Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC Meeting

Virtual MS Teams

25 March 2021 10:30 - 25 March 2021 13:00

INDEX

Hertfordshire Partnership University NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 25 March 2021
Virtual
Time: 10.30am – 13:00pm

A G E N D A					
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**	**TIMINGS**
1.	**Welcome and Apologies for Absence**	Chair			10:30
2.	**Declarations of Interest**	Chair	**Note**	Attached	
3.	**Service User**				10:30
4.	**Minutes of Meeting held on 26 November 2020**	Chair	**Approve**	Attached	11:00
5.	**Matters Arising Schedule**	Chair	**Review & Update**	Attached	
6.	**CEO Brief**	Tom Cahill	**Receive**	Attached	11:05
7.	**Chair's Report**	Chair	**Receive**	Verbal	
QUALITY & PATIENT SAFETY					
8.	**Covid-19 Update**	Dr Jane Padmore	**Receive**	Attached	11.15
9.	**Report from Integrated Governance Committee – 8 March 2021** **a) Quarter 3: Integrated Safety Report** **b) Quarter 3: Safe Staffing Report** **c) Quarter 3: People and OD Report** **d) Quarter 3: Guardian of Safe Working**	Diane Herbert Dr Jane Padmore Dr Jane Padmore Louise Thomas Asif Zia	**Receive** **Receive** **Receive** **Receive** **Receive**	Attached Attached Attached Attached Attached	11.20
10.	**Staff Survey**	Louise Thomas	**Receive**	Attached	11.35
OPERATIONAL AND PERFORMANCE					
11.	**Report of the Finance & Investment Committee – 16 March 2021** **a) Quarter 3: Performance Report** **b) Capital Programme 20/21**	David Atkinson Keith Loveman Paul Ronald	**Receive** **Receive** **Receive**	Attached Attached Attached	11.45
12.	**Finance Report – Month 11**	Paul Ronald	**Receive**	Attached	11.55
13.	**Capital Programme** **a) Albany Lodge Business Case** **b) Public Dividend Capital**	 Paul Ronald Paul Ronald	 **Approve** **Receive**	 Attached Attached	12.00

	drawdown				
14.	**Community Survey Update**	Sandra Brookes	**Receive**	Attached	12.10
	STRATEGY				
15.	**Planning 21/22** **a) Annual Plan** **b) Finance Plan** **c) Capital Plan FY22**	 Karen Taylor Paul Ronald Paul Ronald	 **Approve** **Approve** **Approve**	 Attached Attached Attached	12.15
	GOVERNANCE AND REGULATORY				
16.	**Trust Risk Register**	Dr Jane Padmore	**Receive**	Attached	12.40
17.	**Board Assurance Framework**	Helen Edmondson	**Approve**	Attached	
18.	**Finance and Investment Committee Terms of Reference**	David Atkinson	**Approve**	Attached	12.45
19.	**Six monthly report from Nominations and Remuneration Committee**	Chair	**Receive**	Attached	12.50
20.	**Any Other Business**	Chair			12.55
21.	**QUESTIONS FROM THE PUBLIC**	Chair			
Date and Time of Next Public Meeting: Thursday 29 April 2021					

ACTIONS REQUIRED

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

Chair: Sarah Betteley

Declarations of Interest Register

Board of Directors

25 March 2021

Members	Title	Declaration of Interest
David Atkinson	Non-Executive Director	Goldman Sachs Group Inc equity share owner Trustee of Papworth Trust Independent NED Mizuho Trustee Eternal Forest Trust
Anne Barnard	Non-Executive Director	Share Portfolio managed by a private client stockbroker Independent member of the Audit & Risk Committee of the Department of Health & Social Care Director and minority shareholder in Qube Information Systems Ltd
Tanya Barron	Non-Executive Director	Chair of Affinity Trust Education Development Trust Non-Executive Director at Devon Partnership NHS Trust.
Sarah Betteley	Chair	Director DEVA Medical Electronics Ltd
Sandra Brookes	Director, Service Delivery & Service User Experience	Nil Return
Tim Bryson	Non-Executive Director	Director of Tim Bryson Consultancy Services Ltd Chair of Family Psychology Mutual CIC
Tom Cahill	Chief Executive Officer	Nil Return

Ann Corbyn	Director, People & Organisational Development	Nil Return
Catherine Dugmore	Non-Executive Director	WWFUK Trustee RGB Kew Trustee Natural England Board Member Aldwickbury School Trust Limited
Helen Edmondson	Head of Corporate Affairs & Company Secretary	Nil Return
Diane Herbert	Non-Executive Director	Shareholder in own coaching/leadership business Trustee at London Film School
Kush Kanodia	Associate Non-Executive Director	Chief Disability Officer, Kaleidoscope Group Trustee, Kaleidoscope Foundation Public Advisory Board, Health Data Research UK (HDR UK) Advisory Board, Global Disability Innovation Hub (GDI Hub) Trustee & Director, Center for Access Football in Europe (CAFÉ) Trustee & Director, AbilityNet
Keith Loveman	Director of Strategic Finance	Nil Return
Jane Padmore	Director, Quality & Safety	Director of Nursing Forum, National Mental Health and Learning Disability Board Member of NHS Confederation Mental Health Forum
Paul Ronald	Director of Operational Finance	Chair – MIND in Mid-Herts

Karen Taylor	Deputy CEO & Director, Strategy & Integration	Nil Return
Patrick Vernon	Non-Executive Director	Chair of Citizenship Partnership of Healthcare Investigating Branch Sister works for NHS Resolute Centre for Ageing Better Every Generation Media and Foundation Vice Chair of Bernie Grant Trust Board member of 38 Degrees Sole shareholder and founder of social enterprise Campaign on reforms of NHS
Asif Zia	Director, Quality & Medical Leadership	Nil Return

Minutes of the PUBLIC Board of Directors Meeting
Thursday 26 November 2020
VIRTUAL

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Christopher Lawrence | CL	Chair
Tanya Barron | TBa	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
Sarah Betteley | SBe	Non-Executive Director
Catherine Dugmore | CD	Non-Executive Director
Loyola Weeks | LW	Non-Executive Director
David Atkinson | DA	Non-Executive Director
DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Paul Ronald | PR	Director of Operational Finance
Dr Jane Padmore | JPad	Director, Quality and Safety
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Karen Taylor | KT	Director, Strategy and Integration
Dr Asif Zia | AZ	Director, Quality & Medical Leadership
Keith Loveman | KL	Deputy CEO
IN ATTENDANCE	
Kathryn Wickham	PA to Chair & Company Secretary (Minute Taker)
Helen Edmondson | HE	Head of Corporate Affairs & Company Secretary
Barry Canterford | BC	Public Governor & Engagement Champion
Tim Bryson | TBr	Non-Executive Director
Anne Barnard | AB	Non-Executive Director
Louise Thomas | LT	Deputy Director People & Organisational Development
Cham Manzango | CM	Mental Health Liaison Team
Katie Dyton | KD	Interim Experience Co-ordinator
Lara Harwood | LH	Interim Experience Manager
APOLOGIES	
Ann Corbyn | AC	Director of People & Organisational Development

Item	Subject	Action
112/20	**Welcome and Apologies for Absence** CL welcomed all to the meeting. Apologies for absence were received from Ann Corbyn.	
113/20	**Declarations of Interest** The Declarations of Interest Register was noted. No further conflicts of interest were noted for items on the agenda. **NOTED**	
114/20	**Staff Story to the Board** CM spoke to the Board about how Covid-19 had affected his family life and role as part of the Mental Health Liaison team at the Lister and how the BAME (Black Asian Minority Ethnic) network has developed through Covid. CM also spoke to the Board on the Black Lives Matter movement.	

	CL recorded a thank you for the work CM did stating he was doing an amazing and important job. TC concurred, asking CM to feedback a huge thank you from the Board for their outstanding work.	
114/20	**Minutes of the Meeting held on:** **22 October 2020** The minutes were reviewed and approved as an accurate account of the meeting. **APPROVE** **The Board APPROVED the minutes**	
115/20	**Matters Arising Schedule** The Matters Arising Schedule was reviewed and updated.	
116/20	**CEO Brief** TC presented the CEO Brief to the Board which was taken as read. Headline messages of note to the Board were: **National** The NHS had now moved into a level 4 incident response for Covid and news would be released today on which tiers areas were likely to be in, with Hertfordshire expected to be in Tier 2. The EU exit situation was complex with significant issues and had created a level of uncertainty. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) had written a high-level report which had shown that since the pandemic there had not been a significant increase in suspected suicide rates. TC noted that whilst we welcomed the findings it was likely this would not be the continuing story and we would monitor the situation closely. There was good news regarding resources, with an announcement at the weekend the NHS would receive £3 billion to assist with Covid and winter pressures, however the devil was in the detail. **Regional and System** The ICS continued to develop and embed with the Partnership Board up and running. The MH & LD ICP was making good progress with TC and Beverley Flowers jointly chairing and KT and Kate Linhart supporting. TC reported that the Board and Council of governors would be kept updated with progress with regard to the East of England (EOE) Provider Collaborative – New Care Models . **Trust-wide** The CQC had changed their monitoring approach due to Covid and were requiring providers to carry out self-assessments. he Trust was currently undertaking its a self-assessment. An interview with CQC was scheduled for January, the outcome of which would be reported to IGC and Board. The Trust had achieved 62% to date with a target of 90% with TC highlighting the Trust was aiming to achieve 70% and the 90% target would be challenging.	

	TC advised the Trust would be part of the Covid Mass vaccination and we had been asked to provide support of around 6 staff to provide the vaccinations. Two weekly testing for asymptomatic staff had commenced today (26 November 20). It was noted it was a significant logistical task.. Operational services remain very busy across all areas with young people really struggling and high demand for beds in both CAMHS and Adult services. Trust vacancy rate had improved significantly in the quarter. Sickness levels are down, however this continued to be monitored. The Annual Staff Awards event would take place on the 2 December with TC commenting on the amazing and inspiring stories from our staff. The financial situation was complex however we were hoping to achieve a balanced financial position for end of year. TC advised that we had not altered our governance arrangements for the second wave however had increased Non Executive communications. The Council of Governors recently approved the appointment of 3 new NEDs who would commence on the 1 January 2020. The outcome of the Well Led Review would formally be taken through the Council of Governors in March 2020 following a Board discussion TC invited questions. CD commented on the welcome announcement of the money stating she felt this was an opportunity to use the resources to invest in the future.. TC responded advising the money was likely to be ring-fenced however in a recent conversation with Jane Halpin she had asked the question 'what would you do if you had more money'. LW referred to the good progress with the ICP and ICS querying when the 20 CCGs on our patch would be stood down. TC confirmed that he had spoken with Jane Halpin to ensure the Trust developed a strong relationship with the ICS. TBa also referenced the money announcement asking if LD services might benefit from this. TC stated he was unsure where monies would land. SBe highlighted that the Trust had been shortlisted as a finalist for MH Trust of the Year. **RECEIVED** **The Board RECEIVED the CEO Update**	
117/20	**Chairs Brief** CL provided the Board with a verbal update on his recent activity. Points of note were: Board Away Day - CL noted this had been a wonderful opportunity to have the new NED's join and network. The day had been positive and very helpful.	

	CL reported that he had been working with SBe to handover as Chair and had held several meetings with external stakeholders who had given very positive feedback on the Trust including how we 'live our values'. Staff Awards – CL reported that he had read 57 Inspire Awards from the past year choosing one winner for the Award. All had been moving and all worthy of winning and receiving recognition. The recruitment to the Associate NED post was now underway – a programme we had started 18 months ago for BAME NEDs noting the success of Sarita Dent. There was a strong list of 4 candidates which would be interviewed next week. CL invited questions. TBa highlighted the need to take the learning from the Associate NED, CL supported this. TC acknowledged that it would be beneficial to spend more time at the outset around expectations and rules of engagement within the role. **RECEIVED** **The Board RECEIVED the Chairs verbal Briefing**	
	QUALITY & PATIENT SAFETY	
118/20	**Report of the Integrated Governance Committee held 11 November 2020** SB presented the report which was taken as read asking the Board to put forward specific questions only. The meeting had been held on the 11 November Reports were received from the IGC Sub Committees, QRMC, Quarter 2 Practice Audit Implementation Report, CQUIN Update, Flu Update, Physical Health Annual Report. In response to a request from the Board, the Committee received a report on the status of Accreditation of services in the Trust. The Guardian of Safe Working report had been presented noting during the quarter there had been 8 exception reports raised. The Committee received the Q2 People and Organisational Development Report which appraised it on the performance in Q2 against the metrics and activity as set out in the Annual Plan. The Committee had reviewed and approved the People and Organisational Development Group (PODG) Terms of Reference – previously known as WODG. The Bi-annual Freedom to Speak Up Report had been received by the Committee who had noted the change in person holding the Freedom to Speak Up role; Yusuf Aumeerally would undertake the role for Quarters 3 & 4. The Quarter 2 Safe Staffing report had been presented which outlined the staffing levels achieved against the safe staffing levels that were set for each in patient unit for nursing staff. It had been noted that the emergency alternative staffing levels were not used and business as usual staffing levels were	

	maintained throughout the quarter. There had been an increase in bank and agency use. The Committee had also received an updated Board Assurance Framework (BAF) and Trust Risk Register (TRR) which had undergone a significant amount of work to refresh the risks and noting one new risk around SRS services. In addition the EU exit had been added to the register. The Bi-Annual Caldicott report had been received with the Committee noting the importance of this role. The Committee approved its business cycle and meeting dates for 2021/22 and also reviewed and approved its Terms of Reference which required ratification from the Board. The Committee were provided with a quarter two information governance report for assurance. The Committee received a report for assurance on the Bi annual Claims and had supported the priorities for the second half of the year. The Committee reviewed and approved the proposal for the Committee's self-assessment process, subject to the reduction in the number of questions. Two items were identified for formal escalation to the Board and it is highlighted that both are substantive items on the Board agenda. a) Flu Self – Assessment b) Committee Terms of Reference Questions were invited. CL recorded thanks to SBe acknowledging the sheer amount of hard work undertaken within the Board sub-committees. DH expressed her support for the revised Appraisal process. CL also acknowledged the work which Kevin O'Hanlon had undertaken as Freedom to Speak Up lead. **RECEIVED** **The Board RECEIVED the report**	
118/20 a	**Integrated Safety Report Quarter 2** JPad presented the paper which was taken as read. No comments were put forward. **NOTE** **The Board NOTED the report**	
118/20 b	**Safer Staffing Report Quarter 2** JPad presented the paper which was taken as read. No comments were put forward. **NOTE** **The Board NOTED the report**	
118/20 c	**People & OD Report Quarter 2**	

	LT presented the report which was taken as read. No items were put forward for further discussion. **NOTE** **The Board NOTED the report**	
119/20	**Response to Covid 19** JPad provided the Board with an update on the current position in relation to the COVID-19 pandemic and its management. JPad reported that we were currently in a level 4 alert nationally and level 4 NHS response. Incident control at Strategic, Tactical and Operational command is operational and the rhythm well established. IPC, Vaccinations, staff testing and EU exit was included within this. Locally we were seeing an increase of incidents, in particular incidents within the African community. There had been significant outbreaks in LD care homes resulting in one being decanted to a 'hot' covid site in Buntingford. Our teams had been amazing and over the weekend delivered physical healthcare training, and on-going care and support for one service user who was on end of life care. To date there had been 103 deaths of our service users. 78 in the community and 25 in the inpatient services with 13 reported as they died whilst physically in our bed. The second wave was seeing an increase in deaths in those with a learning disability. Currently we have no inpatient positive cases and have not had an outbreak since the one at Forest house. We have 25 community service users who are currently positive. In terms of Covid related absence, there were 37 working from home in isolation, 11 not able to work and 101 shielding. Staff testing of service user facing staff commenced today. There were packs of 25 which lasted 12 weeks. Testing was twice a week on a Monday and Thursday or Tuesday and Friday. If positive 14 days isolation was required. JPad noted the risk of having further staff off with positive results but highlighted the benefit longer term. AZ provided a verbal update as lead Exec for the Vaccination Programme advising this would be run centrally. The vaccine was due to be delivered in the first week of December when a mass vaccination programme would commence. As a Trust we would carry out our own vaccinations. LT added that a Sit Rep report would be undertaken. A helpline had been set up and information put on the HIVE. It was agreed for a session to be held for the NEDs around the vaccination programme. **RECEIVE** **The Board RECEIVD the report**	**HE**

120/20	**Flu Update** AZ presented the report which was provided to the Board for assurance that the flu campaign for 2020-21 was progressing well. The self-assessment as recommended by IGC was approved by the Board for submission.. No questions were put forward. **RECEIVED** **The Board RECEIVED the report and APPROVED the self-assessment.**	
121/20	**EU Exit Update** KL provided the Board with background to the EU Exit and the completion of the transition phase on 31 December 2020. The report was taken as read. Points of note for the Board were: A task and finish group with subject matter experts had been established with weekly meetings to monitor risk and take or recommend mitigating actions through incident command as necessary. The previous risk on the TRR had been stood down and refreshed with a new risk. No substantial national guidance had been received to date, with KL advising this may materialise over the next few weeks, noting that it was positive that the Trust had undertaken a large amount of work in 2019 and that contingency plans in place. It was noted that the EU Sit Rep process had not recommenced. There was concern around supply chains for roll on/roll off freight and potential border issues. Assurance had been provided around the stock pile of drugs and fuel with no expected issues. Chetan Shah had also ensured as a Trust we were optimising our levels of drugs. It was of note to the Board that we had written to all EU national staff to offer our support. PR confirmed that the Trust's PPE supply was mostly UK based.. No questions were put forward. **RECEIVED** **The Board RECEIVED the report**	
OPERATIONAL & PERFORMANCE		
122/20	**Report of the Finance & Investment Committee held 17 November 2020** DA presented the report advising that an overview of the work undertaken was outlined in the body of the report and took the paper as read. Of note to the Board was one item in relation to the Forrest House capital proposal which required Board approval.	

	Key messages to highlight to members were: The Committee had received an update on the Q2 Annual Plan which reported we were on track to deliver four of the seven objectives. Areas of challenge were experience, joined up care and system influence. The Committee had held a discussion around the ambition to deliver on all our objectives. The Committee had received the Q2 Performance report which detailed the Trust performance against the 67 indicators. Overall underlying performance had remained strong during a period of challenges. Areas of focus for the next quarters related to Out of Area Placements, IAPT, CPA reviews and PDP rates. The Committee had considered the financial summary for the period ending October 2020 and a forecast for the year end. For months 1-6 the Trust had achieved an overall break-even position for the month; however the Trust had to claim c. 350k for month 6 to break even. For month 7 the Trust reported a small surplus. DA reported it was critical the Board were aware of the considerable financial uncertainty. The Committee had considered a detailed report regarding the tender process for the renewal of its Total Facilities Management (TFM) contract, noting the cost increase due to the enhanced specification. FIC had provided their approval to move to the next stage which would then see a 10 day consultation period. The Committee had reviewed and approved the proposal for the Committee's self-assessment process. The Committee considered a report on the New Care Models Collaborative which was working towards an April 2021 "go live" date. The Committee had been provided with an update on the Hertfordshire contract noting good progress was being made. The Committee received an update on the 2020/21 capital programme noting it was progressing well. In addition to the capital programme the Trust had secured additional central funding investment of circa £2m. The Committee had received a detailed presentation on the project to develop bed provision in East and North Herts Bed Provision. The Committee had supported the design principles outlined. The Committee had considered the Forest House Adolescent Unit HDU Capital Proposal noting the significant investment and provided their approval. **RECEIVED** **The Board RECEIVED the report**	
123/20	**Forest House HDU – Capital Proposal** PR presented the business case advising he was seeking Board approval of Trust capital of £1,395,083 across 20/21 and 21/22 financial years. This was to support the conversion of the existing Forest House facility to create a 2 bedroom high dependency unit (HDU) whilst maintaining the overall capacity of 16 beds.	

	PR noted that the proposed programme of work would significantly enhance the quality of the environment for both young people and staff at Forest House. The proposal had been discussed in detail at FIC and received strong support from members. **APPROVE** **The Board APPROVED the Capital Proposal**	
	GOVERNANCE & REGULATORY	
124/20	**Integrated Governance Committee Terms of Reference** SBe presented the report which outlined the amendments made to the terms of reference for the Integrated Governance Committee as appended in the report. It was noted there were no significant changes made and the terms of reference remained in line with the Trust's Constitution and good corporate governance. **APPROVED** **The Board APPROVED the IGC Terms of Reference**	
	STRATEGY	
125/20	**AOB** Members of the Board paid tribute and thanks to CL for his time with the Trust and his leadership in taking the Trust from Good to Outstanding. Tributes and acknowledgement were also recorded for LW. No further business was put forward.	
126/20	**Questions from the Public** BC recorded his thanks to CL and LW for their work and contribution to the Trust.	
127/20	**Date of Next Meeting** The next Public meeting is scheduled for 28 January 2021.	

