for formal escalation to the Trust Board.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

None

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

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

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

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

Not applicable.

Report from Audit Committee held on 8 September 2022

Hertfordshire Partnership University NHS Foundation Trust

1. Introduction

1.1 This paper provides the Board with a summarised report highlighting key Committee business and issues arising from the meeting.

1.2 Since the last Audit Committee report to the Trust Board in Public, the Audit Committee ["the Committee"] held a meeting on 8 September 2022 in accordance with its terms of reference and was quorate.

1.3 Andrew Van Doorn and Anne Barnard were welcomed as new members of the Committee. The Committee was chaired for the first time by David Atkinson, Non-Executive Director.

1.4 The Committee received and considered a number of items to provide assurance, appendix 1 details the agenda for the meeting. Detailed below are the key areas to be highlighted to the Board and areas that the Committee discussed.

2. East Lancashire Financial Systems (ELFS)

2.1 The Committee received a presentation on the progress with the actions identified by the Service Auditor Report at ELFS. The Committee were assured that there remained only two outstanding actions. One of these had been tested during the recent cybersecurity incident and the other one would be tested later in September 2022.

2.2 The Committee were updated on the impact of the recent cybersecurity incident. Committee members noted the feedback from external parties that the Trust's response had been thorough and matched the seriousness of the incident. Committee members were assured on learning identified and focus on payments being made to small, medium enterprises.

3. Standard of Business Conduct

3.1 The Committee received a report that provided assurance on the compliance against the annual conflict of interest declaration process. The Committee received the gifts and hospitality register for the first five months of the year, noting the low number of declarations.

3.2 The Committee identified that further work would be done to clarify how gifts and hospitality should be declared and how to encourage more declarations. It was noted that this would be considered when the Policy for Standards for Business Conduct is reviewed before the end of 2022.

4. Charitable Accounts 2021/22

4.1 The Committee received and recommended for approval the Charitable Accounts for 20212/22. It was noted that the funds were of relatively low value but that it was important to encourage the appropriate spending of the funds.

4.2 The Committee agreed that a future meeting would consider the opportunities to secure additional charity funding and arrangements for the management of the staff lottery.

5. Cybersecurity

5.1 The Committee received an update on the recent cybersecurity incident which had meant that Trust had temporarily cut access to the financial and procurement systems. The stopping of access to the systems had been precautionary and the Committee noted that both systems were now up and running.

5.2 The Committee were updated on the systems that had operated whilst there was no access to the digital systems and the work underway to ensure the backlog was quickly recovered.

5.3 It was confirmed that solutions had been secured to migrate all relevant information from legacy digital systems and it was agreed that the Committee would receive an update on the completion of this by the end of 2022/23.

5.4 It was noted that cybersecurity risk on the Trust Risk Register had been reviewed, but that the score had not be amended.

6. Internal Audit reports and recommendations

6.1 The Committee received the regular report that summarised the Trust's progress in implementing internal audit recommendations and progress of the Internal Audit Plan.

6.2 It was noted that the Internal Audit Plan was on target and there had been one audit finalised since the last Committee meeting. This audit was considered in detail, and it was reported would be considered by the Integrated Governance Committee at its September meeting.

6.3 The Committee noted the number of actions on the Internal Audit tracker. It was noted that the majority of the actions relating to DPST had been completed but that evidence needed to be provided. It was reported that this would be provided in the next couple of weeks.

7. External Audit Progress Report

7.1 The Committee received the external audit progress report.

7.2 The report set out activity that had taken place since the last meeting and the planning work underway to prepare for 2022/23 year end. The Committee noted the introduction of ISA (UK) 315 for 2022/23 which has been introduced to achieve a

more rigorous risk identification and assessment process. The Committee noted that to meet the requirements of the new standard, auditors will be required to spend an increased amount of time across the risk assessment process, including more detailed consideration of the IT environment. It was noted that the audit plan for year end 2022/23 would be considered at the December Committee meeting.

8. Procurement of Externa Audit

8.1 The Committee were updated on the agreed procurement process for External Audit.

8.2 It was noted that the Invitation to Quote would be issued on 9 September 2022, with quotes due to be received by 7 October 2022. The December Committee meeting will consider the outcome the procurement process and make a recommendation to the Council of Governors for the appointment of External Audit.

9. Matters for Escalation to the Board

9.1 There were no items for formal escalation to the Board.

9.2 One item was agreed to be highlighted for the Board of Trustees namely the recommendation for them to approve the Charitable Accounts for 2021/22.