Close of Meeting

Agenda Item 4

Hertfordshire Partnership University NHS Foundation Trust

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 25 March 2021

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
26/11/20	**119/20**	Response to Covid 18	Session to be held for NEDs around the vaccination programme.		AZ	Nov/Dec 2020	G

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 6
Subject:	CEO Briefing	
Presented by:	Tom Cahill, CEO	

National update

There is currently a lot of activity nationally which is summarised below:

COVID

Nationally the NHS response remains at level 4 with a clear 'road map' to the easing of lockdown in place. The number of positive cases and deaths continue to decline and the first phase of the easing of lockdown in England has started with schools opening, supported by testing. The national vaccination programme continues with the UK Government now inviting all people with a learning disability and individuals with schizophrenia or bipolar disorder, or any mental illness that causes severe functional impairment for a vaccination as per JCVI priority group 6.

The NHS is also starting to think about the resilience for possible future phases in the autumn, and planning the winter.

Staff Survey

Nationally the results of the 2020 Staff Survey have been published. Over 595,000 staff responded to the 2020 survey, a response rate of 47.3% (compared to response rates of 48.5% in 2019 and 45.7% in 2018) from 220 Trusts. The results show that in most areas the NHS have sustained improvements or moved forwards, in particular the scores for both the health and wellbeing and safety culture themes are the highest for five years, while the morale score is the highest since the theme was introduced three years ago. Unsurprisingly, the impact of Covid means that work-related stress has increased among staff indicating the national and local efforts needed to support the health and wellbeing of staff.

2021/22 Planning

Discussions with NHS England and Improvement indicate that planning for 21/22 will restart in the coming weeks. This will include reviewing phase III plans, with a particular focus on workforce, activity and finance. It is worth noting that acute hospital are facing significant recovery plans to tackle waiting lists.

Workforce Race Equality Report

NHS England and NHS Improvement published the latest workforce race equality standard data for 2020. The report provides key workforce data, including number of BME staff in Very Senior Manager and in Board member roles; likelihood of BME staff entering the formal disciplinary process or not being appointed following interview. The report highlights continued disparities that face BME staff working in the NHS compared to white colleagues. While the report indicates some progress is being made it is clear there is still a long way to go.

Budget

On 3 March the Chancellor set out his second budget. It was focused on supporting people and businesses through the pandemic with the majority of the speech focused on packages to support business and households. It was reported that the Office of Budget Responsibility (OBR) holds a fairly positive, for the medium term prospects for the UK economy. With regard to the NHS, NHS England revenue budget for 2020/21 (excluding. COVID-19 costs) will be £129.7bn, which is £0.2bn lower than forecast. This will then rise to £136.1bn in 2021/22, consistent with the trajectory in the November 2020 Spending Review and the long-term funding settlement originally announced in 2018. COVID-19 costs in 2021/22 remain the same as previously outlined as a £3bn 'NHS recovery package', this includes £1bn to tackle elective backlog and funding to help to address waiting times for mental health services, give more people the mental health support they need, invest in the NHS workforce.

Annual Survey of the Freedom to Speak Up (FTSU) Guardians

The National Guardian's Office has published the report from its fourth annual survey of the Freedom to Speak Up (FTSU) Guardians. The report outlines FTSU Guardian's views on a number of key areas relating to their experience and how it can be improved. The report states that the Speaking up culture was found to have improved from 2019 to 2020, with a correlation between CQC rating and respondents believing their organisation had a positive culture of speaking up. The results show that the vast majority of boards are directly accessible to FTSU Guardians. Over three quarters of those surveyed had presented reports to board meetings or equivalent in person, indicating the level of visibility being placed on the work of the FTSU Guardian role by senior leaders. There remain issues around support and detriment at other levels of organisations, which leaders must play an active role in tackling. Further detail can be found in the survey report.

ftsug_survey_report_2020.pdf (nationalguardian.org.uk)

Regional and System update

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

NHS White Paper

As previously reported, the White Paper sets out the creation of statutory integrated care systems (ICSs). These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body. The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together partners across systems to support integration and develop a plan to address the systems' health, public health, and social care needs.

The Trust continues to consider the implications of the White Paper in conjunction with system partners, noting the continued emphasis on the primacy of 'place' and development of 'collaboratives'. We are considering and will respond to the consultation on the new provider selection regime, which places emphasis on stability across the provider landscape to support local providers deliver quality services that provide value to their communities and support integration.

MH & LD Integrated Care Partnership

Since the last Board in February the ICP has continued to focus on the continued delivery of safe and effective services throughout the pandemic second wave, delivering the vaccination programme and planning for future demand.

In February the ICP identified that ensuring access to vaccinations for people with learning disabilities and/or severe mental illness, was an immediate priority. Great progress has been made in this area with over 70% of people with learning disabilities and over 53% of people with Severe Mental Illness having received their first vaccination. The Hertfordshire approach is being shared nationally as an exemplar of good partnership working.

The ICP is further progressing the demand modelling and mitigation work with the support of Niche Consultancy. Stakeholder interviews are now in progress and in April partners will work together to develop a strategic response plan which will be presented to the MHLD ICP Board in May and the ICS Partnership Board in June.

The ICP is now moving into the next phase of Partnership development, and over the next few months the ICP will be exploring collaborative operating models, commissioning budgets and seeking to further strengthen and formalising the Partnership, in line with the recent White Paper.

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

There is no change to the 'Go Live' extension period of 1 July 2021. There are ongoing negotiations between the Provider Collaborative and NHSEI regarding potential risk sharing arrangements, to mitigate the risks identified with the forecast increase in activity, particularly due to Covid-19. The conclusion of these discussions will enable both the full commercial business case and collaborative risk gain share agreement to be finalised, both of which are key Collaborative Agreement schedules. To ensure preparedness for Go live, HPFT continues to focus on completing financial due diligence for the Trust from the perspective of collaborative partner, lead provider and provider. The LD&F MD and Forensic LD clinical lead have completed a round of engagement with the regional ICS/STPs, and the clinical design and plans for a community forensic offer have been well received. System level meetings for CAMHS are scheduled during April to start aligning collaborative and ICS/STP plans, to ensure a coherent service offer for young people across the clinical pathway.

Finally, HPFT led a successful CAMHS Review meeting with NHSEI and ICS colleagues on 11th March. This session was arranged to provide colleagues with an opportunity to further explore the proposed clinical design and transformation and resulted in a wide ranging discussion recognising the challenges brought by Covid, workforce and timetables for transformation. Preparation for the joint Forensic MH/LD session scheduled for 7th April 2021 is now underway.

Scrutiny attendance

On 16 March 2021 the Trust attended the Hertfordshire County Council Health Scrutiny Committee to provide an update on the Trust's response to Covid. The meeting provided an opportunity to provide feedback on the position with regard to demand for CAMHs services and in particular how the Trust has responded to the impact of Covid on services users with a Learning Disability. The Trust also provided details of the recovery programme in place for both services users and staff and the work underway to ensure that all mental health and learning disability service users are offered the Covid vaccine.

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

Whilst, demand on services has remained high during March, services have stabilised and have moved out of business continuity as the number of Covid outbreaks and sickness has reduced. We continue to see high demand for CAMHS eating disorders, and across the adult community and in-patient pathway. Demand for acute beds and the impact of cohorting and outbreaks, has resulted in continuing use of out of area beds. As part of the acute pathway transformation, CQI is being used to continue to work on improving flow across the acute pathway.

We have seen a significant reduction of referrals into dementia services. This can be seen in the low numbers of referrals into EMDASS and in the under-occupancy of beds within the assessment and treatment units. This trend in referrals and low bed occupancy is being seen across the country and

appears to be a result of low GP attendance for dementia diagnosis, families reluctant to seek help, elderly people not being visited by relatives and picking up cognitive deterioration and very sadly a high number of deaths in the older people's population. Teams are working with GPs to encourage referrals.

IAPT services in North Essex have been focussing on the transition of services to Essex Partnership University Trust as our contract expires at the end of March 2021. Senior leaders have been working with staff who have requested an opportunity to remain in HPFT.

The six key areas of the service recovery plan continue to be worked on; current service pressures, demand modelling, performance, transformation, inequalities and workforce. The SBUs are working with the performance team to monitor demand into services in order to be able to respond appropriately and maintain performance. The priority for this work is to monitor the impact of schools returning on referrals into the CAMHS services. The Transformation Board are ensuring that the transformation programme supports the recovery plan in terms of demand management going forwards and improving performance against key indicators.

In recent weeks, there has been a national announcement that the GP Contract for 2021/22 includes a commitment to develop new mental health roles in primary care as part of the Additional Roles Reimbursements Scheme (ARRS). We are working with the PCNs to develop an approach that builds on our existing workforce, learning from the primary care pilots and GP Plus and aligns to our shared vision for community mental health. This may include consideration of the particular make up of PCN networks and what roles might best support these. This is an exciting development that will see a significant expansion of primary care interventions to meet mental health needs in local populations.

All the rehabilitation units have been successfully awarded AIMS accreditation.

Covid Update

Trust continues to have incident control cover 24 hours a day, 7 days a week to support the management of the level four incident. It is run in such a way as it has been flexed so it can be responsive to the needs of the incident.

During this phase of the pandemic the Trust has seen 14 different outbreaks in the inpatient services and a number of isolated positive cases in community although there number is now decreasing with 4 outbreaks currently being managed. Sadly 190 service users have died as a result of Covid during the pandemic, which the Trust is aware of.

Since, the last paper to Board, the COVID-19 vaccination programme and staff testing have continued to be with 85% of Trust staff had at least one dose of vaccine. All Trust staff now having access to regular Lateral Flow Testing (LFTs) and approximately 55% are submitting their results daily and 170 people have been found to be positive through this method, thereby mitigating the risk of transmission of the virus. We will continue to improve the compliance rates, working with staff and the networks.

Early in the vaccination programme the Trust successfully advocated successfully for people with a learning disability and mental illness to be able to access vaccinations and has supported this across Essex and Hertfordshire. The Trust is committed to ensuing all our service users have access to the vaccine and to that end the Trust is working with the vaccination hubs to ensure that all service users aged 16 years and over and open to CAMHs, Adult Community Mental Health Service, PATH (First Episode Psychosis), Perinatal and Adult Community Eating Disorder Service are invited for a vaccination. This will also apply to carer's of service user.

Essex CQC

Recently the Trust received formal notification that the CQC would be visiting the Mid and South Essex Learning Disability Services to undertake a Provider Collaborative Review (PCR). This PCR, is a system wide review and will focus on the provision of services for people who live with a learning disability in the community and consider how providers are working together to ensure the provision of learning disability services in light of COVID-19. The CQC will select LD cases for the review and speak to next key staff involved in this case and separately to the family and person. There will also be staff focus groups and the Managing Director will be interviewed. The PCR will not provide ratings but is an important piece of external assurance for the service, an update on the outcome will be provided to the Board when it is available.

Our People

During quarter three, our vacancy increased slightly, however, our Bank and agency fill rates remain above 90% for our registered and non-registered nursing shifts, which ensures that we can maintain safe staffing levels and great care. Our unplanned turnover and stability rate have both improved and remain within target. We are proactively recruiting to reduce our vacancy rate by the end of quarter four, in particular through our Healthcare Support Worker recruitment project.

We also launched our Winter Wellbeing programme, with 266 staff attending one of our virtual sessions, covering a wide range of wellbeing activities, such as exercise, craft, mindfulness and healthy eating. Whilst we have seen sickness absence increase from quarter two as the coronavirus pandemic entered a new phase at the end of the quarter, however the rate remained significantly lower than the same period of the previous year.

Our appraisal rates have increased significantly but the changing nature of the pandemic had an impact on achieving full compliance, both in relation to appraisal and mandatory training compliance. We have launched a new strengths based appraisal conversation approach.

Our focus is on our people recovery strategy, which comprises of five key pillars: paying witness to what's happened; rest and recuperation; reward and recognition; health and well-being; and keeping our people. These are underpinned by our Great Teams and Great Leaders work, continuing engagement and collective leadership, our just and inclusive culture and a person-centred, values driven approach.

Staff Survey

The 2020 annual staff survey results for the Trust have been published. The Trust achieved a response rate of 52%, (57% in 2019) compared to a median response rate of 49% among all other 52 Mental Health and Learning Disability Trusts which comprises a total of 52 trusts.

A report later on the agenda will provide details of report but it is worth noting that overall it is a positive set of results, particularly considering the year that the NHS has experienced. Over the ten themes in seven the Trust scored higher than the national average, with health and wellbeing, safety culture, support from immediate managers, morale, engagement and quality of care being most notable. Although the results are positive, there are areas we can improve on; in particular we will focus on equality, diversity and inclusion, especially in relation to career progression/promotion and as experienced from service users/relatives/the public; bullying & harassment, especially as experienced from service users/relatives/the public.; and Violence experienced by staff from service users/relatives/the public. We are now engaging with all our people to ensure that we have team, business unit and Trust level action plans to keep improving the experience of working at the Trust.

HSJ Awards

On the 17 March 2021 the Trust attended the HSJ awards event as the Trust had been shortlisted as a finalist in the Health Service Journal Awards, Mental Health Trust of the Year category. The event was compered by Sir Lenny Henry and showcased a wide range of the fantastic work by health and care providers during the last year. The Trust as successful and was announced as the Mental Health Trust of the year. The judges said "*was an outstanding entry and clearly showcased a values-driven, innovative, high-performing NHS organisation. The*

presentation was inspiring and really moving. One judge said they were blown away! And another said that everything sings and hums. There is an embedded learning culture supported through an Innovation Hub and Panel to enable continuous quality improvement. The approach to individual risk assessments demonstrated that the safety and wellbeing of both staff and service users is at the centre of everything the organisation does".

The award is a testament to all of the team at HPFT, for their continued commitment to our services, users, staff and carers.

Finance 20/21

The Trust is reporting an overall position of being on Plan for the period to 28 February 2021; this was break-even for the first 6 months; a deficit of £174k for the month of February; and deficit of £937k for the year to date. The deficit in Quarters 3 and 4 relates to the progressive increase in pay costs; and to significant cost pressures within external bed costs to meet additional demand or to provide specialist care not provided within HPFT's own services. This is in line with the revised forecast submitted by the Trust via the ICS, forecasting a £1.2m deficit.

Financial Plan 21/22

A full 12-month financial plan for the Trust is expected to be provided through the ICS for each Mental Health system and the full details of this planning requirement are awaited. The financial plan will be reviewed and this will enable a full discussion with commissioners and the system on the key financial drivers and the opportunities to influence these. At this point however we continue to forecast a range with a 'likely' outturn of deficit noting the uncertainties in key element of the planning assumptions and the identified mitigations that will be implemented to address the current projected deficit.

Senior Team

The process to recruit a new Executive Director of Finance is well underway. The search has identified a strong field and it expected that the recruitment process will be completed by end April. The recruitment process for a recent NED vacancy has also been agreed by the Appointments and Recruitment Committee and Council of Governors. It is hoped that this will be completed by the beginning of April.

Governance

The Trust Board recently held a workshop to discuss the draft report from the external well-led review. The workshop was facilitated by Deloitte and provided a great opportunity to consider the findings and agree next steps. The final report and associated action plan will be reported to the Board and Council of Governors at future meetings.

Preparations are underway for the Governor elections for 2021, with the results expected in early July. The Council of Governor sub-group meetings have also re started and provide an opportunity for Governors to be briefed and review the work of the Trust.

Tom Cahill

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 8
Subject:	Covid-19 Update	**For Publication:** No
Author:	Fiona McMillan Shields, Interim Managing Director, East & North SBU	**Approved by:** Dr Jane Padmore – Executive Director, Quality & Safety/Chief Nurse
Presented by:	Dr Jane Padmore – Executive Director, Quality & Safety/Chief Nurse	

Purpose of the report:

To update the Board on the current position in relation to the COVID-19 pandemic and its management.

Action required:

The Committee is asked to note and discuss the report.

Summary and recommendations:

Nationally and locally the Covid pandemic surge has been significant. Although there is now evidence that incidence rates and community transmission is decreasing the NHS remains at a high level of emergency preparedness, level 4, and the Trust continues to have incident control cover 24 hours a day, 7 days a week. The way this is run has flexed and been responsive to the needs of the incident.

The Trust has seen 14 different outbreaks in the inpatient services and a number of isolated positive cases in community although there number is now decreasing with 4 outbreaks currently being managed. 190 service users have died as a result of Covid during the pandemic that the Trust is aware of.

Since, the last paper to Board, the COVID-19 vaccination programme and staff testing have continued to be with in excess of 80% of Trust staff had at least one dose of vaccine. All Trust staff now having access to regular Lateral Flow Testing (LFTs) and approximately 55% are submitting their results daily and 170 people have been found to be positive through this method.

Oversight is maintained through the incident command structure and through the COVID-19 risk register.

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

Health and Social Care Act 2008 (Regulated Activities) Regulations

Regulation 12: Safe care and treatment

- Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is

as low as is reasonably possible. They should review methods and measures and amended them to address changing practice.

Regulation 17: Good Governance
- Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.
- Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.
- Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.
- Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate.
- Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.

Care Quality Commission Key Line of Enquiry; Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions

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

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

Equality & Diversity and Public & Patient Involvement Implications:

Individual risk assessments of BAME staff.

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

None

1. Introduction

1.1. Nationally and locally within the Trust COVID-19 infections and transmission rates have come down further since the last update to the board in February 2021.

1.2. This paper presents the current position and will update the Board on the work being managed through the ongoing incident command structure and the changes that have been made in response to management of the incident and associated activity.

1.3. The paper describes how the Trust has streamlined the incident response with the ability to increase should the need arise and concludes with an update on the COVID-19 related risks. It summarises how the Trust leadership and incident management structures have flexed to address and monitor these risks, remaining responsive to changes in need and demand.

1.4. The paper builds upon previous papers that have been to Board and the Integrated Governance Committee and will focus on updating the committee.

2. Current position

2.1. Nationally the incidence of COVID-19 has continued to decline. From 8 March in England Step 1 of the 'roadmap out of lockdown' began with the return of children to school.

2.2. Surveillance from the Hertfordshire system tells us that the Incidence Rate is now at 43 per 100,000, with the incidence rate for 60+ now down to 19.06 per 100,000. This reflects the national vaccination campaign success in reaching a significant proportion of older adults.

2.3. Within the Trust, the peak numbers of staff reporting Covid-related sickness happened over the Christmas and New Year period into January and has come down significantly over the 3 month period. The position is only 9 staff currently off sick with Covid on the 15th March. There are currently no positive cases of service users within our wards and that has been the case for the past 2 weeks (Table 1 and Figure 1).

	28 Dec	4 Jan	11 Jan	18 Jan	25 Jan	1 Feb	8 Feb	15 Feb	22 Feb	1 Mar	8 Mar	15 Mar
service users inpatient cases	12	16	32	38	26	23	12	9	10	5	0	0
Service users in community cases	15	16	78	137	117	83	62	34	16	16	12	8
staff inpatient cases	31	34	30	33	31	25	16	14	8	3	5	5
staff community cases	34	32	35	30	35	26	19	11	6	6	5	4
Total positive staff cases	65	66	65	63	66	51	35	25	14	9	10	9

Table 1 Covid Cases Inpatients and Staff

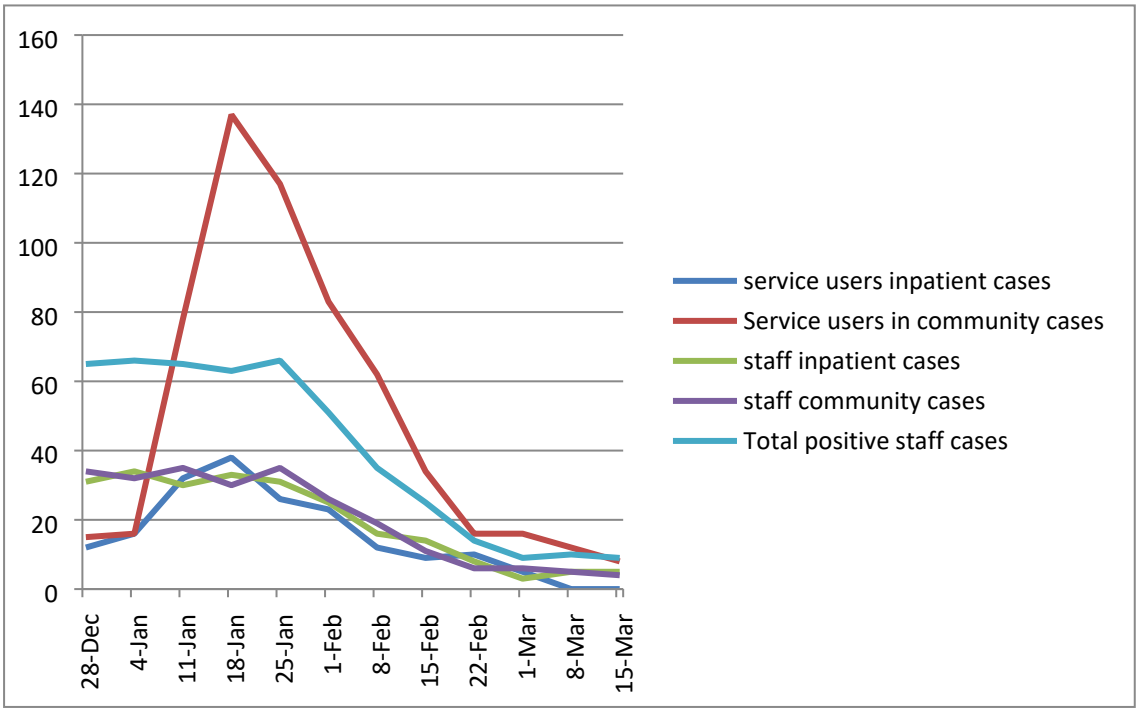

Figure 1 - Covid Cases Service users and Staff

2.4 The Trust has seen the number of outbreaks being actively managed come down during March to 4 active outbreaks that are all in the adult acute pathway; (Owl, Swift, Robin (post 14 days), and Albany (first 14 days). There is also one cluster of cases on Aston Ward.

2.5 The number of service user deaths reported has however continued to increase. There have been 190 Covid-19 related deaths of Trust service users, with 15 that were reportable. 168 were of Community service users and 34 were of in patients. These are distributed between the services as below;

LD&F - 26; East and North - 133; West -13; Essex and IAPT- 18.

2.6 The responsibility for the day to day management and assurance relation to infection prevention and control, including outbreak management, moved from the incident management to the Infection Prevention and Control team, business as usual, from 15th March 2021. Escalation to incident management will occur if incidents or outbreaks rise significantly or are impacting on staffing levels. Escalation may also occur if new guidance indicates an immediate, Trust wide change to practice.

2.7 Risk management and the admission or transfer of service users to and from outbreak wards continues to require Executive level sign off. Work is being undertaken to ensure that decisions taken regarding inpatient movement are made and communicated as early as possible in the morning to allow time, in hours, for timely completion.

2.8 Business continuity contingencies have been in place since Christmas for a small number of service areas and inpatient staffing arrangements continued to remain under pressure until the end of February, but without falling to emergency minimum staffing levels for inpatient areas for significant periods, enabling staffing to be sustained through very close operational management

on a 'shift by shift' basis. The additional measures of additional Bank staff booking that had been in place to cover last minute sickness has now been stopped.

2.9 A number of Trust services have instigated business continuity plans including children's eating disorders due to unprecedented recent and continued demand, adult community services in a small number of teams affected by staff sickness and in older adult inpatients also affected by staff sickness. The pressures are now easing on the community services and adult inpatient areas but have not decreased for children's eating disorders which continue to see a gap in the capacity available to manage the ongoing excessive demand. Further risk management and mitigation is being pursued with commissioners and primary care to manage this pathway safely.

3 Incident management

3.1 The incident has continued to be managed using the Trust framework presented in previous papers to the Board, with the addition of 'communication' which includes ongoing focus on:

- Infection prevention and control
- Service users
- Business continuity plans
- Our people
- Communication
- Infrastructure
- Leadership capacity & capability
- System & partnership working
- Governance

3.2 In response to the changing needs of the pandemic, the following changes to incident response structures were recommended and accepted by the Executive Team and will be operational from 21st March 2021. This demonstrates the incident command structure is responding to the needs of the incident whilst maintaining safe services.

Strategic Command

- The Executive Director Quality and Safety is the Strategic Commander 9am to 5pm Monday to Friday.
- When the Executive Director Quality and Safety is on leave, the Deputy Director Nursing, Quality and Safety will be the Strategic Commander.
- Out of hours the Executive on call will be the strategic commander.
- Strategic Command will formally meet with Tactical Command on Monday and Friday. Additions to this will take place as required in response to the incident.
- The Executive Team will use SPIKE to obtain the information about current infection numbers, absence rates and outbreaks or can request the current position directly by emailing the COVID inbox. The Strategic Commander will only email exceptions or escalating concerns.
- Weekly brief update reports will continue to the executive team meeting.

Tactical Command

- Tactical Commander rota will retain 4/3 day split and continue to be covered by all members of the SLT.
- Tactical Command meetings will reduce to twice weekly. On Mondays the full complement of participants, including communications, HR, finance and

facilities will attend and on Fridays IPC and operational will attend, with others invited as required.

Senior Nurse on call

- The Senior nurse on call rota out of hours will continue and be actively involved in ensuring safe and effective IPC practice.
- Tactical and Strategic meetings have been running on Monday, Wednesday and Friday with weekend activity significantly reduced and solely focussed on admission and transfers within the context of outbreak management.

Administrative support

- It is proposed that the administrative support to the incident command is reduced to 8am-5pm daily Monday to Friday and 8am-12noon at weekends, with the ability to increase if the outbreak management requires it.

4 Staff testing

4.1 The Trust programme of twice weekly staff Lateral Flow Testing for all Trust Staff has continued with staff expected to undertake the test every Monday and Thursday or Tuesday and Friday. This is a key part of the strategy for maintaining safe service delivery.

4.2 The reported numbers of staff undertaking twice weekly testing is monitored closely and has fluctuated between 45-60% of staff. There is continued effort to promote testing including performance monitoring with a dashboard of compliance available on Spike for all Teams and Service Lines; strong messaging every testing day via email in all staff communication and repeated in all staff email messaging; a joint statement made with the Chief Executive and Staff side has been issued and is being turned into a poster for staff areas and publicised via newsletters and compulsory meeting with all inpatient Team Leads organised to focus on ‘ Keeping Covid out of our wards’.

4.3 To date 170 asymptomatic staff members have been found to be positive through Lateral Flow Testing.

5 COVID-19 Vaccination programme

5.1 From January the Trust has been delivering its own vaccination clinics in multiple locations, including Essex and Norfolk, and now have in excess of 85% of Trust staff who have had at least one dose. Second dose clinics are now being planned. All staff that have not taken up the offer of the vaccination have had supportive conversations and the predominant reason being expressed for refusal is centring on family planning-related caution.

5.2 The Trust has advocated successfully for people with a learning disability and mental illness to be able to access vaccinations and has supported this across Essex and Hertfordshire. The UK Government is now inviting all people with a learning disability and individuals with schizophrenia or bipolar disorder, or any mental illness that causes severe functional impairment for a vaccination as per JCVI priority group 6.

5.3 The Trust is working with the vaccination hubs to ensure that all service users aged 16 years and over and open to CAMHs, Adult Community Mental Health Service, PATH (First Episode Psychosis), Perinatal and Adult Community Eating

Disorder Service are invited for a vaccination. This will also apply to carer's of service user.

6 Risks and challenges

6.1 COVID-19 has continued to present many risks and challenges to service users, staff and the organisation as a whole. These risks are managed through mitigation and contingency planning using the COVID-19 risk register, which is reviewed weekly in the command structure and presented weekly for scrutiny, to the executive team. The current risks are relating to quality, performance, workforce and infrastructure. Following review the following risks have been reduced

- **The Trust is unable to manage subsequent COVID19 Waves** (was 9, now 6) on the basis that the current wave has peaked and on the decline with the decision taken to streamline strategic, tactical and operational commands.
- **Unable to sustain safe staffing during COVID19** (was 20, now 15) on the following basis of a significant reduction in staff absence due to COVID19. Support measures in place for inpatient units have eased or ceased.

6.2 The pandemic presents risks to the Trust ensuring that core services continue to be delivered safely and effectively whilst performing well. This means preventing avoidable incidents and death both as a result of mental health and physical health problems, including infections. Engagement, assessment and treatment services have been adapted to be delivered in a safe way that remains responsive to need. In addition, risk assessment and management plans as well as RAG ratings continue to be reviewed regularly.

6.3 Robust leadership for infection prevention and control has been put in place at Trust, service line and local level which is supported by appropriate infection prevention and control policies, procedures and practice. Work is continually underway to prevent infections and is responsive if and when an infection or outbreak occurs.

6.4 The pandemic brings with it additional pressures on finances and resources. There is a risk that the work will not be maintained within the financial envelope. Also, the supply of essential clinical equipment, although currently robust, may be challenged as increased demand is present from the wider system. Partnership working within the system continues to prove essential.

6.5 All this is underpinned by the work with partners within the system and a communications and engagement plan that is aimed at service users, the workforce, partners and the public. The risks and ensuring a responsive approach are managed through incident management and the governance processes to assure this that have been put in place and are described above.

7 Conclusion

7.1 This paper has shown that nationally and locally the latest COVID-19 surge is declining and the Trust alongside the rest of the NHS is managing to plan, live and work with Covid.

7.2 The impact of staff Covid related sickness and absence has meant that a number of Trust services have been working to continuity plans, although most of these services are now reverting to business as usual, other than Children's community eating disorder services.

7.3 The Trust will continue to flex the levels of activity and support managed through the incident command according to national and local guidance and intelligence.

7.4 In conclusion, the Trust has retained robust oversight of the impact of the pandemic through the incident command structure, dedicated resource for the associated staff testing and vaccination programmes and continued review of the risks and mitigations in place to support continued delivery of effective and safe services.

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 9
Subject:	Integrated Governance Committee Report: 8 March 2021	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Diane Herbert, Non-Executive Director, Committee Chair
Presented by:	Diane Herbert, Non-Executive Director, Committee Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Integrated Governance Committee at its most recent meeting held on the 8 March 2021.

Action required:

The Board is asked to receive and note the report.

Summary and recommendations to the Board:

Summary

An overview of the work undertaken at the meeting held on 8 March 2021 is outlined in the body of the report.

Recommendation:

To receive and note the report.

a) Note that the Committee will be undertaking a deep dive into workforce planning and staff survey at its May meeting.
b) Approve the Board Assurance Framework as recommended by IGC.

Relationship with the Business Plan & Assurance Framework:

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

Summary of Financial, IT, Staffing and Legal Implications:

None.

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

The Committee regularly receives updates regarding Equality, Diversity and Inclusion.

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

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

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

None.

1. **Introduction**

1.1 The latest Integrated Governance Committee (IGC) was held on the 8 March 2021 in accordance with its terms of reference and was quorate. The meeting welcomed the new Associate NED, Kush Kanodia to the meeting and Karen Taylor in her role as Deputy Chief Executive.

1.2 The Committee was streamlined in terms of numbers of items discussed in recognition of the Trust's need to support start to focus on responding to the Covid pandemic and ensuring continued delivery of safe and high quality services. The agenda was organised around People, Quality and Governance to reflect the priorities of the Trust.

1.3 Under matters arising it was noted that the update on Infection Prevention and Control (IPC) Board Assurance Framework would be provided as part of the biannual IPC report, due to be considered at the May Committee meeting.

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

2.1 <u>People and OD Group</u>
The Committee received a report from the People and OD Group meeting held on 1 March 2021. It was reported that the meeting had received an update on the People Plan; restarting of the Great Teams programme; update on statutory and mandatory training, including the recovery plan; recruitment of health care support workers and plans for the Virtual Big Listen. The meeting also considered the headlines from the Staff Survey for 2020.

Two areas were particularly highlighted to IGC. The first of these related to an audit of supervision undertaken by the PACE team. The audit had been commissioned to ensure that the Trust was addressing the areas identified by CQC when they inspected in 2019. PODG were informed that the audit report highlighted areas for improvement and PODG had recommended the establishment of a multi-disciplinary working group to develop an action plan.

The second area highlighted for IGC was mandatory and essential training. PODG received a report setting out the mandatory and essential training recovery plans and trajectory for Intermediate, Paediatric and Basic Life Saving (ILS, PBLS and BLS), Respect, Basic and Advanced Patient Handling. The Group noted that each SBU had plans and mitigations in place and were asked to submit these in order to provide assurance. In addition, IGC heard that PODG has commissioned the Interim Head of Safety and Patient Safety Specialist to set up a task and finish group to increase the pace at which compliance will be achieved and to recommend an approach in relation to the Respect training model.

Following discussion, it was agreed that IGC would receive assurance on progress with both supervision and mandatory and statutory training through the quarterly People and OD reports to the Committee. It was also agreed that there would be a deep dive into the implementation of the MOSS Together strategy at a future meeting.

2.2 <u>Quality, Risk Management Committee (QRMC)</u>
The Committee received a report from the QRMC which had met on 24 February 2021. It was reported that East and North Herts SBU had presented an update on the transformation programmes in place as well as the quality and risk issues they were managing. The QRMC discussed the

increase in children safeguarding referrals. It was noted that a number of Allied health Professional staff had transferred from Anglia Community Enterprise and the integration of them into HPFT was underway. QRMC also received a report from Essex and IAPT SBU on their review of seclusion and rapid tranquilisation due to an increase in incidents. IGC were updated on the findings and the most up to date data which showed a reduction in incidents. In response to Anne Barnard's question, it was clarified that concerns in the report regarding organisational abuse did not relate to the Trust.

3. **People**

3.1 Quarter 3 People and OD

The Committee received a report that appraised it on the performance in quarter three against the key people and organisational development (OD) metrics and activity as set out in the Annual Plan.

It was reported that during the Quarter three, the Trust remained aligned with the People Plan Priorities. The Committee also noted the slight increase in the vacancy rate and the slight improvement in unplanned turnover and stability rates. It was noted that there had been a deterioration in the sickness absence figure, but it remained significantly lower than in quarter three of the previous year.

The actions to improve the position regrading appraisals and piloting the new strength-based approach were noted. The Committee heard that mandatory training compliance had reduced and had been impacted by the pandemic and recovery plans were in place to achieve compliance in 2021/22. There was a strong focus on staff engagement in quarter three; including 19th Big Listen and annual staff award ceremony

The Committee received an update on work underway in quarter four with regard to the recruitment of health care support workers and international recruitment.

Following discussion at the February Audit Committee IGC were updated on the recent internal audit report on Workforce Planning which had given partial assurance. IGC were informed that an action plan in response to the audit had been considered by PODG at its last meeting. It was agreed that workforce planning would be deep dive at the next Committee meeting. It was noted that as well as robust workforce planning processes there was a need to address vacancy hotspots. The Committee received an update on the current recruitment campaigns for Health Care Support Workers and trained nurses, including international recruitment. The Committee was assured that services were safely staffed due to the monitoring and management through safe staffing.

The Committee received an update on the staff survey, the details of which are embargoed until 11 March 2021. It was agreed that a detailed report of the results would be considered by a future Committee, including the proposed action plan.

3.2 Quarter 3 Guardian of Safe Working

It was reported that during the quarter there had been 11 exception reports raised by our trainees and Trust doctors. There had been a reduction in locum spend in comparison to quarter two, as a result of further cross cover

being implemented. The Committee was informed that during the reporting period the sickness absence and self-isolation following symptomatic /positive COVID test, resulted in on-call rota gaps. There were also a number of vacant rota slots due to LTFT (less than full time) trainees; the Committee was informed of the plan in place since December 2020 to reduce reliance on locums to cover the LTFT slots.

Asif Zia assured the Committee that the issues that had caused the exception reports had been resolved and the Trust continued to have the lowest reported exception reports in the Region.

3.3 Quarter 3: Safe Staffing

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

The Committee were updated that many services used significantly higher staffing levels than usual to address higher acuity and the resulting safe and supportive observations. It was reported that this quarter had continued with the increased scrutiny of how staffing is managed on a shift-by-shift basis and *SafeCare* is utilised resulting in strengthening the processes. The *SafeCare* contract had been renewed and additional functionalities will be explored in the quarter four. The committee were informed that bank and agency use has increased in the quarter and, as a result additional scrutiny and approval systems have been put in place to explore alternative and safe means of ensuring safe staffing levels.

The report outlined that there continued to be challenges, which are reflected nationally, in the vacancy rates for nursing staff which the Trust is addressing through a multifaceted approach to recruitment, developing the pipeline (introducing multiple roots to registration) and retention of staff generally and post retirement.

4. Quality and Safety

4.1 Quarter 3 Integrated Safety Report

The Committee received the quarter three report. The report provided assurance and the detail on the actions taken in response to safety related incidents particularly at a time of reported higher acuity on inpatient wards and increases in physical health needs.

Key highlights were: all Serious Incidents in process were completed within the expected timeframe with the majority of actions from investigations being completed within timescales; increase in overall reported incidents from the previous quarter and increase in incidents declared externally as serious incidents; number of unexpected deaths reported increased when compared to the previous quarter and the number of deaths thought to be through suicide was the same as per the previous; decrease in reported incidents of head banging; significant increase in ligature incidents; increase in unexplained injuries or witnessed falls resulting in a fracture when compared to the previous quarter; increase in reported service user to staff assaults in inpatient services; slight increase in the reported Absence Without Leave and Missing Person incidents; reduction in the total length of time in seclusion

compared to the last quarter; no incidents classed as Never Events; no category 3 or category 4 pressure ulcer incidents and a reduction in category 2 pressure ulcers acquired whilst receiving Trust care; number of individuals in Long Term Segregation at any one time remained the same this quarter; safeguarding adult referrals returned to expected levels following a drop in the previous two quarters.

It was noted that key staff had been trained to support the management of Long Term Segregation and there had been the introduction of the Covid Early Response Team. The Committee were informed that the use of National Early Warning Score2 had gone live across several wards. The quarter had also seen an internal audit of the Trust's Incident Management process and had reported reasonable assurance in place to manage this risk and ensure that there is learning from serious incidents which embed changes in process

The Committee supported the priorities for quarter four: of the continued roll out the National Early Warning Score2 across all inpatient services; integration of the Violence Reduction Standards into the MOSStogether Strategy; increased focus on the reduction of ligature incidents and launch the Patient Safety Dashboard on SPIKE.

Tim Bryson sought clarification regarding the patient safety dashboard, and it was confirmed that it would use live data. It was confirmed that the Trust were not an outlier with regard to number of learning disability service users as a result of Covid-19. In response to Anne Barnard's question, it was reported that the situation had improved on Dove ward with regard to feeling safe. It was agreed that proportion data with regard to incidents would be included in a future report.

4.2 Covid Update

The Committee were updated with regard to incident management and the well-established Trust processes and systems in place. It was noted that nationally had changed to level 4 and this had been reflected locally. The Committee considered the report that set out that the national picture of decrease in incidents and reduced pressure on all partners in the system.

The Committee received an update on number of cases, deaths and outbreaks in the Trust. The Committee were informed of the actions being taken to manage Infection Prevention and Control and ensure vaccination of staff and service users.

It was noted that guidance was still being issued nationally and the Trust was responding to and ensuring the Trust was compliant with.

4.3 Quarter 3: Health, Safety and Security Report

The Committee considered the report that provided detail of the health, safety and security incidents, the actions that have been taken, the assurance given and the priorities for the coming year. The key highlights were: slight decrease in violence and aggression incidents; refresh of the memorandum of understanding with the police; increase in RIDDOR reported incidents; work to fit additional anti ligature rails; security incidents; one worker devices and fire safety.

The report also highlighted the priorities quarter four: pilot and launch to health and safety audits; continue work to reduce service user to staff

violence and aggression by, completing the work of the community violence group including the review of CCTV in the community, develop and implement a communication plan in relation to violence and aggression to staff, identify and investigate unwarranted variation in the number and type of violence and aggression incidents across services and improve the return of the submission of flushing reports of little used outlets.

In response to Anne Barnard's question, it was confirmed that the Trust had changed the provider of lone worker devices to help with compliance and monitoring. Jane Padmore confirmed that the Trust was up to date with fire risk assessment and were addressing issues with regard to recording of evacuation procedures.

5. **Quality – Effectiveness**

5.1 Quarter3: CQI Report

The Committee received the quarter three report. At the start of quarter three the CQI Team were re-deployed to support Trust response to the latest phase of the pandemic. This included the vaccination programme and Incident Management command.

The Committee were informed that the redeployment impacted on CQI training. Innovation and change activities took place more on-line. The Committee were assured that there was increasing evidence that CQI is becoming more embedded in the Trust.

In response to Tim Bryson's question, it was confirmed Experts by Experience involved in CQI were supported by a member of the CQI team and received all appropriate training.

6. **Governance and Regulation**

6.1 Trust Risk Register

The IGC considered and approved updates to the Trust's Risk Register, including recommended changes to grading, new risks and updates in relation to the mitigations. It was noted that there were eleven risks under seven themes.

It was noted that a new risk was being added to the Register relating to CAMHS demand outweighing the capacity of services, both within general CAMHS and CAMHS Eating Disorder Services.

Anne Barnard sought clarification with regard to closure of the Winter Pressure risk, it was confirmed that the risk scored had been reduced and that supported the closure of the risk from the Register. Jane Padmore confirmed that the short-term finance risk remained on the Register as the Trust looked forward to quarter one of 2021/22.