Hertfordshire Partnership University NHS Foundation Trust

Appendix One: Audit Committee 8 September 2022, agenda items

Welcome and apologies for Absence:
Declarations of Interest
Minutes of the meeting held on 14 July 2022
Matters Arising Schedule a) ELFS Action Plan b) EoE Collaborative internal control systems c) Register of Guidance
Deep Dive Financial sustainability audit
Other Matters a. Use of Waivers Q1 b. Provision for Irrecoverable Debt Q1 c. Use of Corporate Seal Q1 d. Standards of Business Conduct Compliance Report e. Charitable Accounts 2021/22 f. Cyber security update. g. National Clinical Audits
External Reports a. Internal Audit Progress Report b. Internal Audit Action Tracker Exception Report c. External Audit Progress Report d. Counter Fruad Progress Report
a) Minutes of Finance and Investment Committee held on 22 March 2022 b) Minutes of Finance and Investment Committee held on 10 May 2022. c) Minutes of Integrated Governance Committee held on 17 March 2022 d) Minutes of Integrated Governance Committee 12 May 2022 e) Trust Risk Register f) Committee Planner
Any Other Business
Risk/Governance Matters a. Update on External Audit Procurement
Date of next meeting; 1 December 2022

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 17
Subject:	Annual Review of Fit and Proper Person Test Checks	**For Publication:** Yes
Author:	Maria Gregoriou, Associate Director of People	**Approved by:** Janet Lynch, Interim Executive Director, People and OD
Presented by:	Janet Lynch, Interim Executive Director, People and OD	

Purpose of the report:

The purpose of this paper is to provide annual assurance that all Board directors remain fit and proper for their roles.

Action required:

Members of the Board are asked to approve the recommendation.

Summary and recommendations to the Board:

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the introduction of regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations"), the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'. The Test is carried out by way of various checks, certain of which must be repeated annually. This paper sets out the checks that must be carried out as part of the Annual Review and the outcome of the Annual Review for 2021/2022.

The Board is asked to note and record that the Annual Review of the Fit and Proper Persons Test has been conducted for the period April 2021 – March 2022 and that all Directors satisfy the requirements.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

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

The recruitment and selection process complies with the Equality Act, NHS and Trust requirements in relation to equal opportunities in recruitment and selection.

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

N/A

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

N/A

Annual Review of Fit and Proper Person Test Checks

1. Introduction

1.1 The purpose of this paper is to provide annual assurance that all Board directors remain fit and proper for their roles.

1.2 As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the introduction of regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations"), the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'.

1.3 The Fit and Proper Person Test is undertaken upon appointment to a Board role and certain checks are repeated annually. This paper presents the outcome of the checks carried out for the period April 2021 – March 2022.

2. Annual Review

2.1 As part of the Fit and Proper Person Test, the Trust is required to undertake regular reviews by way of annual checks against certain of the Fit and Proper Person Test criteria for people holding Director posts.

2.2 The Trust's agreed process (dated November 2017) sets out that the Annual Review includes the following items:

a. Confirmation of renewed insolvency and disqualified directors' checks
b. Confirmation of renewed self-declaration form
c. Confirmation of up-to-date photograph
d. Confirmation of DBS check having been carried out within the last three years.

3. Outcome of the 2021/2022 Annual Review

3.1 In Q1 of 2021/22, all Executive and Non-Executive Directors' (including the Chair and Chief Executive) insolvency and disqualified directors checks were completed. All checks were clear.

3.2 In Q1 of 2021/22, all Executive and Non-Executive Directors (including the Chair and Chief Executive) were asked to reconfirm their self declaration. All self-declaration forms have been completed and returned and were clear, i.e. none contained any self-declared reason that would mean the individual was not a fit and proper person under the Regulations.

3.3 In Q1 of 2021/22, it was reconfirmed that the Trust holds up to date photographs of all Executive and Non-Executive Directors (including the Chair and Chief Executive).

3.4 In Q1 of 2021/22, it was confirmed that all Executive and Non-Executive Directors (including the Chair and Chief Executive) have a DBS check carried out within the last three years and that these were all clear.

3.5 All self-declaration forms and annual review documentation have been sent to the Trust Chair and signed off in accordance with the Trust's agreed process. The self-declaration form for the Chair has been signed off by the Senior Independent Director.

4. Conclusion

4.1. All current and newly appointed Directors of the Trust Board satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

4.2 The next annual review will take place in March 2023 and will be reported to the Board in April 2023. The guidance on the Trust's annual review process has also been updated with support from Bevan Brittan and will come to both the Nomination and Remuneration Committee and Appointments and Renumeration Committee for consideration in due course.

5. Recommendations

5.1. The Board is asked to note the content of this paper and record that the Annual Review of the Fit and Proper Persons Test has been conducted for the period April 2021 – March 2022 and that all Directors satisfy the requirements.