In response to Diane Herbert's question, it was confirmed that the impact on recruitment and retention of the pay award for NHS staff would be monitored with regard to the risk to the Trust.

6.2 Risk Management and Board Assurance Framework Internal Audit Report
The Committee received the report on the Risk Management and Board Assurance Internal Audit undertaken in January 20212. It was noted that the audit formed part of the internal audit programme and supports the development of the Annual Governance Statement and feeds into the Head of Internal Audit Opinion for 20/21

It was reported that the audit had provided a positive reasonable assurance opinion and outlined that overall adequate controls are in place for the monitoring of risks across the Trust and within the Board Assurance Framework. The audit identified areas of improvement which led to five low priority actions, in the main to ensure consistent application of the defined processes within the Risk Management framework, including consistent formats of SBU risk registers and ensuring owners and timeframes are recorded for all mitigating actions.

6.3 Board Assurance Framework
The Committee received an update on the revised Board Assurance Framework (BAF) that is in line with Annual Plan for 20/21. The revised BAF had been updated to include the most relevant dates for Board, Committees and other groups, and details of the controls in place as a result of the systems and processes set up to respond to the Covid19 Pandemic. It also included feedback from the last Committee meeting.

In response to Anne Barnard's question, it was confirmed that the risk linked to section 136 suite is held on the Trust Risk Register rather than the BAF. It was agreed that the risks associated to the East of England Collaborative would be added to section 7.2.

Subject to the amendment above the Board Assurance Framework was approved for recommendation to the Board to approve.

6.3 Quarter 3: Quality Indicators
The Committee received a report that set out the Trust's performance with regard to the 2021/22 Quality Indicators noting that there was not a requirement for them to be externally audit for this year. The Committee were informed that the NHS improvement has not yet announced which priority indicators are mandated for mental health Trusts for 2021/2022.

Asif Zia confirmed that the Trust was on the trajectory to see improvement in the one quality indicator not being met by end of March 2021/22.

6.4 Quarter 3: Information Governance
The Committee were provided with a quarter three report for assurance. The key areas discussed were that: work on FOI requests had resumed with a significant backlog; work on SAR continues and priority is being given to police and court requests. The number of data incidents was discussed and noted that they predominantly related to primarily misdirected emails or correspondence. The Committee noted the open cases with the Information Commissioner.

The Committee received an update on the data breach relating to board papers.

7. **Recommendations**

The Board is requested to:

c) Note that the Committee will be undertaking a deep dive into workforce planning and staff survey at its May meeting.
d) Approve the Board Assurance Framework as recommended by IGC.

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Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 9a
Subject:	Quarter 3 2020/21 Integrated Safety Report	**For Publication: Yes**
Authors:	John Fanning, Interim Head of Safety Nikki Willmott, Head of Safer Care and Standards Andrew Cashmore, Practice Development and Patient Safety Lead Ingrid Richardson, Interim Head of Social Work and Safeguarding Anne Hunt, Interim Head of Nursing Physical Health and Education Dr Rakesh Magon, Clinical Director, East and North SBU	**Approved by:** Dr Jane Padmore, Executive Director, Quality and Safety/Chief Nurse
Presented by:	Dr Jane Padmore, Executive Director, Quality and Safety/Chief Nurse	

Purpose of the report:

This paper is presented to the Board of Directors to provide assurance on actions taken in Quarter 3 2020/1 in response to safety related incidents, themes, learning in keeping with the Quality Strategy, CQC regulations, and the commitments that are set out in the Annual Plan.

Action required:

Receive: To discuss in the integrated Safety report and its implications for HPFT.

Summary and recommendations:

The Committee is asked to receive and discuss the Quarter 3 Integrated Safety Report and its implications. This report has previously been received and discussed at the Integrated Governance Committee.

This quarter saw:

- All Serious Incident investigations were completed within the expected timescales
- The majority of actions resulting from Serious Incident investigations closed with only three overdue actions outstanding which are being addressed
- An increase in overall reported incidents from the previous quarter
- An increase in incidents declared externally as serious incidents
- The number of unexpected deaths reported increased when compared to the previous quarter
- The number of deaths thought to be through suicide was the same as per the previous quarter and remains on track to achieve the annual plan objective of a 10% reduction to the previous year
- The number of self-inflicted harm Serious Incidents remain the same in this quarter when compared to the previous quarter
- A decrease in reported incidents of head banging.
- A significant increase in ligature incidents (large numbers attributed to a small number of service users)
- An increase in unexplained injuries or witnessed falls resulting in a fracture when compared to the previous quarter
- An increase in reported service user to staff assaults in inpatient services
- A slight increase in the reported Absence Without Leave and Missing Person incidents
- A reduction in the total length of time in seclusion compared to the last quarter

- An internal audit of the Trust's Incident Management process found there was reasonable assurance in place to manage this risk and ensure that there is learning from serious incidents which embed changes in process
- No breaches of the Eliminating Mixed Sex Accommodation
- No incidents classed as Never Events
- No category 3 or category 4 pressure ulcer incidents and a reduction in category 2 pressure ulcers acquired whilst receiving Trust care
- The number of individuals in Long Term Segregation at any one time remained the same this quarter
- Key staff trained by MerseyCare on the use of the HOPE model to support the management of Long Term Segregation
- The introduction of the Covid Early Response Team, which offers support and clinical advice, focusing on proactive pressure area care and keeping service users moving while in isolation due to Covid-19
- The use of National Early Warning Score2 went live across several wards
- Safeguarding adult referrals returned to expected levels following a drop in the previous two quarters.

The priorities for Quarter 4 are:

- Roll out the National Early Warning Score2 across all inpatient services
- Integrate Violence Reduction Standards into the MOSSogether Strategy
- An increased focus on the reduction of ligature incidents
- Launch the Patient Safety Dashboard on SPIKE.
- All overdue Serious Incident actions to be closed and the Clinical Commissioner Groups' clarifications to be responded to within agreed timescales. Introduce the Trauma Risk Management Model across the Trust including a peer support system, to support and offer timely interventions post events.

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

Relation to the Trust Risk Register:

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

- **Quality and safety:** The Trust may not be able to sustain service user safety due to risks of COVID, flu outbreak and other winter pressures
- **Quality and Safety:** The Trust may not be able to sustain core operational services during the continued COVID19 outbreak, combined with winter pressures
- **Workforce:** The Trust is unable to maintain staff safety, wellbeing, morale during the pressures of Covid, winter and increased demand
- **Quality and safety:** S136: Unlawful detention of service users under S136 breaching beyond 24hrs which has legal implications and an impact on service user care, treatment and experience
- **Workforce:** Insufficient workforce to meet predicted increase demand and deliver commitments in Long Term Plan
- **Workforce:** The Trust is unable to maintain staff safety, wellbeing, morale during the pressures of Covid, winter and increased demand

Relation to the BAF:

1. We will provide **safe** services, so that people feel safe and are protected from avoidable harm.
2. We will deliver a great **experience** of our services, so that those who need to receive our support feel positively about their experience

3. We will improve the health of our service users & support recovery through the delivery of **effective** evidence-based practice 4. We will **improve, innovate and transform** our services to provide the most effective, productive and high-quality care 5. We will deliver **joined up care** to meet the needs of our service users across mental, physical and social care services in conjunction with our partners

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

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

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

There are no implications arising from this report.

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

This report sets out actions taken in Quarter 3 2020/21 as part of the Care Quality Commission Key Lines of Enquiry.

Seen by the following committee(s) on date:

Quality and Risk Management Committee- 18th February 2021 Integrated Governance Committee (IGC)- 8th March 2021

Quarterly Integrated Safety Report Quarter 3 2020/21

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 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. IPC, Safe Staffing, Health and Safety related matters, including RIDDORs are addressed in other 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 to the objectives and achieving the outcomes within the Annual Plan.

2. Priorities

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

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

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

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

3. Trust Risk Register

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

- **Quality and safety:** The Trust may not be able to sustain service user safety due to risks of COVID, flu outbreak and other winter pressures
- **Quality and Safety:** The Trust may not be able to sustain core operational services during the continued COVID19 outbreak, combined with winter pressures
- **Workforce:** The Trust is unable to maintain staff safety, wellbeing, morale during the pressures of Covid, winter and increased demand
- **Quality and safety:** S136: Unlawful detention of service users under S136 breaching beyond 24hrs which has legal implications and an impact on service user care, treatment and experience
- **Workforce:** Insufficient workforce to meet predicted increase demand and deliver commitments in Long Term Plan
- **Workforce:** The Trust is unable to maintain staff safety, wellbeing, morale during the pressures of Covid, winter and increased demand.

3.2. The Trust Risk Register report was last presented to the IGC on 11th November 2020 providing additional information about the work being undertaken to address and to mitigate against these risks.

4. Health and Safety Executive

4.1. Following the Health and Safety Executive (HSE) inspection in May 2019, an update report was presented to the IGC, regarding the regulatory notices which have been formally closed and previously reported.

4.2. The Trust received correspondence from the HSE in November 2020 following concerns raised with them by a driver in the Trust's Transport department, regarding standards of health, safety and welfare, whilst transporting vulnerable children and adults. The Trust was already aware of these concerns through an incident and a complaint and an investigation had taken place.

4.3. The Trust fed back to the HSE the findings of the investigation and action and the HSE closed the query. The learning included the reiteration to all staff the requirement for risk assessments to be undertaken prior to transporting all individual service users and ensuring the provider of the transport at the time of the request is informed of any risks identified and assessed with transporting an individual service user, and advised of the mitigations in place.

5. Safety Alerts

5.1. This section gives an overview of the safety reports, internal and external, that the Trust has actioned this quarter. An issue was highlighted with regard to two safety alerts not being closed in a timely manner. In response, the system for managing and escalating safety alerts has been strengthened in this quarter.

5.2. There were a total of 37 Central Alerting System (CAS) Alerts received from 1st October 2020 - 31st December 2020, including 1 Patient Safety Alert, 20 Medication/Drug Alerts (including supply distribution alerts), 2 Field Safety Notices, 10 Other External Alerts, 4 HPFT Internal Alerts issued.

5.3. There were 2 alerts in this reporting period with actions overdue**:**

- **NHS/PSA/RE/2018/003: Resources to support the safe adoption of the revised National Early Warning Score (NEWS2)**
  13 inpatient services (including all older aged adult services) and the Section 136 Place of Safety Suite (S136) have all gone live with NEWS2, with 8 inpatient services requiring further training. There has been some impact on the progress with the training due to the Covid-19 pandemic. A video regarding how to complete physiological observations is also available on the Hive. The Trust's Covid Early Response Team (CERT) are providing training and assessment of competency across the service areas. An audit of completion of NEWS2 forms will be completed during quarter 4.
- **FSN86100186: Phillips HeartStart AED Field Safety Notice**
  This alert affects 38 of the Trust's Automated External Defibrillators (AEDs). The Trust has received confirmation from Phillips that these do not need to be taken out of service. Replacement devices have been received by the Trust and have been distributed.

5.4. There are 2 open alerts with deadlines within date:

- **NatPSA/2020/006/NHSPS Foreign body aspiration during intubation, advanced airway management or ventilation**
  ECT have confirmed they have received the alert and, since then, have changed the electrodes – on the basis that the alert identified that the most common types of foreign body identified in incident reports were transparent backing plastic from

electrocardiogram (ECG) electrodes and plastic caps of unclear origin. The compliance and risk team are awaiting confirmation that all actions in the alert have been completed. The deadline is 1st June 2021.

- **NatPSA/2020/005/NHSPS Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults.**
  There is an action plan in place led by the Chief Pharmacist and the Lead Clinical Pharmacist and Medication Safety Officer. The deadline is 13th May 2021.

6. Conclusion

6.1. This section of the report has set out how assurance is received in relation to safety and how all intelligence relating to safety is triangulated effectively. It demonstrates robust reporting but has highlighted an issue with two safety alerts not being closed in a timely manner. The system for managing and escalating safety alerts has been strengthened in this quarter.

Part B- INCIDENTS INCLUDING SERIOUS INCIDENTS

1. Introduction

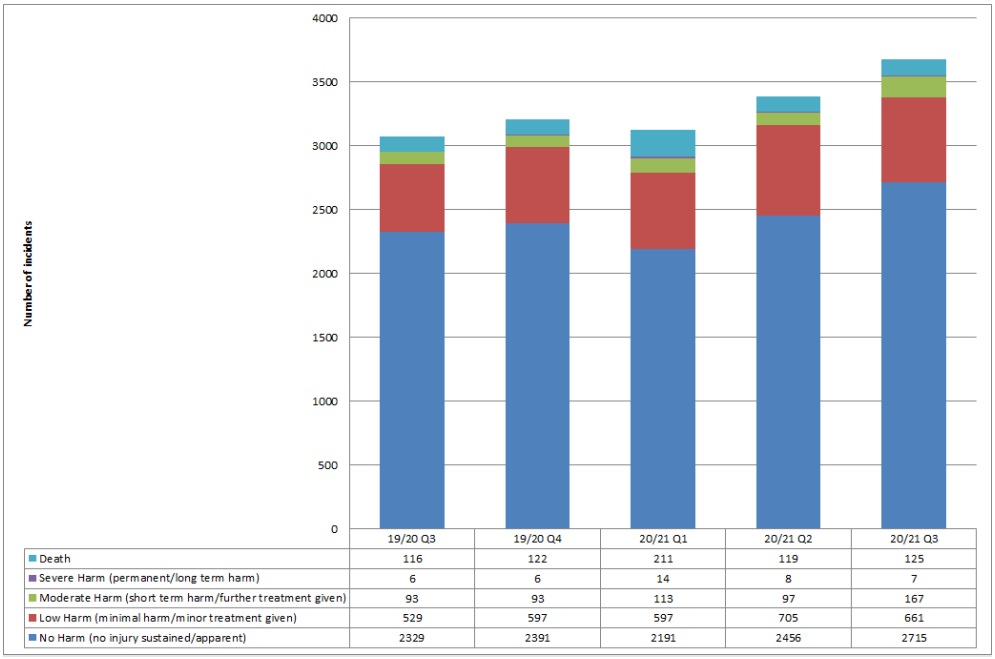
1.1. Part B of the safety report specifically considers incidents, including serious incidents. It begins by giving an overview of reporting trends and then goes on to explore themes and trends as well as severity of harm. How the Trust meets its Duty of Candour is detailed and then specific attention is given to mortality governance and suicide rates. It concludes with never events.

2. Incidents

2.1. Patient (service user) safety incidents are defined as *'any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting those supports the NHS to learn from mistakes and to take action to keep patients safe*.' (NHS Improvement 2017). This section of the report considers the quality and type of incidents reported.

2.2. The total number of incidents reported on Datix in quarter 3 was 3,675, an increase from 3,329 reported in the previous quarter and also in comparison to the same quarter in 2019/20 (3,073).

2.3. The number of incidents graded as moderate or severe harm increased (174), when compared to quarter 2 (105) (Chart 1). The weekly Moderate Harm Review Panel, where incidents of moderate harm and above reported on Datix are reviewed and Serious Incidents (SI) are called, has continued throughout the pandemic.



	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2	20/21 Q3
Death	116	122	211	119	125
Severe Harm (permanent/long term harm)	6	6	14	8	7
Moderate Harm (short term harm/further treatment given)	93	93	113	97	167
Low Harm (minimal harm/minor treatment given)	529	597	597	705	661
No Harm (no injury sustained/apparent)	2329	2391	2191	2456	2715

Chart 1: Incidents and level of harm

2.4. The increase in moderate harm incidents in this quarter has been due, primarily, to an increased focus on ensuring incidents of service users and staff testing positive for Covid-19 being recorded on Datix. Safeguarding incidents remain a challenge to categorise as actual harm is often unclear at the time of reporting; staff therefore, often choose moderate or severe harm for incidents of this type.

2.5. Reporting of incidents continues to be and, with the exception of quarter 1 2020/21 (first pandemic wave), incident reporting has continued to increase quarter on quarter, arguably a sign of a safe culture, were reporting is encouraged.

Never Events

2.6. Never Events are specific categories (determined by national guidance) of event that are serious and largely preventable safety incidents that should not occur if the available preventative measures are implemented. The Trust reported no incidents that would meet Never Events criteria during this quarter.

Eliminating Mixed Sex Accommodation (EMSA)

2.7 Due to the Covid-19 pandemic and the need to release capacity across the NHS to support the response, NHS England and NHS Improvement (NHSE/I) have paused the collection and publication of official statistics, including EMSA with a further temporary suspension EMSA until March 2021. Despite this, the Trust has chosen to self-monitor EMSA and there were no breaches. Managing EMSA has been challenging during the Covid-19 pandemic, with the additional complexity of cohorting service users, but work has ensured breaches have not taken place.

National Reporting and Learning System (NRLS)

2.8 The Trust reports patient safety incidents to the NRLS in accordance with the national guidance. For the NHS as a whole, there was a slight decrease in the number of incidents reported to NRLS. The Trust reported 35.5 incidents per 1000 bed days, an increase from the previous reporting period; this is against an average for mental health trusts of 57.9. The National Reporting and Learning System (NRLS) indicates that for the period October 2019 – March 2020 shows that the incident reporting rate was slightly higher when compared to the previous 6 months and did not indicate that there was evidence of potential under-reporting.

Serious Incidents (SI)

2.9 SIs in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified' (*Serious Incident Framework 2015)*.

2.10 The Trust reported 46 SIs external to the Trust in Quarter 3 2021, compared to 26 in the previous quarter. The number of unexpected deaths reported in quarter 3 increased (19) when compared to the previous quarter (11). This increase is primarily attributable to an increase in unexpected deaths, slips, trips and falls and violence and aggression (Table 1).

2.11 Further exploration of this will be undertaken through the investigation process but initial findings indicate that the impact of deconditioning on service users in the Trust's older aged adult services is being explored through the Falls Group and the Physical Health Committee. Violence and aggression may be in response to frustrations at the restrictions seen during the pandemic.

2.12 Of the 19 service user deaths reported as an SI in quarter 3, 4 were reported retrospectively and therefore occurred in previous quarters. 14 were males and 5 were females; 2 occurred in the Trust's inpatient services (Robin and Beech) and 9 involved service users in the Trust's Adult Community Mental Health Services.

StEIS Category	Q2 2020 /21	Q3 2020/ 21
Unexpected/avoidable deaths	11	19
Apparent/actual/suspected self-inflicted harm	9	9
Disruptive/aggressive/ violent behaviour	2	6
Slip/trip/fall	1	6
Personal accident	1	0
Safeguarding Adults	0	1
Safeguarding Children	0	0
Unauthorised absence	0	0
Practice & Clinical Care	1	2
Sexual assault	1	0
Confidential information leak/information governance breach meeting SI criteria	0	1
HCAI/Infection control incident meeting SI criteria	0	2
TOTAL	**26**	**46**

Table 1: Serious incident categories

2.13 The number of self-inflicted harm serious incidents remained the same in this quarter (9) when compared to the previous quarter. Of the 9 self-harm SIs, 7 were females and 2 were males and 2 involved service users on Thumbswood, 2 involved service users in Adult Community Services and 2 involved services users in the Trust's Child and Adolescent Mental Health Services (CAMHS). The remaining cases were across 3 other teams.

2.14 Key learning to date from the SI this quarter includes:

- Communication with primary care
- Did Not Attend
- Dual Diagnosis
- Carer identification and involvement
- Collateral information gathering
- Record keeping
- Risk formulation
- Risk assessment documentation
- Safeguarding
- Observation and search procedures
- Falls risk assessment and management.

2.15 The impact of the pandemic on service users' mental health has been identified in recently completed SI reviews which have included worries about lockdown or contracting Covid-19, struggling with working from home, loss of job, relationship difficulties, and isolation impacting on access to usual support network.

2.16 Actions taken in response to the learning is included within the action plan for each SI and a summary is included in Part C of this report.

Ethnicity Data

2.17 From this quarter, the Trust will report on ethnicity data for SIs to consider any potential additional learning in keeping with the National Inclusion Strategy.

2.18 New SIs are considered and called at the weekly Moderate Harm Review Panel and occasions when they are called by the Strategic Business Unit (SBU) outside the panel if, for example, it is clear that an incident meets the SI reporting criteria. Three Day Fact Find Reports did not record ethnicity data but this has been added to enable monitoring and responsiveness to any identified issues early.

2.19 In quarter 3, the majority (30) serious incidents involved service users of White British origin and the next highest category was Not Stated (10) (Table 2). Of note, in 3 SIs, there was more than one service user involved and StEIS does not provide an option for recording this data.

Ethnic Group	Number Reported on StEIS
White British	30
Not Stated	10
White Other	2
Black or Black British Caribbean	1
Black or Black British Other	1
Mixed White Asian	1
Not Applicable	1
Total	**46**

Table 2: Ethnicity data for serious incidents.