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 18
Subject:	Non-Executive Champion Roles	**For Publication:** Yes
Author and Approved by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To update the Board with the regard to the NED leads agreed in line with NHSE guidance.

Action required:

The Board is asked to note the NEDs and their champion roles as outlined.

The Board is asked to consider and approve the Committees identified for the other areas to be overseen.

Summary and recommendations to the Board

Summary

Following a period of consultation NHS England published guidance that sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures. It sets out the which roles should be retained and provides further sources of information on each issue.

Recommendation

The Board is asked to:

a) Note the identified Trust NEDs for the NED champion roles
b) Consider and approve the Committees identified for the other areas to be overseen.
c) Note the Executive lead for the areas identified
d) Note further work to be undertaken as detailed in sections 3.4-3.6

Relationship with the Business Plan & Assurance Framework:

This covers all Strategic Objectives of the Trust

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:

Executive Team 21 September 2022

Non-Executive Champion Roles

1. Introduction

1.1 This report will provide an update on the guidance published by NHS England on the new approach to Non-Executive Director Champion roles.

1.2 The report will set out the requirements of the guidance and confirms the Trust's NED Champion roles.

2. Background

2.1 Following a period of consultation NHS England published guidance that sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures. It sets out the which roles should be retained and provides further sources of information on each issue. For the purposes of this guidance the term NED champion includes 'named NEDs' and 'NED leads'. B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf (england.nhs.uk)

2.2 The guidance describes a new approach which will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by committees. The aims is that the risk of false assurance among chairs and directors who are not designated 'champions' will be reduced, as oversight and to constructively challenge will rest with the whole committee and not an individual.

2.3 In developing the guidance for each issue the original review or report was that recommended the establishment of a NED champion role was identified. They worked with the relevant national policy team to consider the current status of the role and the best way of responding to the issue at this point in time. In many cases, it was agreed that board oversight would be enhanced through a change from NED champion roles to committee discharge. It was also noted that the new approach should sit alongside other effective governance tool, for example visits.

2.4 The role of NED Champions is to provide oversight of the identified area and increase visibility of relevant issues at Board level. Each of the areas identified in the guidance have a lead Director (see tables 2 and 3) and it is their role to have operational leadership of the area and to ensure appropriate assurance is provided through the Trust's governance processes.

2.5 Table 1 below sets out the NED champion roles that were in scope for the review and their status under the new approach.

Table 1.

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management-violence and aggression		

3. HPFT's Approach

3.1 Following publication of the guidance it was reviewed by the Head of Corporate Affairs and Company secretary identified the NED Champions identified for the retained roles and the lead Committee.

3.2 Table 2 below details the NEDs identified for the Champion roles.

Retained role	**HPFT NED**	**Executive Lead**
Wellbeing Guardian	Tim Bryson	Janet Lynch, Director of People and OD
Freedom to speak up	Diane Herbert	Jacky Vincent, Director of Quality and Safety
Doctors Disciplinary	Anne Barnard	Asif Zia, Director of Quality and Medical Leadership
David Atkinson	Security management	Paul Ronald, Director of Finance and Estates
Maternity board safety champion	Not applicable	Not applicable

3.3 Table 3 below details the Committees who will oversee the other areas identified.

Areas	Trust Committee	Executive Lead
Hip fracture, falls and dementia	Integrated Governance Committee	Asif Zia, Director of Quality and Medical Leadership
Learning from deaths	Integrated Governance Committee	Jacky Vincent, Director of Quality and Safety
Safety and Risk	Integrated Governance Committee	Jacky Vincent, Director of Quality and Safety
Palliative and End of Life Care	Integrated Governance Committee	Asif Zia, Director of Quality and Medical Leadership
Health and Safety	Integrated Governance Committee	Jacky Vincent, Director of Quality and Safety
Children and young people	Integrated Governance Committee	Sandra Brookes, Director of Service Delivery and Experience
Resuscitation	Integrated Governance Committee	Jacky Vincent, Director of Quality and Safety
Cybersecurity	Audit Committee	Hakan Akozek, Director of Innovation and Digital Transformation
Emergency Preparedness	Integrated Governance Committee	Sandra Brookes, Director of Service Delivery and Experience
Safeguarding	Integrated Governance Committee	Jacky Vincent, Director of Quality and Safety
Counter Fraud	Audit Committee	Paul Ronald, Director of Finance and Estates
Procurement	Audit Committee	Paul Ronald, Director of Finance and Estates
Security Management – violence and aggression	Integrated Governance Committee	Jacky Vincent, Director of Quality and Safety

3.4 The Trust is in the process of confirming the reporting structures from the relevant committees, to identify if the assurance requirements are covered through existing reporting mechanisms or by establishing new periodic updates on issues that were previously the responsibility of a NED champion. Once finalised these will be included in the committee and Board forward plans.

3.5 When the Committee terms of reference are viewed in 2022/23 consideration will be given to ensure that the committee's terms of reference reflect any new responsibilities and respective reporting requirements because of these changes.

3.6 The Trust is also considering which other roles it may want to identify as benefitting from a NED Champion, for example Inclusion and Belonging; Digital and Service User Experience. To recognise the importance of these

areas but also the wealth of experience an knowledge NEDs would be able to bring.

4. Summary

4.1 The Board is asked to:

a) Note the identified Trust NEDs for the NED champion roles
b) Consider and approve the Committees identified for the other areas to be overseen.
c) Note the Executive lead for the areas identified
d) Note further work to be undertaken as detailed in sections 3.4-3.6

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 19
Subject:	Annual Quality Assurance for Responsible Officer and Revalidation 2021/2022	**For Publication:** Yes
Author:	Abiemwense Giwa-Osagie, Revalidation Co-Ordinator	**Approved by:** Prof Asif Zia, Executive Director of Quality and Medical Leadership
Presented by:	Prof Asif Zia, Executive Director of Quality and Medical Leadership	

Purpose of the report:

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

Action required:

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

Summary and recommendations to the Board:

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

Medical revalidation was launched in 2012 to strengthen the way doctors are regulated, improve the quality and safety of care provided to patients, and increase public Trust and confidence in the medical system.

The Executive Director of Quality and Medical Leadership is the Responsible Officer and oversees the process for HPFT. As part of medical appraisal and revalidation within HPFT, a robust appraisal system for doctors incorporates trained appraisers and a bespoke IT system. All relevant policy updates from the NHS England, the GMC, NHSI, GMC and the Academy of Medical Royal Colleges on the medical appraisal 2020 model.

This report informs the HPFT Board of its statutory responsibilities to ensure that all doctors linked to HPFT keep up to date with their clinical knowledge and remain fit to practise. Annual quality assurance for the responsible officer and the revalidation report informs the Board that systems are in place to monitor those regular appraisals.

This report sets out that the quality assurance for responsible officers and revalidation carried out by HPFT as of the 31st of March 2022. One hundred and sixty-one (161) doctors were due for appraisal in 2021/2022; of these one hundred and fifty-three (153) doctors completed their appraisals within 28 days of their first appraisal. Of the remining eight (8) , five (5) doctors were off with short-term sickness, two (2) doctors missed their appraisals, and one (1) doctor had an approved missed appraisal by the RO following the GMC national guidance on reporting.

The Trust reported that eight (8) doctors had missed their appraisal as defined by NHS England.

The doctors were either unwell or had other well-founded reasons, with 95% actual compliance.

The GMC guidance on doctors due for revalidation states that forty-four doctors (44) were due for revalidation during 2021/2022. The RO approved 39 doctors with positive recommendations. The RO deferred five doctors; two doctors were on long-time sickness, one doctor was on maternity leave, and two doctors due to insufficient evidence to revalidate in line with the GMC guidance.

Since the above recommendation, the RO has revalidated most of the doctors deferred in line with the GMC guidance. The RO revalidated the one doctor on maternity leave and two doctors due to insufficient evidence to revalidate within six months from their due dates.

The Trust currently has 63 fully trained appraisers to appraise 181 doctors annually. The Trust trained 11 new appraisers by an external trainer on the 11th of February 2022 to ensure the ratio is three to four appraisees to one appraiser.

The Trust organised a Simulation Appraisal Training Workshop on the 25th of March 2022 for appraisers by an external trainer, and ten doctors participated in the training. The training sessions focused on some challenges doctors encounter during their appraisals, such as patient feedback, PDP and well-being. During the debriefing with the external appraiser trainer, the doctors reflected on ongoing challenges to support and improve the appraisal process.

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

Relationship with the Business Plan & Assurance Framework:

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

Summary of Implications for:

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

N/A

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

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

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

Executive Team 27 July 2022

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

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

Annual Organisational Audit (AOA):

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

Board Report template:

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

A link to the letter is below:

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

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

Section 2a – Effective Appraisal

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

Section 2b – Appraisal Data

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

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

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

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

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

c) act as evidence for CQC inspections.

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

Statement of Compliance:

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

Designated Body Annual Board Report

Section 1 – General:

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

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

Comments: The Executive Director of Quality and Medical Leadership is the Trust's responsible officer (RO). The Board of Directors confirmed his position on the 28th of June 2017. The Deputy Medical Director is the Lead Appraiser with the support from the Revalidation Coordinator. The Deputy Medical Director is responsible for all non-training grade medical staff (including NHS locums but excluding agency locums).