2.20 At present it is not possible to extrapolate the ethnicity data for all incidents (other than SIs) as ethnicity not a mandated field in Datix. The Trust are currently exploring options for when the current contract with Datix ends, in quarter 1, and this will be a priority when procuring the replacement incident reporting system. Further work in this area is highlighted as a priority for future work later in the report.

Duty of Candour

2.21 The Trust's Duty of Candour policy sets out the requirement to meet the Statutory Duty and this is assessed through the Quality Schedule. The Trust's SI reports have a Duty of Candour section which includes contact made with a service user or family member post incident, a Duty of Candour letter having been sent and information gathered from the service user or family to inform the review process. The full reports are routinely shared with the service user or family on conclusion of the review.

SI Process Improvements

2.22 Work has continued in this reporting period to address the timeliness of Root Cause Analysis (RCA) completion in line with the National reporting framework. In quarter 3, work continued to maintain this and to address the overdue action plans. At the end of Q3 significant progress has been made to close any outstanding actions and respond to outstanding clarifications. By the end of Q4 we are on target to have non overdue actions plans or outstanding clarifications. The Safer Care and Standards team have been attending both Herts CCG's SI panels on invitation to respond to any clarifications the panel have in person which has enabled a more efficient and timely response.

2.23 The Trust successfully maintained its position of having all RCA reports submitted within 60 working days timeframe. At the end of the quarter there remained 11 action plans that continued to be overdue, down from 58 at the beginning of the quarter. At the time of writing this were 2. Balancing getting closure with robust assurance that they had been completed to a high standard, whilst managing the pandemic, led to deciding it was preferable to be overdue and have robust assurance.

3 Mortality

3.1 This section considers mortality and encompasses mortality governance including Learning Disability Deaths Reviews (LeDeR), suicides and prevention of future death (PFD) reports.

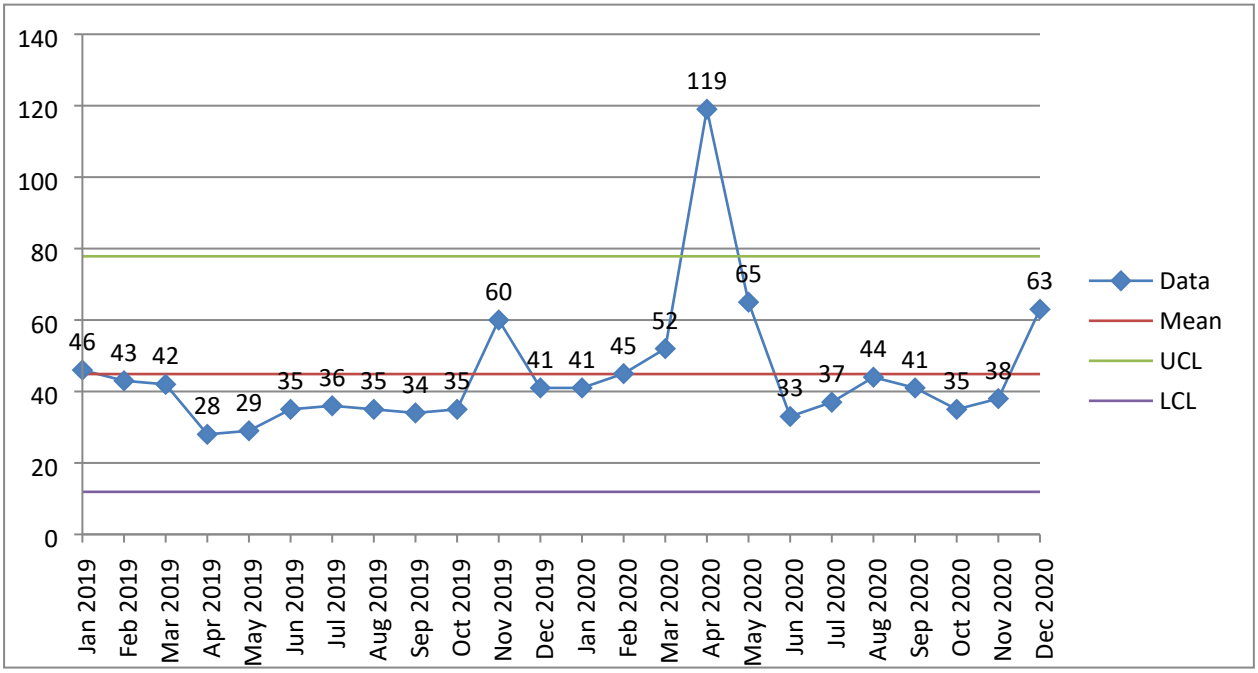
Structured Judgement Reviews

3.2 In line with national guidance on learning from deaths, the Trust monitors and publishes mortality data quarterly through the Integrated Safety Report. All deaths are considered in the mortality governance process and are screened to identify whether a Structured Judgement Review (SJR) should be undertaken. A SJR is completed on any death meeting red flag criteria, with data analysis used to inform improvements in care.

3.3 A total of 19 SJRs were completed in quarter 3. The SBU has oversight of the SJRs, cascaded down to the relevant teams through the Practice Governance structures. The Mortality Governance team has not identified any deaths in quarter 3 where care concerns are thought to have contributed to the outcome for service users.

3.4 It should be noted that there is a data lag in the reports and the figures may change in subsequent reports. There is evidence of the 'potentially deceased' mortality dashboard introduced in quarter 3 on SPIKE is aiding timely recording of deaths on the Electronic Patient Record (EPR) and screening of deaths.

3.5 The number of deaths increased as a result of Covid-19. Indications are that April 2020 was the peak month for deaths from the start of the financial year 2020. The volume of deaths increased in August and December in line with the national picture (graph 1).



Graph 1 Number of deaths

3.6 125 deaths were reported in quarter 3, a slight increase of 4 compared with the previous quarter. Fluctuations in numbers are expected, particularly in view of the pandemic, and the higher numbers of deaths have occurred in the older aged adult services (table 3).

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
East and North Hertfordshire SBU	89	44	25	22	24	32	21	19	37
Essex & IAPT SBU	6	6	3	5	6	3	4	3	3
Learning Disabilities & Forensic SBU	11	9	1	3	8	1	2	5	7
West Hertfordshire SBU	10	3	3	7	6	4	7	10	7
Total	116	62	32	37	44	40	34	37	54

Table 3 Number of deaths in each SBU per month

Covid-19 deaths

3.7 The total number of confirmed Covid-19 deaths, from April – December 2020, was 97. The total number of confirmed Covid-19 deaths this quarter was 20, 10 male and 10 female. There were no deaths reported to the Covid-19 Patient Notification System (CPNS).

3.8 Age at death ranged from 34 to 95 years (table 4) with most in the 75-84 age range. All 7 service users in the 35–54 range had a learning disability. A 75-year-old individual with a learning disability was on end-of-life care with a Do Not Attempt Resuscitation (DNAR) in place. 9 were in the older aged adult services; 3 over the age of 75 were seen by Mental Health Liaison Team (MHLT) in the acute general hospital.

Age range	No.
35 - 44	3
45 - 54	4
65 - 74	1
75 - 84	6
85 - 94	5
95	1

Table 4 Age of those who have died with COVID 19

3.9 10 individuals had confirmed Covid-19 as their cause of death, with a further 2 who were diagnosed with Covid-19 but not stated as a cause. 8 individuals did not have a cause of death recorded although had been informed that the service user died of Covid-19.

3.10 With the exception of 1 individual who was an inpatient since October 2020, all were service users in the community with 17 dying in an acute general hospital and 3 at their care home. 4 individuals lived alone with help from carers or family and all others within a care home setting.

3.11 Among the comorbidities were Downs Syndrome, Epilepsy, Dysphagia, Dementia, alcohol dependency, B12 deficiency, Diabetes, Hypothyroidism, Urinary Tract Infection (UTI), falls, carcinoma and obesity. Some had been admitted to an acute general hospital due to physical illness and subsequently died of Covid-19.

3.12 A rapid review of the deaths of service users, with a learning disability, from COVID, was undertaken for the period up to the end of quarter 3. In summary this found:

- Of the 141 deaths in total of service users known to HPFT (at 22/1/21), 29 (1/5) of these had a learning disability, 13 of which have been since November.

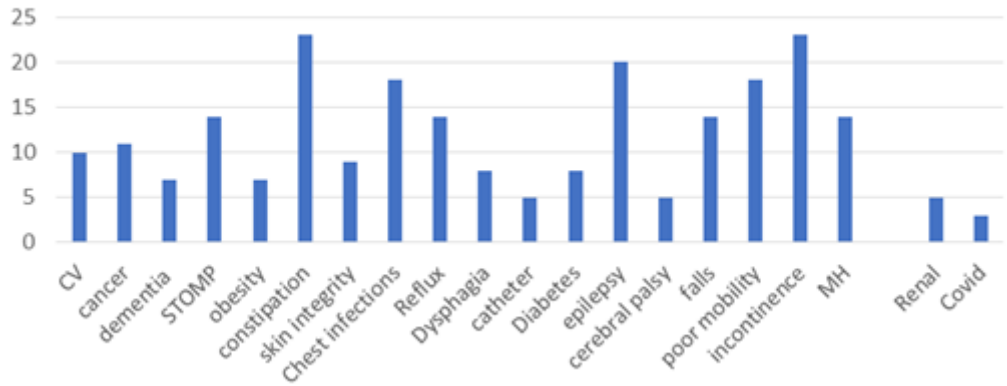
- 23 died in hospital but only one was ventilated. Only one person has a DNACPR and they died at home.
- Average age of death for those with a Learning Disability was 60, whereas in the non-learning disability population it was 79.
- No deaths were in the Trust in patient services,
- The majority of service users (22) lived in residential/care homes. 5 service users lived in supported living accommodation and 2 service users lived with their families.

3.13 These concerns have been raised within the ICS to gain an understanding of this is a picture elsewhere and to ensure action is taken on the immediate concerns. The acute Trust have agreed to review their Emergency Treatment Plans (ETP) for those people with a learning disability who are currently in patients.

LeDeR

3.14 The total number of deaths of people with a learning disability was 14, lower than the figure for the same period last year, which was 26. All deaths of people with a learning disability are referred to the LeDeR programme. A SJR is completed if it meets red flag criteria.

3.15 Of the summary of cases discussed at the LeDeR case review meeting in Hertfordshire in December, the average age at death was 63. A majority died at hospital and had White British recorded as ethnicity. A high proportion of the reviews revealed the need for provision of equipment and lacked evidence of a completed Annual Health Check. There were several comorbidities linked (graph 2). Not all those reviewed were under the care of the Trust.



Graph 2: LeDeR review comorbidity in Hertfordshire

3.16 Good practice was evident from the SJRs completed. Documentation was an area that has improved, particularly with contemporaneous record keeping. Physical health was monitored well with recognition and prompt escalation of any issues. Medicines reconciliation was prompt and discussion of concerns was evident.

3.17 From the learning, key areas to learn from included:

- Antipsychotic medication
- Documentation
- NEWS chart
- End of life care medication
- Follow up
- Initial assessment
- Mental health monitoring

- Physical health
- Risk assessment.

Suicide

3.18 The Annual Plan sets out a minimum of 10% reduction in the number of deaths that are thought to be as a result of suicide. In quarter 3, the number of deaths that were thought to be as a result of suicide was 12; the total number of deaths thought to be as a result of suicide for 2020/21 to date is 33 (table 5). The Trust acknowledges that each death is one too many and continues with its zero ambition.

	Q1	Q2	Q3	Q4
2019/20	10	13	13	12
2020/21	9	12	12	

Table 5 Suspected suicides

3.19 When a death is reported and thought to be a suicide, it is included in the Trust's data set as a suspected suicide. It is investigated and followed through inquest to the outcome (graph 2)**.** The Trust will classify as suspected suicide until the outcome of the inquest is known. Every quarter since quarter 3 2015/16, has shown that at least 1, and at most 8, per quarter have been returned as not being a suicide.

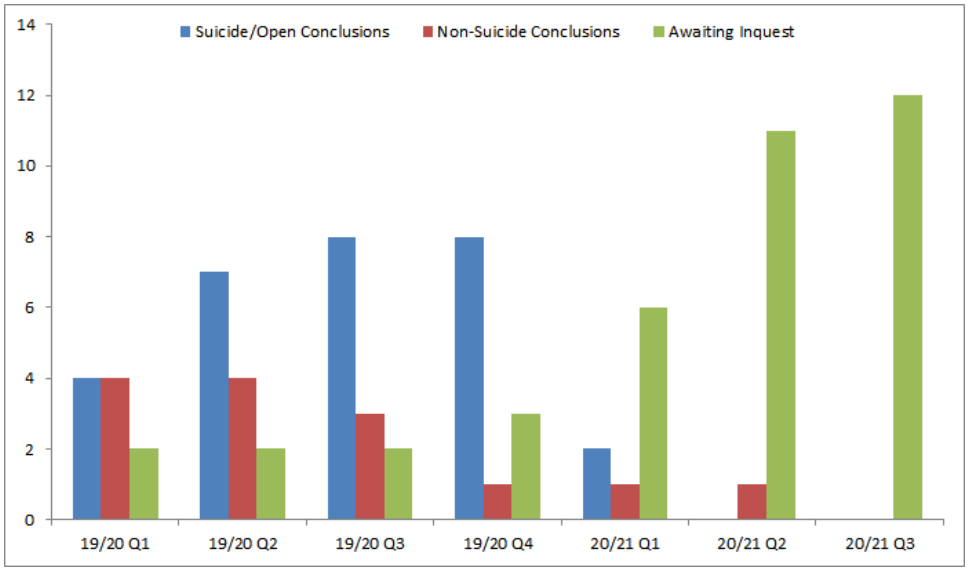


Chart 2 Inquest verdicts over time

3.20 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). 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 but historical data can be found in previous reports.

3.21 The Trust is represented on Hertfordshire's Suicide Prevention Programme Board which aims to provide strategic leadership and oversight of the suicide prevention programme being delivered across Hertfordshire. The vision is to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option. The Trust has contributed to the refreshed strategy.

3.22 The Trust's Zero Suicide Action plan is based on the principles of the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) 10 ways to improve safety and progress against the plan is monitored by the Trust's Suicide Prevention Group.

Prevention of Future Deaths Reports (PFDs)

3.23 Coroners have a statutory duty to issue a PFD report to any person or organisation where, in the opinion of the coroner, action should be taken to prevent future deaths. The report is sent to whoever the coroner believes has the power to take such action and the recipient then has 56 days to respond. In quarter 3, the Trust received no Regulation 28 PFD reports from HM Coroners.

3.24 Whilst it is acknowledged that PFD reports only provide a snapshot of evidence heard at an inquest and therefore have some limitations, these reports provide an opportunity to review processes and systems and reflect on whether any actions are required. PFD reports are disseminated to Clinical Directors and Managing Directors in each of the SBUs, Subject Matter Experts (SME) and are considered at the Safety Committee.

3.25 A total of 7 national publications of PFD reports were deemed relevant for the purposes of learning. Key areas of learning included:

- Quality of record keeping
- Blood test result confirmed high level of Clozapine, which was not escalated and Clozapine dose was not adjusted
- Understanding about the importance of monitoring Clozapine levels
- Ensuring prescribers work with reference to the up-to-date edition of any resource on which they rely for prescribing guidance
- Ensuring risk assessments are completed for service users going on leave and share with relevant staff
- Failure to carry out a Venous Thromboembolism (VTE) risk assessment
- Quality assurance of the Discharge Summary Letters.

3.26 Learning from PFD reports is discussed at the Safety Committee and SBU Quality Risk Meetings for onward dissemination and has informed suicide prevention work streams, as well as used in safeguarding training.

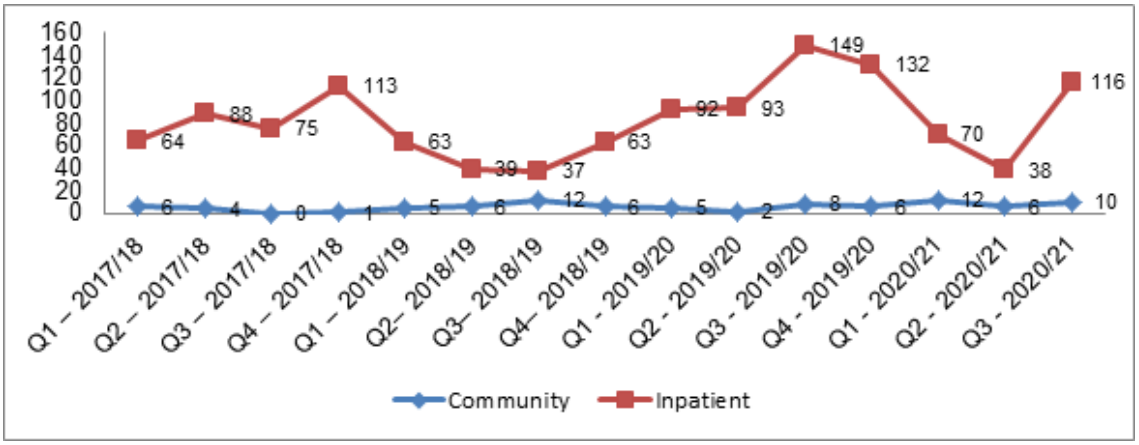
4 Harm free Mental Health Care

Self-harm – ligature incidents

4.1 There were 116 ligature incidents reported across the Trust's inpatient services, which shows an increase of 68 incidents (179%) compared to the 38 incidents reported in the previous quarter (Graph 2). There were 10 ligature incidents reported in the Trust's community services, including Learning Disability, Adult, Wellbeing services and CAMHS.

4.2 Analysis of this increase shows that Robin ward reported 40 incidents (34%), Albany Lodge 37 (32%) and Forest House Assessment Unit (FHAU) 13 (11%). There were 3 service users who accounted for a total of 67 (58%) incidents, with 1 individual accounting for 41 (35%) incidents at both Robin ward (10) and Albany Lodge (31). The other 2 individuals were from Robin ward and accounted for 17 (15%) and 9 (8%) incidents respectively.

4.3 Further analysis demonstrates that 1 service user accounted for 84% of ligature incidents within Albany Lodge and 3 individuals accounted for 90% of incidents within Robin ward.



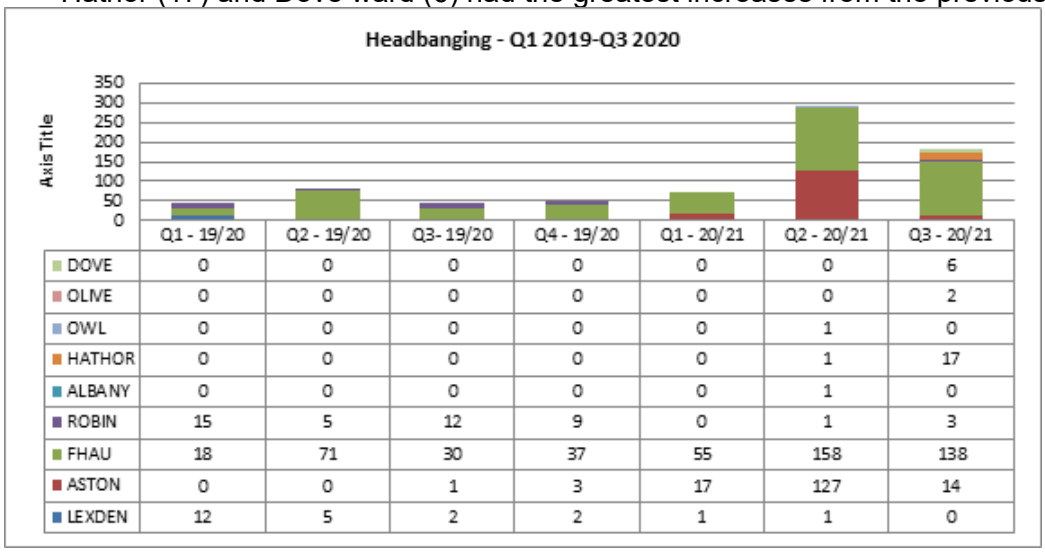
Graph 2: Ligature incidents in the community and in patient services.

4.4 There were 8 reported anchor point ligature incidents. 5 were on Albany Lodge, of which 4 involved radiators and 1 a sanitary bin. Action was taken to manage these risks, with specific and targeted Safety Plans and a Learning Note with regards to risks relating to Sanitary Bins. This was also shared on the National Directors of Nursing Forum. All sanitary bins on Albany Lodge were replaced with disposable 'Bunny' bins to manage the initial risk. Additionally, an alternative bin has now been sourced from another supplier that does not have a handle and this will replace the current sanitary bins.

4.5 There were also singular reported incidents on Aston Ward, Logendene and Robin ward involving a door, curtain and shower, which were individually risk assessed with plans put in place. Ligature incidents using clothing remains the highest reported category with 47 of the 116 reported (41%). Additional work is being undertaken to review standards around anti-tear clothing as a proportional response to the challenges of clothing based on a case-by-case review.

Self-harm – headbanging

4.6 There has been a decrease in reported incidents of head banging from 290 to 180 incidents, with Aston Ward reporting a decrease of 113. The number has not returned to the previous low levels and work will continue to reduce the number of incidents. FHAU numbers remain the highest reporting 138. The three service users with the most reports of headbanging were from FHAU, accounting for 81 of the 180 (45%) incidents. Hathor (17) and Dove ward (6) had the greatest increases from the previous quarter.

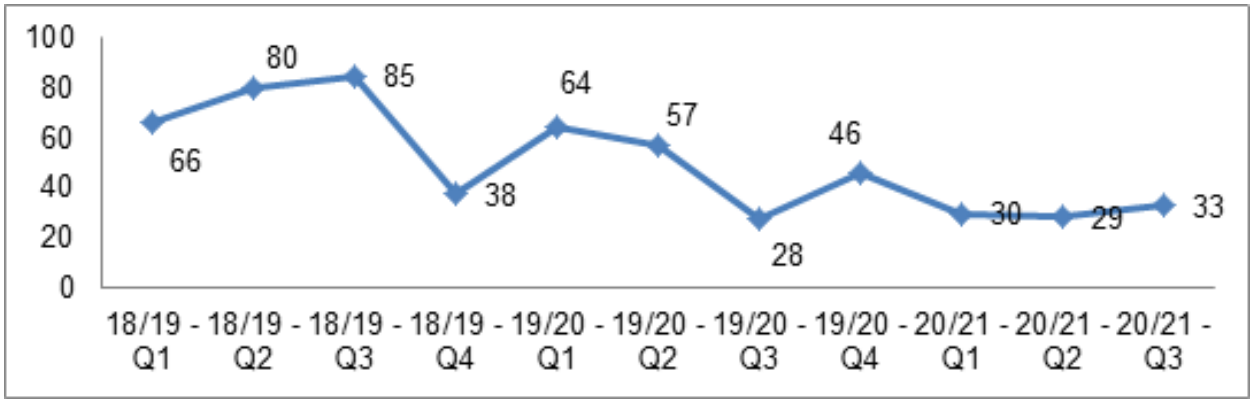


	Q1 - 19/20	Q2 - 19/20	Q3- 19/20	Q4 - 19/20	Q1 - 20/21	Q2 - 20/21	Q3 - 20/21
DOVE	0	0	0	0	0	0	6
OLIVE	0	0	0	0	0	0	2
OWL	0	0	0	0	0	1	0
HATHOR	0	0	0	0	0	1	17
ALBANY	0	0	0	0	0	1	0
ROBIN	15	5	12	9	0	1	3
FHAU	18	71	30	37	55	158	138
ASTON	0	0	1	3	17	127	14
LEXDEN	12	5	2	2	1	1	0

Chart 3 Incidents of Headbanging per ward

Absence Without Leave (AWOL) and Missing Persons

4.7 There was a slight increase to 33 in the AWOLs and Missing Person incidents when compared to the previous quarter of 29 (graph 3). The reduction that was achieved has been maintained.



Graph 3 Number of AWOL and missing person incidents per quarter.

4.8 The areas who reported most were Albany Lodge reported 12 (36%), Oak ward 5 (15%) and Owl ward 4 (12%). Missing informal was the highest category (11) reported. Failure to Return from Section 17 leave (9) was the second highest reported sub category whereas it is the highest reported category nationally.

4.9 The AWOL and Managed Entry and Exit Policy (MEEP) was reviewed and updated as well as a quality impact assessment to incorporate learning from Covid-19 and also from SIs as well as to support routine exit and entry from the ward. Additional training has been developed and will continue into quarter 4

Violence and Aggression

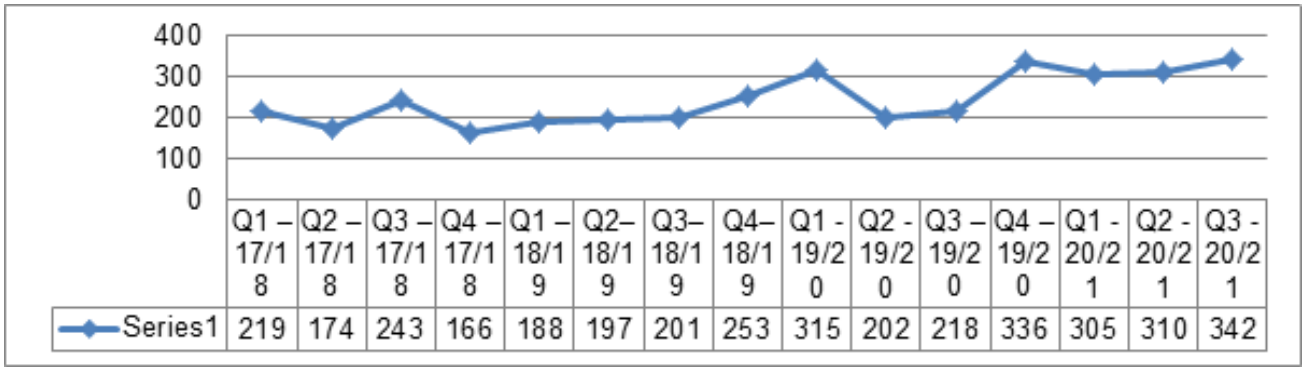
4.10 As part of the assurance process for violence and aggression incidents, each SBU has developed local approaches, in line with the MOSS together Strategy, to reduce violence and ensure the least restrictive practices. These, alongside monthly objectives for harm reduction, support the Trust targets as part of the Annual Plan.

4.11 A recovery plan for the Trust's RESPECT training remains in place with modified courses, supported by NAVIGO guidance and assistance. Reasonable adjustments have been made to enable 6 staff to be taught with 1 instructor for both modules 4 (refresher) and 5 (training). Additional instructors have been trained, allowing for greater flexibility. Further options are being explored to review the overall training provision.

4.12 The use of the Safety Pods continues to be taught in module 5 and has been effective in FHAU in reducing the time overall time of restraints, facilitating a less restrictive approach.

Service user to staff assaults

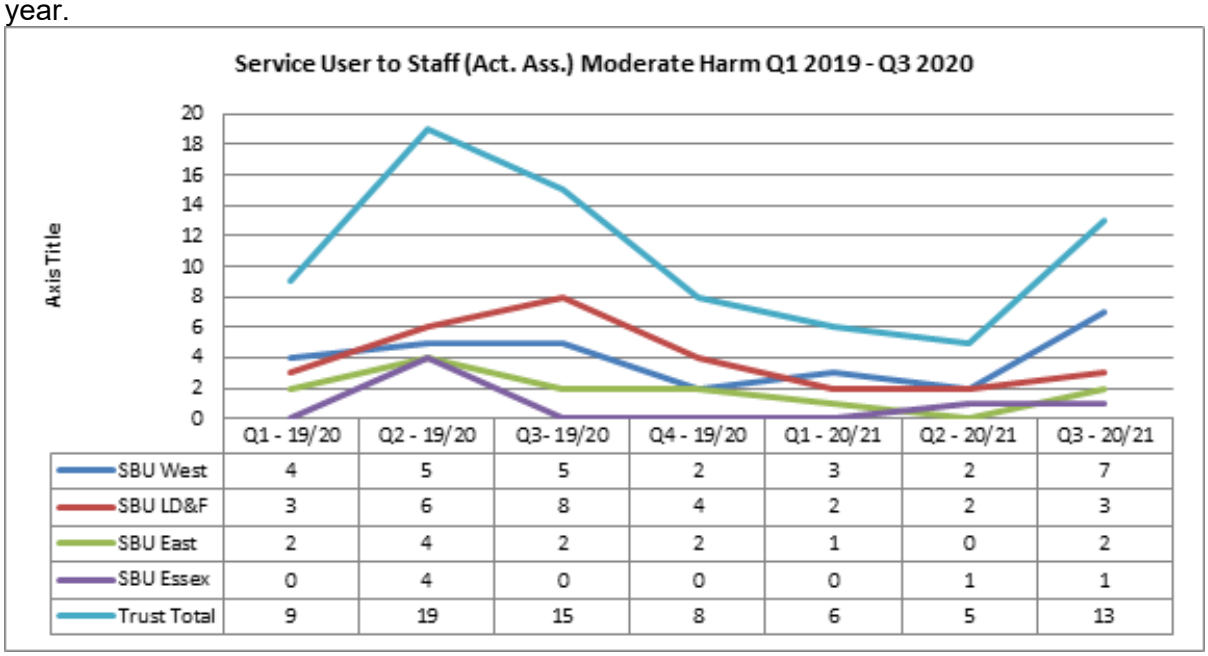
4.13 There has been an increase in reported service user to staff assaults in inpatient services (graph 4) to 342, of which Lexden accounted for 166 (49%). Of the total, 187 (55%) resulted in no harm, 139 (41%) in low harm and 13 (4%) in moderate harm, with none in severe harm.



	Q1 – 17/18	Q2 – 17/18	Q3 – 17/18	Q4 – 17/18	Q1 – 18/19	Q2– 18/19	Q3– 18/19	Q4– 18/19	Q1 - 19/20	Q2 - 19/20	Q3 – 19/20	Q4 – 19/20	Q1 - 20/21	Q2 - 20/21	Q3 - 20/21
Series1	219	174	243	166	188	197	201	253	315	202	218	336	305	310	342

Graph 4

4.14 The Trust annual plan sets a target for a reduction in service user to staff violence and aggression that resulted in moderate or severe harm. This quarter there was an increase in this number from 5 to 13 incidents but is 2 fewer than the same quarter last year.



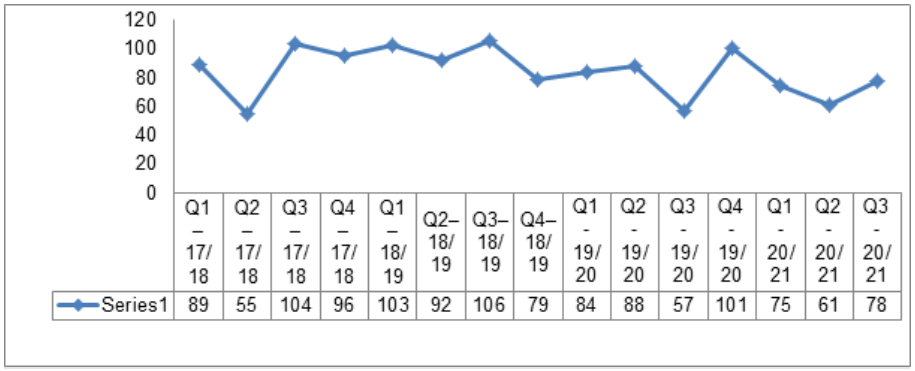
	Q1 - 19/20	Q2 - 19/20	Q3- 19/20	Q4 - 19/20	Q1 - 20/21	Q2 - 20/21	Q3 - 20/21
SBU West	4	5	5	2	3	2	7
SBU LD&F	3	6	8	4	2	2	3
SBU East	2	4	2	2	1	0	2
SBU Essex	0	4	0	0	0	1	1
Trust Total	9	19	15	8	6	5	13

Graph 5 Service user to staff violence moderate harm

4.15 There were 7 incidents reported within the community services, 4 resulted in no harm and 3 in low harm. The Community Violence Task & Finish Group has formed and the focus of the work has been related to community CCTV, review and ratification of the Lone Worker Policy, Trust Security and Police Liaison group, refresh of the Memorandum of Understanding , Lone Worker training and implementation of new lone worker devices and a mobile phone App, review of Community Violence with Professor Brian Littlechild at the University of Herts, development of a lone worker champion role, development of Post Incident Support, a focus on data informed approaches to community violence, with proposed development to add to the patient safety dashboard.

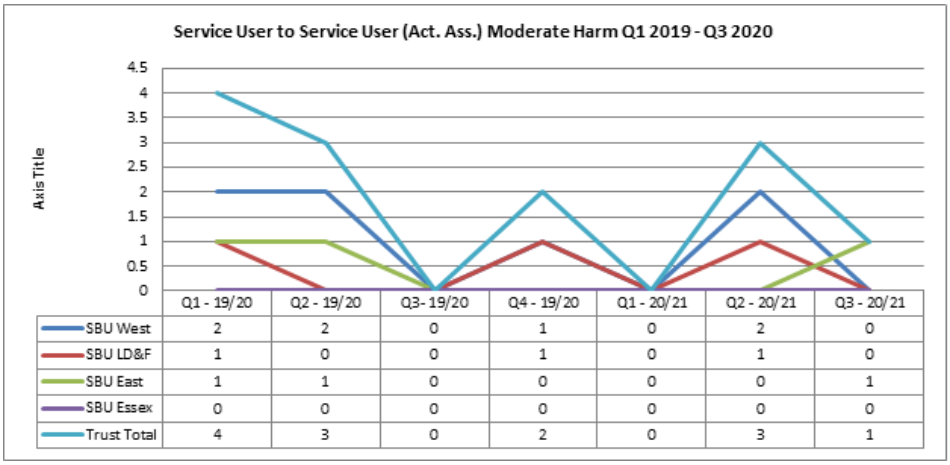
Service user to service user assaults

4.16 There were 78 incidents of service user to service user assaults, an increase of 28% compared to quarter 2 (graph 6); 1 (1%) resulted in moderate harm, 44 (57%) in no harm and 33 (42%) in low harm.



Graph 6: Service user to service user assaults

4.17 The Annual Plan has a target of reducing the number of incidents resulting in moderate or severe harm. There have been no incidents of severe harm to service users from other service users and the number of incidents resulting in moderate harm is small but has decreased from 3 to 1 from the previous quarter. The range per quarter is 0-4.



Graph 7: Service user to Service user Assaults resulting in moderate harm

4.18 Dove ward reported 12 incidents, Owl ward 9 and Victoria Court, Seward Lodge 7. The Safeguarding Team continues to monitor these incidents and follow up to ensure safeguarding concerns are raised, as appropriate.

5 Least Restrictive Care

5.1. Assurance and support to teams has been strengthened in this quarter, with targeted support from subject matter experts in response to need identified in the live scrutiny of data. In addition learning from huddles and safety crosses are reviewed as well as Safewards, including positive behaviour support plans.

Restraint

5.2. There has been an increase by 65 (17%) in the use of restraint since quarter 2 to 551**.** There was 1 reported prone restraint incidents reported in October 2020 within the S136 suite. This is not classified as an inpatient area so was a non-reportable incident to the Mental Health Minimum Data Set (MHMDS).

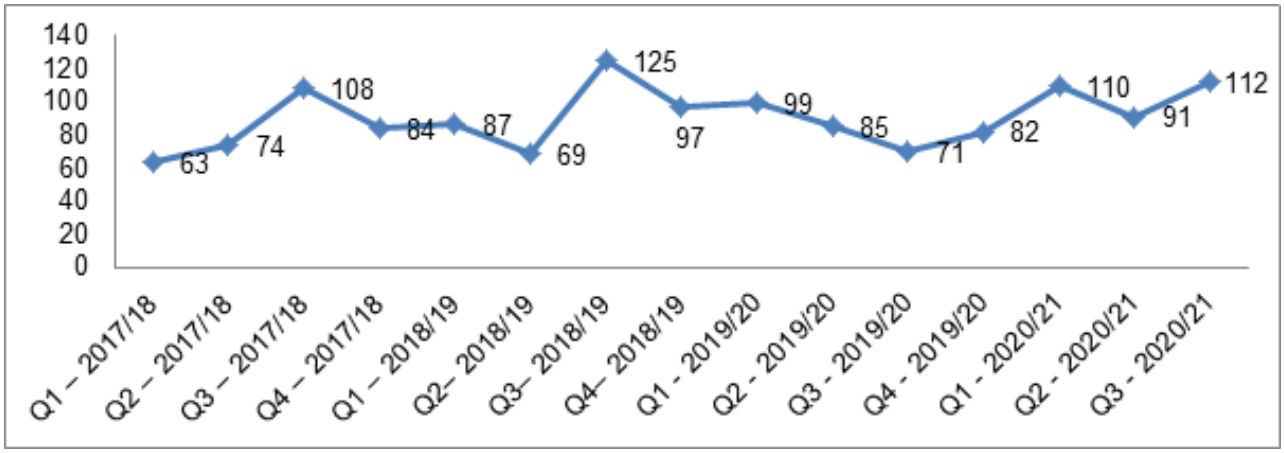
5.3. 357 (65%) took place in three services- 160 (29%) FHAU, 156 (28%) Lexden and 41 (7%) Dove ward, with 1 individual at FHAU accounting for 68 (12%) of the total incidents within the quarter. Three service users accounted for 170 (31%) of the total incidents.

5.4. Lexden reported 156 incidents involving 5 service users within the quarter, due to specific challenges regarding the complexities of both the service user group and environmental issues. A review of Lexden undertaken by the Patient Safety and Practice Development Team and Management from Dove Ward found there to be significant environmental challenges within Lexden and lack of visible MDT working on the ward. An improvement plan was developed and work is underway to embed other disciplines within the unit. Improvements to the environment have been made, including installing safety mirrors to address blind spots.

5.5. The review found over reporting of incidents with several datixes being completed for the same incident. It also found that delayed transfers of care, was a source of frustration for service users, leading to increased incidents of violence and aggression. Joint working with the local authority has now ensured discharge plans are in place for all service users at Lexden.

Seclusion

5.6. There were 112 incidents of seclusion, with 46 in Learning Disability and Forensic, 45 in Essex and IAPT, 19 in West and 2 in East and North (Graph 8). 1 service user accounted for 19/45 (42%) of the total incidents at Lexden and 17% of the overall seclusion incidents.



Graph 8 Incidents of seclusion

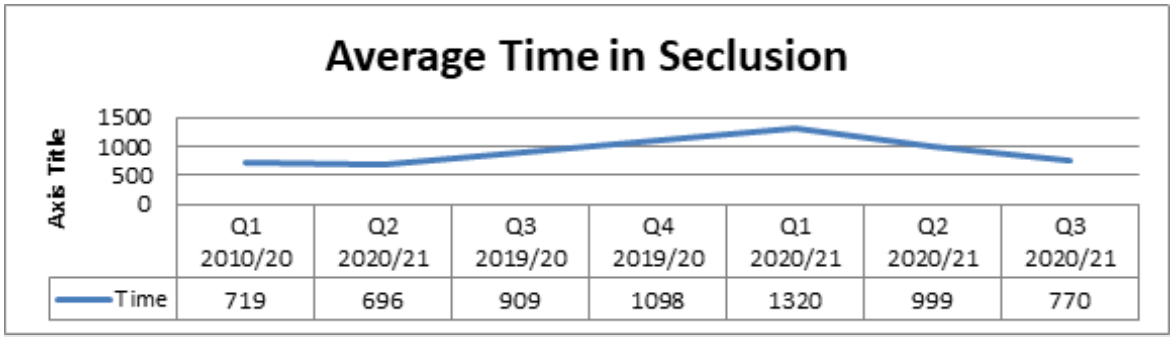
5.7. There were 38 service users identified and 19 involved in a singular event and a further 9 involved in 2 events accounting. Most episodes of seclusion related to 3 individual service users who were at Lexden and Astley Court.

5.8. The Annual Plan set the objective of reducing the average length of time in seclusion. Overall, there has been a reduction in the total length of time for the second quarter running. Quarter 2 to Quarter 3 saw a reduction by 4665 minutes (table 5) and a reduction in the mean length of time by 229 minutes (graph 9). There continues to be variation across SBUs and work is being undertaken to understand whether this is unwarranted variation.

	West	LD&F	East	Essex	SBUs Total
Total Time Mins	23783	44868	8300	9373	86324

Mean Time Mins	1251	975	4150	208	770

Table 5: The total number of minutes and mean



Graph 9: Average length of time in seclusion.

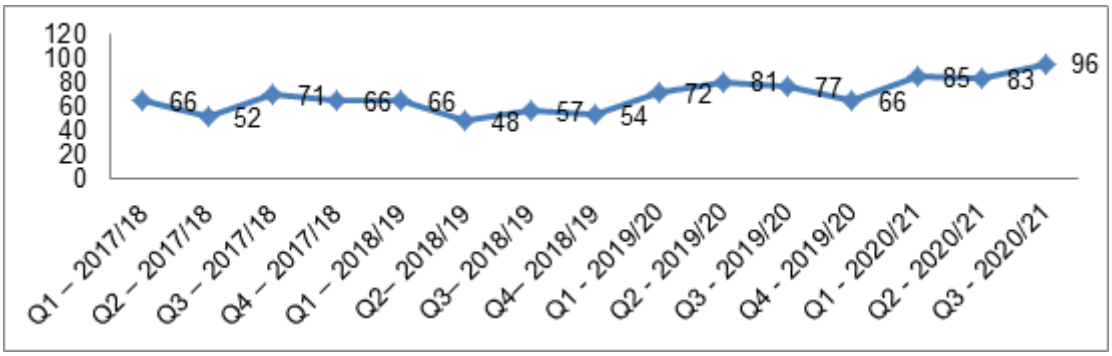
Long Term Segregation

5.9. There were 4 individuals subject to Long Term Segregation (LTS) during the quarter at FHAU, Lexden, Dove ward and Specialist Residential Services (SRS). The increased scrutiny and assurance for LTS, strengthened with guidance developed through policy and newly developed reporting systems on PARIS, including a weekly multi-disciplinary team (MDT) review of care and treatment with specific reference to their Human Rights is now well embedded.