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

Yes Comments: There is a designated resource of the revalidation coordinator. The Deputy Medical Director acts as the lead appraiser. The Trust also uses the 'Allocate' system for appraisals and Job planning purposes.

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

Comments: The Medical Appraisal and Revalidation department maintain a record of new doctors' recruitment with support from the medical staffing department, formal trust induction, and the GMC Connect to ensure that the doctors have a prescribed connection to the Trust.

The GMC connect sends the Trust a notification email to verify new doctors' connection to the Trust; the Trust verifies with the Medical Staffing department to ensure the doctor is an employee of the trust.

Verification from the Medical Staffing department, the Medical Appraisal and Revalidation department disconnects doctors within two weeks from leaving the Trust to ensure the doctor connects to their new designated body. The GMC notification email confirms the doctor's disconnection from the Trust as their designated body.

The Trust uses the Allocate appraisal system to complete medical appraisals. This system electronically completes the medical job planning and appraisal elements before the final signoff. The appraisal system checks the progress and provides an accurate record of the status across all doctors with a prescribed connection to the Trust.

An appraisal portfolio of individual doctors undergoes a screening process for quality assurance by trained appraisers against recognised national standards. Appraisee and appraiser give independent feedback after each appraisal which the RO reviews.

The Revalidation Co-ordinator and the RO check the input and output of every appraisal to ensure all relevant information is available for the signoff and revalidation.

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

Comments: The Medical Appraisal and Revalidation policy are updated after GMC and NHS England update their policies. There is a formal review process for policy updates in line with Trust processes.

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

Comments: The Trust provides a GMC-approved appraiser training workshop by a GMC-approved tutor to all appraisers every year to update the appraiser with current updates, and every appraiser must attend the training workshop. The Trust is organising a peer review for 2022-2023 and should be available to the Board in the following report.

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

Comments: The Trust offers the same level of support to all doctors regarding their continuing professional development, appraisal, revalidation, and governance, irrespective of their post, position, or contract, as it offers to those who work substantively. The CPD programme (internally) is open to all doctors. Additionally, different grades have their own teaching and training programmes to meet their clinical and training requirements. These programmes are open to locum and short-term placement doctors. Similarly, monthly Trust-wide teaching and training programmes are available to all doctors.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change.

Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Comments: HPFT adopted Appraisal 2020 model, with a reduced requirement for preparation by the doctor and a greater emphasis on reflection and discussion during appraisal meetings. Feedback from doctors during the appraisal meeting suggest that the model is the preferred model among doctors. The feedback from 122 out of 164 appraisal feedback forms completed as of 31/03/2022 was;

1. "There is sufficient time for the appraisal to discuss last year's performance and expectations for the coming year, given the choice of having a virtual meeting as a very supportive space for the appraisal meeting to take place".

2. "Extremely quick, well organised, very supportive during the appraisal, beneficial appraisal, realistic goal setting, supportive plans around areas of development, and dedicated time for discussion".

3. "Beneficial meeting to reflect on the appraisee's general clinical practice, professional and personal development, CPD needs, quality improvement activities, and community challenges and determine a clear focus on the following year".

4. "Very helpful and inspired to focus on other relevant areas to support a long-term career. A critical and constructive reflection of appraisee clinic practice and professional development needs".

5. "A positive experience helped the appraisee identify their strong and weak points and a plan to work on professional and personal development via an informative discussion".

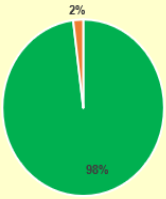
6. "An outstanding, professional and balanced appraisal received the necessary information, guidance and support before and during the appraisal and received constructive feedback about the appraisee's CPD and PDP proposals and reflections".

7. "An excellent opportunity to reflect on the quality of work and discuss the importance of learning, reviewing practice, reflecting, and implementing changes".

The Appraisal Overall

Was the appraisal useful overall for …

Personal Development



Yes	98%
No	2%

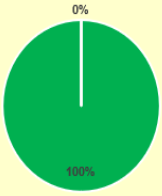
Yes No

Professional Development

Yes	98%
No	2%

Yes No

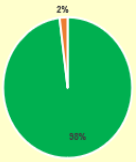
Preparation for Revalidation



Yes	100%
No	0%

Yes No

Promoting Quality Improvement at Work



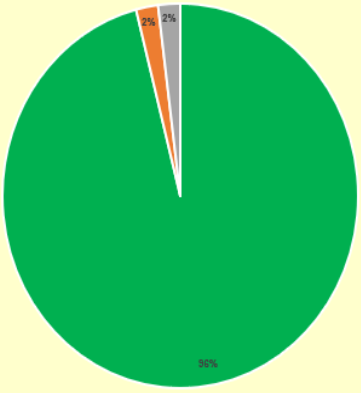
Yes	98%
No	2%

Yes No

The Appraisal Overall

Was the appraisal useful overall for …

Improving Patient Care



Yes	96%
No	2%
N/A	2%

Yes No N/A

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

Comments: The appraisal 2020 is implemented.