5.10. Key individuals received training the trainers from MerseyCare on the use of the HOPE model, as per Annual Plan, to support the management of LTS with an agreed outcome for all current LTS to be reviewed using the model.

Rapid Tranquilisation

5.11. The use of rapid tranquilisation increased to 96 from 83 (16%) with the East and North SBU accounting for 49 (51%) incidents (Graph 10). Three areas accounted for 67 of the incidents (70%)- FHAU 45 (47%), Oak ward 12 (13%) and Albany Lodge 10 (10%). In FHAU, an individual service users accounted for 25 (53%) their rapid tranquilisation incidents.



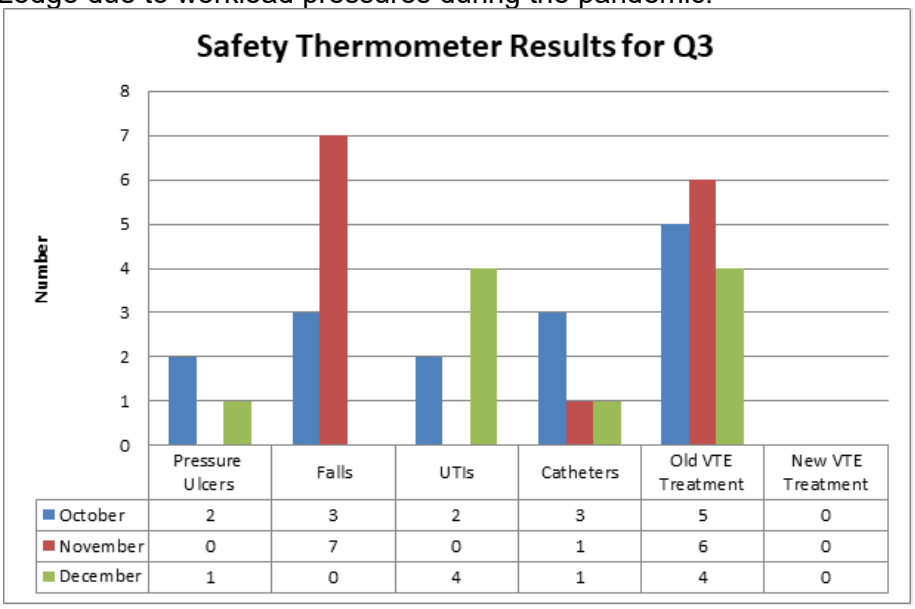
Graph 10: Incidents of rapid tranquillisation

6. Harm free physical health care

6.1. The Trust aspires to provide harm free care, which is physical healthcare that encompasses harm and deemed avoidable. Specific attention is given to pressure ulcers and slips, trips and falls.

6.2. The NHS Safety Thermometer was a local improvement tool for measuring, monitoring and analysing service user harms and 'harm free' care at a single point in time. The tool measures five high-volume service user safety issues. Following a national consultation, the national collection of Safety Thermometer data ended from April 2020, and alternative data sources were used to continue improving pressure ulcer prevention, falls prevention, VTE prevention and prevention of healthcare-associated infection. The introduction of a nationally produced replacement data was planned, but has been temporarily paused due to the national response to Covid-19. Data collection has continued locally until an alternative is in place.

6.3. All safety thermometer returns (table 5) were received from all locations for October and November 2020. Returns were not received in December from SRS, Victoria Court and Seward Lodge due to workload pressures during the pandemic.



	Pressure Ulcers	Falls	UTIs	Catheters	Old VTE Treatment	New VTE Treatment
October	2	3	2	3	5	0
November	0	7	0	1	6	0
December	1	0	4	1	4	0

Table 5 Safety Thermometer

6.4. 3 pressure ulcers reported in quarter 3, 2 were old Category 2 pressure ulcers on Logandene and Lambourn Grove and one was a new Category 2 on Victoria Court. 10 falls were recorded, 1 resulted in moderate harm on Lambourn Grove. 6 UTIs were recorded, 4 of these were new UTIs, with 3 on Logandene and 1 on Lambourn Grove. 5 catheters were recorded, 3 reported on Seward Lodge and 2 reported on Wren ward. 15 old VTEs reported and being treated at Lambourn Grove and Logandene.

Pressure ulcers

6.5. There were no category 3 or category 4 pressure ulcers incidents in this quarter and a reduction in category 2 pressure ulcers acquired whilst receiving Trust care. There were 2 reported category 2 pressure ulcers incidents, 1 each at Seward Lodge and Lambourn Grove and 1 category 1 pressure ulcer incident at Astley Court.

6.6. There is a consideration with a new category 2 pressure ulcer that early signs of pressure damage (category 1) have not been recognised. Category 1 pressure damage, non-blanching erythema, manifests as a darker pigment, warmth and hardness in darker pigmented skin rather than "redness" in white skin. This is covered in the current pressure ulcer policy and teaching. To seek assurance that early signs of pressure

damage are being recognised in all skin colours, Datix reporting of pressure ulcers will be updated from quarter 4 to document skin colour. The service user with the category 2 pressure ulcer reviewed by the Tissue Viability Nurse (TVN), has dark skin.

6.7. There has been an increase in moisture associated skin damage from quarter 2. Of the six reported cases in quarter 3, 5 were at Lambourn Grove, 2 for the same service user, and 1 at Victoria Court. All were reviewed by the TVN or support worker and were appropriately documented in care plans and continence management plans and referrals were in place.

6.8. Tissue Viability teaching was cancelled during quarter 3 due to the Covid-19 pandemic and Business Continuity Plans (BCP); resources continued to be available on the Hive. The TVN is working towards retirement and the replacement is out for recruitment. The Covid Early Response Team (CERT) has also offered support and clinical advice, focusing on proactive pressure area care and keeping service users moving while in isolation due to Covid-19.

VTE

6.9. The death of an inpatient service user from a Pulmonary Embolism induced cardiac arrest this quarter is currently subject of a SI investigation and learning will be shared in due course.

6.10. The National Institute for Health and Care Excellence (NICE) issued a rapid guideline to address the increased risk of VTE associated with Covid Pneumonia in November 2020. The Trust VTE policy was reviewed and updated to reflect the recommendations, approved at the Trust's Clinical and Professional Advisory Committee (CPAC) and disseminated via Tactical Command. This has been incorporated into the care of service users with Covid-19 through teaching and advice of the CERT.

Slips, trips and falls

6.11. The Trust is part of the regional Frailty Pathway work to inform best practice and innovation around frailty and falls prevention and is overseen internally by the Trust's Falls Steering Group.

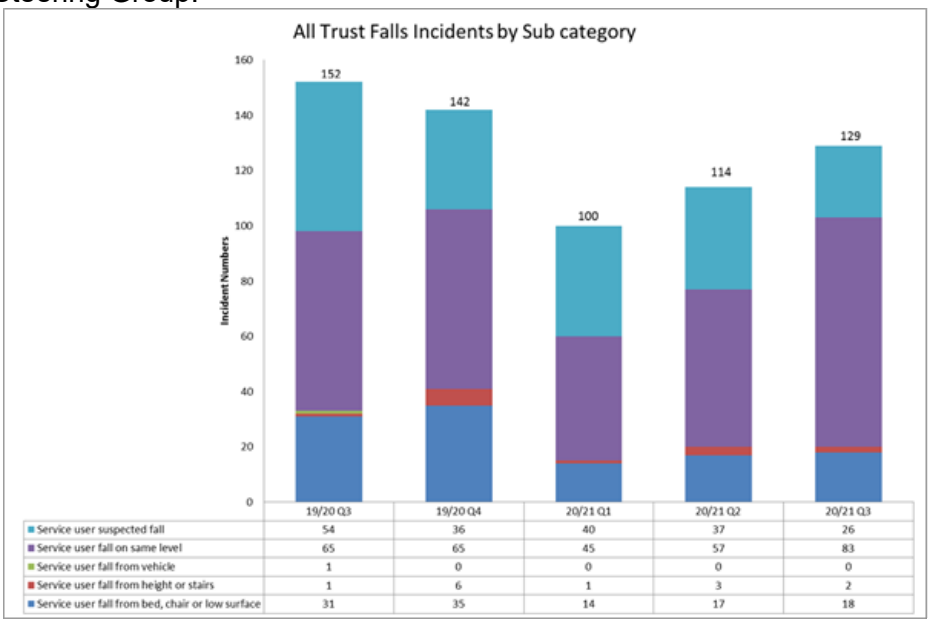


Chart 4: falls by subcategory per quarter

6.12. The number of falls being reported is still below pre-pandemic numbers, although there has been an increase of 13.5% on the last quarter. This continues to be a low reporting period for falls and should be considered alongside the reduced number of service users currently on the inpatient wards and an increase in services users who were physically unwell or isolating due to Covid-19. The reporting highest areas were older aged adult inpatient with 73, adult acute inpatient with 18 and the SRS with 10 (Chart 4). A majority of the reported falls were recorded as 'service user fall on same level'.

6.13. 4 of the reported incidents in older aged adult in patient services resulted in fractures and were reported as SIs; 1 incident occurred in quarter 2 and reported as an SI in this quarter. 2 of the 18 falls in adult acute resulted in moderate harm and were reported as SIs (1 reported in this quarter and 1 in quarter 4.) The SRS incidents all resulted in no or low harm and 8 of the 10 incidents involved the same individual service user. SRS has dedicated physiotherapy support and staff training on falls prevention and physical frailty has been delivered.

6.14. There is updated enhanced moving and handling training with a comprehensive falls workbook to train care staff to prevent falls. Work is also in progress to fit hand rails, paint kerbs, fit toilet frames and other adjustments following environmental audits. All service users are receiving the recommended daily dose of vitamin D to support bone strength, with those at higher risk being screened for a titrated dose.

6.15. There is concern regarding the deconditioning of service users due to the restrictions of the pandemic both in community and in-patient services. Some individuals with a learning disability rely on large pieces of equipment at day centres to stand and move and with the closure of the services, they have not been able to spend appreciable time standing, increasing the risk of fragility and loss of bone density as well as an impact on confidence to mobilise. The physiotherapists have developed a virtual training package to support people to keep mobile in isolation.

7. Feeling Safe

7.1. The question "Overall, have you felt safe on the ward?" is asked on the Having Your Say Inpatient surveys and used to understand key areas of feeling safe, enhance physical support, privacy, dignity and respect, quality of treatment and care and equity. The feeling safe score Trust-wide increased to 81% in quarter 3 compared to 71% in the previous quarter although the number of responses fell slightly to 113 compared to 128 in quarter 2.

7.2. The feeling safe score for adult acute inpatient services was 81%, with 74 responses, compared to 84% and 49 responses in the previous quarter. Those service areas with scores above the 85% target were Thumbswood 100%, Swift Ward 100% and Robin Ward 88%. The Section 136 Suite at Kingfisher Court scored below target at 67%, Albany Lodge 71% and Owl Ward 75%; Aston Ward was just below target at 83%.

7.3. There were 39 responses in the Learning Disability and Forensic SBU compared to 79 in quarter 2. 4 Bowlers Green, Astley Court EATS service, Gainsford House and The Beacon all scored 100%; Warren Court 90% and Hampden House 86%. Dove Ward received 9 completed surveys and had a low score of 44% with comments received about other service users making people feel unsafe and wanting to go home.

7.4. There were 461 compliments received across the services, of which 12 mentioned the word "safe". There were also 3 complaints received where the description of the concerns contained the word "safe", "unsafe" or "safety". There were 2 Patient Advice

and Liaison Service (2 PALS) enquiries recorded relating to “safety”; 1 related to Swift ward and 1 to the East Adult Community Mental Health Services. The Peer Observation Project, to understand the experience of care in older aged adult inpatient services, will continue with the next phase of the project when visiting resumes on the units.

8. Safeguarding

8.1. Following the challenges raised regarding Covid-19 and continuing to ensure service users and families safety, the Safeguarding Team instigated a business continuity plan for a ‘business as usual’ approach to ensure consistent oversight of all concerns and processes. All safeguarding policies have been updated to reflect practice changes due to Covid-19 and now include a Covid-19 impact assessment. Unlike some other areas of the Care Act 2014, the Coronavirus Act 2020 did not allow for any easement of Safeguarding Adults responsibilities.

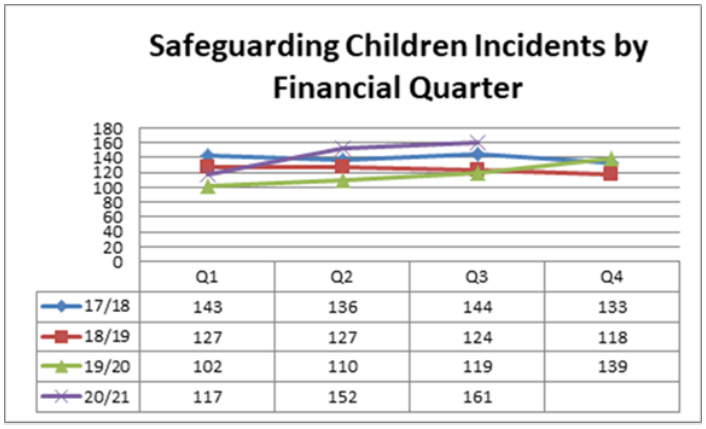
8.2. The adoption of technology has created opportunity in terms of staff development and the Corporate Safeguarding Team delivered online seminars on topics including Domestic Abuse, Self-Neglect and Gangs with more sessions planned for quarter 3.

8.3. The annual section 11 assurance (children) and adult safeguarding assurance visits by the CCG took place virtually. There was a positive action with some areas of improvement to address (Appendix A). These have been developed into an action plan that will be overseen by the Safeguarding Strategic Committee.

Safeguarding Activity Children

8.4. Safeguarding children remains a high priority in the Trust, 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.

8.5. For the second quarter running, an increase in the number of safeguarding children incidents were reported (161) (graph 11) a trend that has been seen over the past 4 financial years.



	Q1	Q2	Q3	Q4
17/18	143	136	144	133
18/19	127	127	124	118
19/20	102	110	119	139
20/21	117	152	161	

Graph 11: Safeguarding children incidents

8.6. The category of abuse with the largest increase was to emotional abuse primarily due to a combination of domestic abuse, parental conflict, parenting support required, family at risk of breakdown and the child/ young person presenting to the emergency department following an overdose.

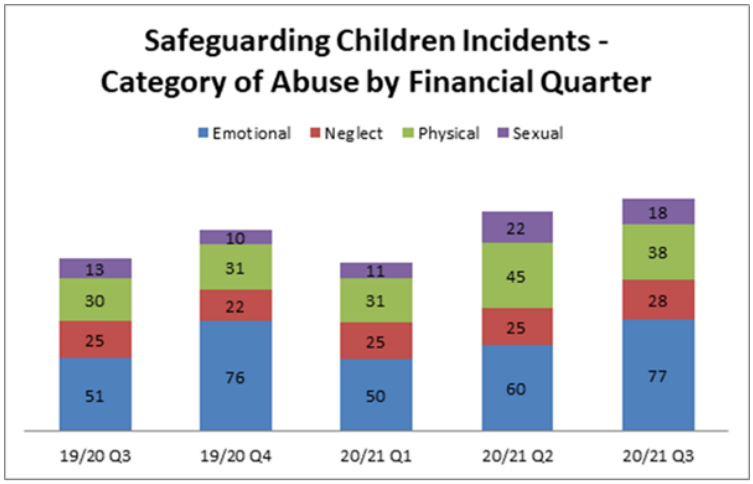
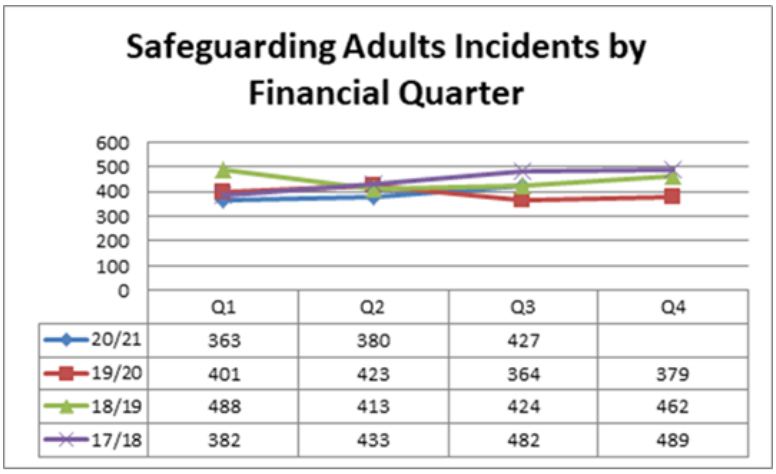


chart 5 category of abuse, children

Safeguarding Activity for Adults

8.7. There was a reduction in adult safeguarding incidents in quarters 1 and 2 2020, previously reported, suggesting a link with the Covid-19 lockdown, where fewer service users were being seen face to face. There were also restrictions on visiting in care homes and other residential settings which may have resulted in fewer episodes of abuse being observed and reported by Trust staff.



	Q1	Q2	Q3	Q4
20/21	363	380	427	
19/20	401	423	364	379
18/19	488	413	424	462
17/18	382	433	482	489

Graph 12: Safeguarding Adults

8.8. This quarter saw an increase in the numbers of safeguarding adult incidents (427) reported representing a return to business as usual' as far as the numbers are concerned. Based upon this data, there has been no significant increase in the amount of abuse reported in comparison with figures across previous years.

8.9. As in previous quarters, data shows that domestic abuse continues to be an area of concern. To ensure that Trust staff have an understanding of the issues around this category of abuse, including how to respond to disclosures, the Safeguarding Team have run online domestic abuse training since the start of the pandemic. It was recognised that domestic abuse and harm to children had increased with the Covid-19 lockdowns, as reported in national press. Awareness of domestic abuse was also feature of the assurance visit action plan and the team will be working on a programme of online events throughout the year which will also be recorded and available on the Hive.

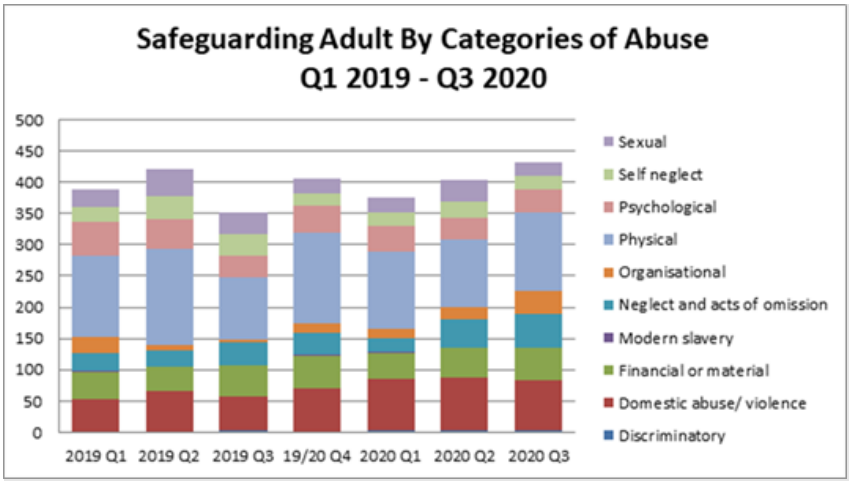
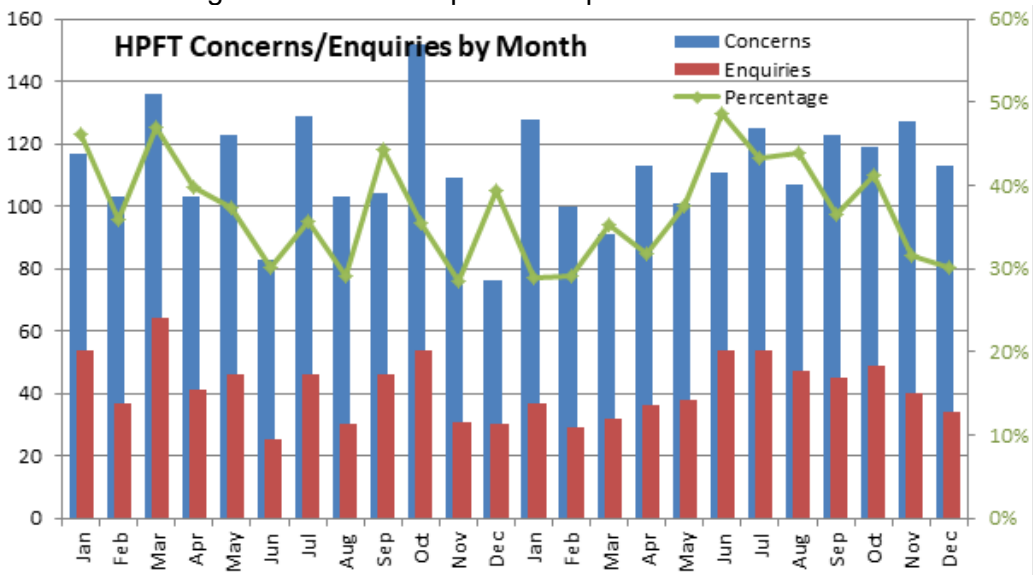


Chart 6: Safeguarding Adults by category

8.10. As with quarter 2, there has been an increase in organisational abuse and neglect incidents. Again, this may reflect Covid-19 pressures and concerns around use of Personal Protective Equipment (PPE) in residential settings, coupled with staffing struggles being experienced in these areas.