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

Comments: The Review of Trust Medical Appraisal and Revalidation will be completed by September 2022, with a review by September 2025.

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

Comments: The Trust currently has 63 fully trained appraisers to appraise 181 doctors annually. The Trust trained 11 new appraisers by an external trainer on the 11th of February 2022 to ensure that doctors do not have more than three to four appraisees to appraise. The Trust organised a Simulation Appraisal Training Workshop by an external trainer, for appraisers, on 25th of March 2022. Ten doctors participated in the training. The training sessions focused on some challenges doctors encounter during their appraisals, such as patient feedback, PDP and well-being.

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

Comments: The Appraiser's Network has a quarterly meeting chaired by the Deputy Medical Director with an update of the appraisal feedback report on the previous year from the RO and discusses various themes from; 1. Learning from good practice 2. The appraisal, appraiser and appraisee feedback, 3. The local audit data 4. The appraiser top-up/refresher training 5. The job planning workshop 6. The practice improvement Areas of staff wellbeing are also covered during these sessions

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

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

Comments: A planned internal and external audit for 2022/2023 is in progress.

Section 2b – Appraisal Data

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

	Name of organisation: Hertfordshire Partnership University NHS Foundation Trust.		
1	Total number of doctors with a prescribed connection as at the 31st of March 2022		**181**
2	Total number of doctors that did not need an appraisal between the 1st of April 2021 and the 31st of March 2022 (following the GMC national guidance on reporting)		**20**
	New staters doctors	11	
	Doctors on long-term sick leave	5	
	Doctors on maternity leave	2	
	Retired doctor	1	
	Died	1	
3	Total number of appraisals due between the 1st of April 2021 and the 31st of March 2022		**161**
4	Total number of appraisals undertaken between the 1st of April 2021 and the 31st of March 2022		**153**
5	Total number of appraisals not undertaken between the 1st of April 2021 and the 31st of March 2022		**8**
	Missed appraisals	5	
	Doctors on short-term sick leave	2	
	RO approved missed appraisal	1	
6	Total number of agreed exceptions		**1**

Section 3 – Recommendations to the GMC

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

Comments: Forty-four doctors (44) were due for revalidation during 2021/2022. The RO approved 39 doctors with positive recommendations. The RO deferred five doctors; two doctors were on long-time sickness, one doctor was on maternity leave, and two doctors due to insufficient evidence to revalidate in line with the GMC guidance. Since the above recommendation, the RO has revalidated one doctor on maternity leave and two doctors who are originally provided insufficient evidence.

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

Comments: The RO and the deputy medical director proactively engage with doctors who have a potential for deferral and will have formal conservation with the relevant doctor regarding a decision to defer or non-engagement in line with the national guidance. The RO discusses all deferral with the GMC Liaison Officer before deciding to defer a doctor.

Section 4 – Medical governance

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

Comments: All doctors must include the complaints and Serious Untoward Incident (SUI) reports in their appraisal. The appraiser feedback report is generated yearly by the Revalidation Co-ordinator and sent to each appraiser to include in their appraisal portfolio.

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

Comments: The updated version of the Trust Appraisal and Revalidation policy in 2018 aligns with the national standards. The appraisal is not a performance tool but may include performance information that doctors need to reflect upon during appraisal meetings. Effective medical appraisal and subsequent revalidation will satisfy the requirements of Good Medical Practice and support the doctor's professional development. All our doctors have their performance discussed at their job planning meetings with their line managers on an ongoing basis; this includes the key performance indicators, complaints, and SUIs within the four Strategic Business Units (SBUs). There is a mechanism for ensuring that individual doctors include the relevant complaint and SUI data in the appraisal portfolio for discussion. MSF 360 feedback from colleagues and patients is conducted at least once during a five-year revalidation cycle (in line with GMC requirements) and may repeat the process more frequently where required or advised during the appraisal process.

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

Comments: The Trust has a Remediation, Rehabilitation and Re-skilling policy for Medical Staff. The key focus is on doctors with concerns around their practice. This policy offers the opportunity to help doctors who need re-skilling after returning to work after a break or exclusion.

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

Comments: Appraisal is not a performance tool but may include performance information that requires reflection. Effective medical appraisal and subsequent revalidation will satisfy the requirements of Good Medical Practice and support the doctor's professional development. Concerns about a doctor can be raised in relation to performance against key performance indicators, complaints and SUIs, MSF 360 feedback from colleagues and patients.

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

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

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Comments: It organises RO to RO meetings to discuss concerns about an individual doctor. An example could be an agency doctor. The RO consults the GMC liaison officer, or the GMC liaison officer is usually part of these meetings where there are significant concerns about a doctor.

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

Comments: The RO has undergone unconscious bias training for overall awareness, understanding, and Maintaining High Professional Standards (MHPS) effectiveness. The RO meets with the medical managers at the Medical Professional leads meeting to ensure HPFT maintain a high professional standard. The RO meets with GMC Liaison and Practitioner Performance Advisors to discuss concerns about the practice and conduct of HPFT doctors.

Section 5 – Employment Checks

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

Comments: The Medical Staffing Team undertakes all pre-employment checks.

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

Section 6 – Summary of comments, and overall conclusion

One hundred and sixty-one (161) doctors were due for appraisal in 2021/2022; of the one hundred and fifty-three (153) doctors completed their appraisals within 28 days of their first appraisal.

The Trust reported that eight (8) doctors had missed their appraisal as defined by NHS England. The doctors were either unwell or had other well-founded reasons, with 95% actual compliance.

Forty-four doctors (44) were due for revalidation during 2021/2022 within HPFT; The RO approved 39 doctors with positive recommendations completed on time and five deferral recommendations. The RO has revalidated most of the doctors deferred in line with the GMC guidance.

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

Overall conclusion:

The Board is requested to note the report, comment and accept (if appropriate). The report will be shared with the higher level (regional), the Responsible Officer.

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

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

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

Name: Prof Asif Zia Signed: _ _ _ _ _ _ _ _ _ _

Role: Executive Director of Quality and Medical Leadership (HPFT Responsible Officer)

Name: Karen Taylor Signed: _

Role: Chief Executive Officer

Date: 20/07/2022

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

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 20
Subject:	Chair's Action	**For Publication:** Yes
Author:	Kathryn Wickham, PA to Chair and Head of Corporate Affairs & Company Secretary	**Approved by:** Sarah Betteley, Chair
Presented by:	Sarah Betteley, Chair	

Purpose of the report:

To inform and seek agreement for Chairs action to be carried out for Annette Grunberg and Barry Canterford to become an MHAM.

Annette Grunberg and Barry Canterford have both successfully completed their 3 observations and training.

Action required:

To approve the Chair's action.

Summary and recommendations to the Board:

Annette Grunberg and Barry Canterford were given initial approval by Sarah Betteley and Tim Bryson to allow them to sit on panels from August.

Relationship with the Business Plan & Assurance Framework:

N/A

Summary of Implications for:

N/A

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

N/A

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

N/A

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

N/A

PUBLIC Board of Directors

Meeting Date:	29 September 2022	**Agenda Item:** 20
Subject:	Board and Committee Planning 2022/23	**For Publication:** Yes
Author and Approved by:	Kathryn Wickham, PA to Chair and Head of Corporate Affairs & Company Secretary	
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To update the Board of Directors with the proposed dates for the Board and its sub-committees for 2023/24. To set out the proposed programme of work for the Board.

Action required:

The Board are asked to APPROVE

Summary and recommendations to the Executive Team:

Summary

The Board of Directors are asked to note that the dates for 2023/24 have been reviewed and signed off by the Chair, Chairs of the sub-committees. The dates have also been presented to the Executive Team at their meeting held 21 September 2022. The proposed dates of Board meetings have been moved to the first Thursday of the week to support the reporting cycle.

Recommendation

The Board are asked to review and approve the proposed dates.

The Board is asked to approve its proposed programme of work.

Relationship with the Business Plan & Assurance Framework:

This covers all Strategic Objectives of the Trust

Summary of Implications for:

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

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

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

Executive Team on 21 September 2022

Trust Board Annual Cycle of Business 2023/24			2023											2024	
Meeting Planning	**Frequency**	**Lead**	**Jan**	**Feb**	**March**	**May**	**Jun**	**June**	**Jul**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
Date of meeting			26	23	30	4	1	8	6	7	5	2	7	11	1
Note each public meetingand workshop is preceded by private Board meeting			Public	Workshop	Public	Public	Workshop	Public For Annual Report and Accounts	Public	Public	Workshop	Public	Workshop	Public	Workshop
Service User Story	M	Director of Service Delivery & Service User Experience	X		X	X		X	X	X		X		X	
Opening Business															
Welcome and Apologies for Absence	M	Chair	X		X	X		X	X	X		X		X	
Declarations of Interest	M	Chair	X		X	X		X	X	X		X		X	
Approval of Minutes from the Last Meeting	M	Chair	X		X	X		X	X	X		X		X	
Matter Arising Schedule	M	Chair	X		X	X		X	X	X		X		X	
Chair's Report	M	Chair	X		X	X		X	X	X		X		X	
Chief Executive's Brief	M	Chief Executive	X		X	X		X	X	X		X		X	
Quality															
Report of the Integrated Governance Committee	Bi-monthly	Chair of IGC	X		X	X			X	X		X		X	
Integrated Safety Quaterly Report/Annual Integrated Safety Report	Q&A	Director of Quality and Safety			Q3	Q4&A			Q1			Q2			
Safe Staffing Report	Q&A	Director of Quality and Safety			Q3	Q4&A			Q1			Q2			
Infection Prevention and Control Annual Report	A	Director of Quality and Safety							A						
Safeguarding Annual Report	A	Director of Quality and Safety							A						
Health Safety& Security Annual Report	A	Director of Quality and Safety								A					
Medical Appraisal & Revalidation of Doctors Annual Report	A	Director of Quality and Medical Leadership							A						
Emergency Preparedness Resilience & Response-Core Standards	A	Director of Service Delivery & Service User Experience								A					
Service User Experience Annual Report	A	Director of Service Delivery & Service User Experience				A									
Equality and Diversity Annual Report	A	Director of People and Organisational Development				A									
Public Sector Equality Duty Compliance Report& Outcome of Equality Delivery System Grading	A	Director of Quality and Safety				A									
WRES and WDES Annual Report	A	Director of People and Organisational Development								A					
Staff Annual Survey Report	A	Director of People and Organisational Development			A										
Operational and Performance															
Annual Planning	A	Director of Strategy and Partnerships			A										
Annual Plan Approval	A	Director of Strategy and Partnerships			A										
Annual Plan Quaterly Updates	Q	Director of Strategy and Partnerships			Q3	Q4			Q1			Q2			
Performance Report	Q	Director of Innovation and Digital Transformation			Q3	Q4			Q1			Q2			
Financial Planning	A	Director of Finance and Estates			A										
Financial Report	M	Director of Finance and Estates	X		X	X		X	X	X		X		X	
Report from the Finance and Investment Committee	Bi-monthly	Chair of the Finance & Investment Committee	X					X		X				X	
People and OD Quaterly Report	Q	Director of People and Organisational Development			Q3	Q4				Q1		Q2			
Community Survey	6 monthly	Director of Service Delivery & Service User Experience			X							X			
Annual Clinical Excellence Awards	A	Director of Quality and Medical Leadership							A						
Governance and Regulatory															
Audit Committee Report	Bi-monthly	Chair of the Audit Committee	X		X			X		X				X	
Freedom to Speak Up	6 Monthly	Director of Quality and Safety				A						X			
Trust Risk Register	Q	Director of Quality and Safety			Q3	Q4			Q1			Q2			
Board Assurance Framework quaterly review	Q	Company Secretary			Q3	Q4			Q1			Q2			
Review of Board Effectiveness	A	Chair/Company Secretary			A										
Board Business Cycle	A	Company Secretary								A					
Board Planner	A	Company Secretary								A					
Fit and Proper Person Compliance	A	Chair/Company Secretary							A						
Annual Accounts	A	Director of Finance and Estates						A							
Internal Audit Annual Report (including Head of Internal Audit Opinion)	A	Head of Internal Audit						A							
External Audit - Annual Governance Report	A	External Auditors						A							
Annual Report including Annual Governance Statement and Quality Accounts	A	Director of Finance and Estates						A							
Audit Committee Annual Report	A	Audit Committee Chair						A							
Use of the Trust Seal	A	Company Secretary						A							
Use of Waivers	A	Director of Finance and Estates						A							
Lossess and Compensation Payments	A	Director of Finance and Estates						A							
Compliance with NHSI Licence	A	Company Secretary						A							
Integrated Governance Committee Annual Report	A	IGC Chair/Company Secretary						A							
Gender Pay	A	Director of People and Organisational Development			A	A									
Finance & Investment Committee Annual Report	A	FIC Chair / Company Secretary				A								A	
Trust Regulatory Documents Annual Review															
Standing Orders	A	Company Secretary							A						
Standing Financial Instructions	A	Director of Finance and Estates							A						
Matters Reserved to the Board & Scheme of Delegation	A	Director of Finance and Estates							A						
Charitable Funds Annual Accounts Sign off	A	Director of Finance and Estates								A					
Trust Constitution	A	Company Secretary										A			
Metal Health Act Manager's Annual Report	A	Committee Chair							A						
Strategy															
System Update	M	Director of Strategy and Partnerships	X		X			X	X	X		X		X	
Strategy Development	6 Monthly	Director of Strategy and Partnerships										X			