8.11. In terms of statutory safeguarding, Hertfordshire County Council (HCC) have developed a process and guidance for dealing with adult safeguarding linked to Covid-19 in care homes and, in quarter 4, this will be adapted to Trust needs.

8.12. In Hertfordshire, the Trust has responsibility to investigate adult safeguarding concerns for people with a functional mental disorder. Since quarter 1, there has been an action plan in place to improve the number of concerns being 'converted' into a full enquiry, which had dropped to a low level (graph 13). The figure for September reported in the previous Safeguarding Adults quarterly report showed a rate of only 20%, however, the full data set has since become available and has now increased to 37%. Further work is being undertaken to improve this position.



Graph 13

Hertfordshire Domestic Abuse Strategic Partnership Governance Review

8.13. The Hertfordshire Domestic Abuse Strategic Partnership has completed a review of the governance structures around domestic abuse in the County, with new forums aiming to respond to changing risks and needs around for victims, perpetrators and their

families. The review recognised that previous sub groups had provided oversight; however, there was a need for an 'action focussed' approach to ensure that, for example, commissioned services meet the needs of people in Hertfordshire. The Trust is fully engaged in this partnership.

Audits

8.14. Three audits were completed in this reporting period

- Not Brought In (NBI) Audit/ Did Not Attend (DNA) Audit
- Recording Practice for Safeguarding Children from Neglect in Hertfordshire Audit
- Statutory Safeguarding Adults practice audit

8.15. All the audits found areas of good practice and areas for improvement but showed an improvement on previous audits in the same area. Actions that were taken in response were

- To reinforce the use and quality assurance mechanisms around the DNA/NBI checklist and policy.
- To improve the recording of the assessment and outcome of the referral.
- Strengthen Training for Investigating Managers around decision making and recording practice

Sexual Safety Collaborative

8.16. The Trust has been participating in the Sexual Safety Collaborative, a national project which was suspended during lockdown. The programme restarted with the resumption of data collection, Action Learning Sets and consultation sessions (online sessions). The ability of Swift ward staff to be involved in the project has been hampered, however, by the sudden increase in infections on the ward and the resultant increased workload.

9. Medicines safety

9.1. The number of medication incidents reported remained stable at 143 reports, compared with 141 in Q2 and 138 in Q1. This was reduced compared to Q3 2019/20 reporting level (157).

9.2. One moderate harm incident and zero severe harm incidents were reported. The moderate harm incident related to a case of Steven Johnsons Syndrome associated with lamotrigine. This is an idiosyncratic reaction and was quickly identified and referred for management by the Trust. A Trust learning note has been prepared and circulated to increase awareness of this potentially serious side effect.

9.3. Administration incidents remain the highest category for reporting, with a theme of blank administration boxes on inpatient prescription charts. Specific ward areas have been offered additional virtual education support to improve medicines administration processes. An internal safety alert has been produced to highlight this issue, and has been disseminated via the SBU QRM structure.

9.4. The pattern of incident reporting between SBUs and between categories (administration, dispensing, monitoring, prescribing, self/carer administration and storage) has remained broadly similar to previous quarters.

9.5. A patient safety alert has been circulated to highlight the risk of self-harm and suicidal ideation related to lamotrigine prescribing as a result of a Prevention of Future Deaths report (not issued to this Trust).

9.6. The following safety related Trust wide memoranda have been circulated in Q3:

- Availability of updated valproate pregnancy prevention programme literature
- Advice on managing the shortage of lorazepam (Ativan) injection
- Safe use of stimulant laxatives
- Risk of serotonin syndrome with bupropion
- Safe management of anticoagulants in patients with concurrent COVID-19 infection
- Reminder on the safe use of opioids for non-cancer pain

10. **Conclusion**

10.1. Part B has provided an overview of incidents reported and demonstrates significant improvements in some areas whereas others require more focus into quarter 4. Of particular concern is the rise of ligature incidents; although a small number of service users are responsible for a large number of ligature attempts, this poses a continued challenge to staff to remain vigilant in order to keep service users safe.

10.2. The number of unexpected deaths reported increased when compared to the previous quarter; however 4 deaths were reported as SIs retrospectively and had occurred in previous quarters. The Trust is on target to achieve a 10% reduction in suspected suicides compared to the previous year as set out in the Annual Plan.

10.3. There has been significant progress with the SI recovery work with all SI RCA reports being submitted to the CCGs within agreed timescales as well as ensuring all actions arising from SIs are completed within the agreed timescales but further work is required in relation to the action plans.

10.4. The number of self-inflicted harm SIs remained the same in this quarter when compared to the previous quarter. There has been an increase in unexplained injuries or witnessed falls resulting in a fracture when compared to the previous quarter. The impact of deconditioning on service users in the older aged adult and Learning Disability services is being explored through the Falls Group and Physical Health Committee. The number of falls being reported is still below pre-pandemic numbers although there has been an increase on the last quarter.

10.5. The pandemic continues to offer challenges to the Trust in terms of ensuring the safety and wellbeing of our service users. Despite this, professionals continue to identify abuse and raise concerns and, where applicable, investigate as per policies and guidance.

PART C LEARNING FROM INCIDENTS AND CHANGING PRACTICE

1. Introduction

1.1. This part of the report summarises key actions and initiatives that have taken place in quarter 3 and have been identified for quarter 4, in consideration of the learning and the detail provided in part B. This is not a full account of the work that has taken place as our Continuous Quality Improvement (CQI) approach encourages and has resulted in many local initiatives. The report concludes with the priorities for Quarter three. Significant work was undertaken in relation to improving safety within the context of Covid-19 and this has been reported in separate reports to the Board.

1.2. Learning from incidents, SIs, complaints, feedback and mortality reviews are integral to the Trust's safety culture. The Trust shares learning by reflective learning sessions, patient safety meetings, SBU Quality Risk Meetings, case study presentations and learning notes.

1.3. Improvements are made based of intelligence from many sources including incidents, serious incidents, complaints, claims, Freedom to speak up, national publications, such as prevention of future death reports, research, Clinical Alert System (CAS) alerts, multiagency reviews and guidance.

1.4. The Trusts MOSSTogether Strategy has been implemented with a 'soft launch' due to the pandemic and is monitored by the Restrictive Practice Committee.

2. Learning from incidents

2.1. The Trust has a suite of measures to discuss and share learning from incidents and SIs which includes SWARMS, Continuous Professional Development (CPD) sessions, local governance meetings, use of learning notes, reflective learning events, suicide prevention partnerships, internal safety alerts and regional action learning sets.

2.2. A monthly Trust-wide virtual learning event held for all staff to come together and reflect and share learning from their day-to-day practice, findings of SJRs, RCAs, and SWARMS has been introduced. This initiative was introduced to allow staff rapidly seek learning from and adapt to the pandemic crisis.

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

- Assurance and processes in relation to 'Search' have been strengthened.
- Carer's Awareness training has been delivered.
- Bespoke training session on sexual side effects of medications was developed and delivered.
- The Trust is working with the Nursing and Midwifery Council (NMC) and the University of Hertfordshire (UH) to develop and deliver training on record keeping standards in addition to a learning note.
- Development of Guidance for the use of the Risk Formulation section on PARIS

3. Learning from Deaths

3.1. As part of the Suicide Prevention Group work plan for 2021/22, a series of learning and teaching events are planned around carer support and involvement, self-harm and suicide in young people and joint working in keeping with the Dual Diagnosis protocol.

3.2. The Trust is taking forward a joint initiative with Samaritans to contact service users and offer additional support following discharge from the S136 suite or contact with the MHLT. The Trust is also working with Network Rail to advertise the Trust's Crisis

number at stations in Hertfordshire to encourage people to seek support as part of reducing suicides on the railway.

3.3. The Support of the Bereaved from Suicide Group, as part of the Hertfordshire Suicide Prevention Strategy work streams, re-launched in January 2021 and will build on work undertaken in Hertfordshire following a commissioned review of bereavement support services. The Group will take forward recommendations from the bereavement support services review and the 'From Grief to Hope' report though development of a Bereavement Strategy and the appointment of a Bereavement Coordinator. Support of the bereaved by suicide also forms part of the Trust's Suicide Prevention Group work plan for 2021/22.

3.4. The management of high-risk service users is being reviewed and changes are being made to ensure that they are identified and given the support needed. Weekly team risk formulation meetings occur on a weekly basis and all teams are aware of high-risk service users, also discussed weekly in the MDT meetings. An alert has been requested to be placed on PARIS, allowing teams to have an easier oversight of service users who at high risk of harm to themselves. The process of the high-risk panels is currently being reviewed and will be replaced by risk formulation meetings that can be attended and supported by senior clinicians to support the teams and agree robust risk management plans.

3.5. The Trust has continued to foster close working relationships with key partners such as CGL, Mind, Samaritans, BTP, Network Rail, Spot the Signs, East of England Collaborative, West Essex STP, Zero Suicide Alliance and Norfolk Suicide Prevention Group over the past year.

3.6. The Trust has also been part of the Suicide Cluster Response Group, following 2 unexpected deaths around the same time in and around a specific Hertfordshire village. This group is chaired by Public Health England (PHE) and comprises colleagues from the Trust, neighbouring Trusts, HCC, Police and the CCG. The group developed a Suicide Cluster Response Plan and ensured close collaboration between organisations to ensure a coordinated response to ensure the wellbeing of the local community, particularly safeguarding individuals who may be at risk of suicidal acts due to the influence of other people's suicidal behaviour and also the effects of suicide on local communities. A lessons learned event is being arranged.

4. Harm Free Mental Health Care

4.1. A Managing Personal Safety Risk Relating to Home Visits and Weapons internal safety alert was issued.

4.2. The Community Violence Task and Finish Group was formed to address concerns relating to Community Violence. The initial group developed a range of work streams and includes the following:

- Community CCTV
- Review and ratification of the Lone Worker Policy
- Trust Security and Police Liaison group
- Review of the Memorandum of Understanding (MOU) with the police
- Lone working and training
- Development of a lone worker champion role
- Development of post incident support
- Development of media to communicate values and purpose
- Data informed approaches to community violence, with proposed development to add to the patient safety dashboard.

5. Least Restrictive Practice

5.1. A CQI project on Safe and Supportive Observations, which will include a review of policy and practice and strengthening assurance is underway.

5.2. The Barriers for Change Check list from the HOPE model has been introduced and the work has been complemented through the review of the standards present in the CQC 'Out of Sight Document,' which involves a self-assessment of standards, which is being rolled out through to the end of quarter 4.

5.3. Guidance has been provided on head banging to assist clinicians assessing the physical wellbeing of service users during and following an episode of head banging. A multi-disciplinary group has been established to consider and oversee the implementation of assessment, evidence-based models and approaches to head banging.

5.4. As an exception, a young person with complex needs was admitted to the CAMHS place of safety, which was decommissioned for the purpose, for 7 weeks. This was due a lack of low secure beds nationally. This young person required frequent physical intervention and caused staff injuries. A coordinated approach enabled the individual to be cared for safely and ensured both their mental health and physical health needs were met throughout the period of admission. The individual has now transferred to an appropriate low secure unit and a system-wide learning event has been held in quarter 4, hosted by NHSE/I with subsequent actions to be carried out and learning shared.

6. Harm Free Physical Healthcare

Physical Healthcare Training

6.1. A physical health care training programme is in development.

Falls

6.2. The Covid-19 pandemic has also caused some delay in the development of the Frailty Pathway and local falls groups work. On initial analysis, there does not appear to be a trend in the location of incidents occurring across the service areas and Falls Steering Group will be exploring the location of falls to determine if there is a high-risk area; furthermore to raise awareness of the risks associated with medication changes. In the East and North SBU, the physiotherapist is developing bitesize falls refresher videos on post falls protocol, measuring lying and standing blood pressure and environmental falls risks.

6.3. A Task and Finish group has been set up to review the Trust's Falls Policy and will include reviewing neuro-observations in the post-falls protocol where there is injury to face or head. Teaching to support the policy will be led by the Head of Nursing for physical health. The FRAX assessment tool, developed by the University of Sheffield to evaluate fracture risk in service users, is to be trialled in Logandene. Furthermore, work to record Falls Assessment on PARIS to inform day to day care has commenced.

6.4. The Trust has a Continuous Quality Improvement (CQI) project to pilot using the 'Blue Box' as supplied by Whzan Digital Health in older aged adult community services and the Trust is the only Mental Health Trust piloting this. The 'Blue Box' is new telehealth equipment which transmits the vital signs from equipment to cloud storage by blue tooth technology via a tablet. The vital signs info can be accessed remotely by Trust staff and GPs and will be held on PARIS.

6.5. To combat deconditioning, the physiotherapists have developed a virtual training package to support people to keep mobile in isolation.

VTE

6.6. NICE issued a rapid guideline to address the increased risk of VTE associated with Covid pneumonia. The Trust VTE policy was reviewed and updated to reflect the recommendations, approved at the CPAC and disseminated via Tactical Command. This has been incorporated into the care of service users with Covid-19 through teaching and advice of the CERT.

7. Safeguarding

7.1. The new Safeguarding Adult and Child action plan for the coming year is in development and will serve to enhance safeguarding practice across the Trust as a whole, utilising a Think Family approach to ensure the safety of service users and carers.

Prevent and Channel Panel

7.2. In quarter 3, Hertfordshire Channel Panel took steps to improve the diversity of the attendees at the meetings in recognition of the fact that the most members were from a white British background. The Panel agreed that, given the nature of the subject under discussion which can sometimes relate to matters of culture and religion, a broader membership would provide a richer conversation and may also bring forward new perspectives and ideas.

7.3. In light of this, the Trust representation at meetings now includes a Band 7 representative from a Black Asian Minority Ethnic (BAME) background who also has specialism in safeguarding (Adult Safeguarding Advanced Practitioner). Support for is provided by the Consultant Social Worker (Safeguarding Adults) who is also a member of the panel.

7.4. New Channel Duty Guidance was published by the Home Office in November 2020. The Trust's Prevent Policy has been updated as part of the regular review programme, and in light of the new guidance. Any necessary changes have been made.

Domestic Abuse

7.5. Refuge is the organisation responsible for providing IDVA services in Hertfordshire. Due to Covid-19 pandemic, most Refuge staff are working from home unless a situation arises where they have to see an individual face to face. In quarter 3, Refuge began offering remote consultations for Trust staff (facilitated by the Safeguarding Team). Staff can book a slot to meet with the IDVA every Friday morning.

Safeguarding children from neglect

7.6. Following the Safeguarding Children from Neglect records audit, changes have been made to the Safeguarding Children and assurance processes have been put in place.

Safeguarding training

7.7. The Safeguarding Team are focussed on ensuring a variety of training events are available and that they are tailored to the needs of clinicians during the Covid-19 pandemic. Development work is ongoing to introduce a training passport, ensure mandatory training compliance is improved, identify and act of learning from reviews and incidents and to ensure a high standard of safeguarding practice by all staff.

8. Priorities for quarter 4

8.1. In addition to the annual plan priorities set out in other papers and the work set out above, which will continue, the following priorities have been identified through learning.

Patient Safety Dashboard

8.2. The Patient Safety Dashboard has been developed for testing, to offer real time data and SPC run charts for all areas. In quarter 4 this will be piloted by the 'super users': Heads of Nursing, Clinical Directors, Managing Directors and Governance Leads for each SBU.

Incidents

8.3. The 3 overdue actions from SI RCAs will be closed and all future actions will be closed within the agreed timescales. All outstanding clarifications from the CCGs will also be closed and all future clarifications will be closed within 2 weeks of receipt.

Simulation Facility

8.4. The Trust is developing a simulation facility at its learning and development centre to deliver mental health simulation programmes for frontline staff. The offer will be extended to partners, service users, carers, ambulance service, police, social services and voluntary sector. This facility will help to improve service user safety and quality of care, particularly those trainees returning to practice.

8.5. Furthermore, evidence from staff surveys, mortality reviews and learning from SIs identify the need to offer an interactive approach to delivering which replicates real life situations to staff in 'risk assessments' and 'risk management'.

8.6. The simulation environment will help teach practical skills, such as risk assessment and management, core psychiatry and physical health skills and will teach teams of staff on how to work well and communicate effectively together. A pilot day will be held in quarter 1, 2021/22.

TRIM (Trauma Risk Management)

8.7. Based on local work in Essex, a Task & Finish group has been set up to develop and introduce TRIM Trust-wide. This involves the development of a peer support system, to support and offer timely interventions post events.

Ligatures

8.8. Following an initial discussion at the Trust's Health Safety and Security Committee regarding the Terms of Reference for the Department of Health (DoH) load testing audit of curtain rails, the justification and scope for work required has been approved. Volvina, the company who undertakes this work, will commence this audit in March-April 2021.

Pressure Ulcers

8.9. To seek assurance that early signs of pressure damage are being recognised in all skin colours, Datix reporting of pressure ulcers will be updated from quarter 4 to document skin colour.

9. Conclusion

9.1. This section of the report has provided headlines of the response to learning and quality improvement initiatives that have taken place in this quarter in relation to safety. It has also set out priorities that are in addition to those set out in the annual plan.

Dr Jane Padmore
Director of Quality & Safety
Hertfordshire Partnership University Foundation Trust
The Colonnades
Beaconsfield Close
Hatfield
Herts
AL10 8YE

7 December 2020

Dear Jane

Re: Section 11 & Adult Assurance Visit - 30 November 2020

It was a pleasure to meet with you and the team on the 30th November to review the robustness of safeguarding across Hertfordshire Partnership University Foundation Trust (HPFT).

The Section11 action plan 2019/20 is complete with only two outstanding items on the adult action plan which are progressing well.

The Safeguarding Team has demonstrated resilience and commitment to protecting children and adults.

The team is valued for their expertise across safeguarding within Mental Health Services and their contribution to the wider multiagency partnership is valued. We look forward to working with you and the Team in the coming year.

The enclosed documents highlight areas of good practices (Appendix 1) and actions to be taken by HPFT (Appendix 2).

We would be grateful if you would action the recommendations in Appendix 2 and provide a Safeguarding Action Plan to the Designated Team by 15th January 2021.

Yours Sincerely

Tracey Cooper
Associate Director Adult Safeguarding
Herts Valley CCG & East & North Herts CCG

Appendix 1

Good Practice

- Safeguarding is embedded in all areas of the organisation to ensure safeguarding continues to be prioritised within the organisation.

- The safeguarding team attend Moderate Harm Panel which gives oversight of incidents should there be any safeguarding issues.

- There is an integrated approach within adults and children safeguarding with a focus on a “Think Family” approach.

- Training and learning during Covid, HPFT have devised ways of supporting front-line staff and produced guidance and publications focusing on current themes and were cascaded to the front lines.

- The successful introduction of virtual training with the development of one hour webinars focusing on emerging themes

- The continuation of audits despite Covid pressures, including Safeguarding Adults Practice, Child Neglect, MCA, Not Brought In, Child Safeguarding Assessment and Domestic Abuse

- The appointment of a substantive consultant nurse for safeguarding children, two new safeguarding practitioners and the appointment of a named doctor.

- The introduction of reflective learning sessions, including introduction of CAMHS reflective learning sessions to enable staff to share case histories and discuss any concerns. This includes involving other organisations such as IDVA and Refuge.

- Implementing learning from audits and training including webinars and reflective sessions, targeting particular groups and learning notes cascaded throughout the organisation

- Continuous awareness of safety on wards, including the Sexual Safety Collaborative on the Swift Ward.

- The introduction of Mental Capacity Act Training for staff, carers and providers.

- Increasing the number of referrals conversion rate from 28% to 48%.

- The introduction of an online training survey which is cascaded following all training which ensures there is a focus on feedback and gives a good oversight of the quality of training.

- The proposed introduction of a virtual training passport to ensure all training is aligned to the intercollegiate document. These passports will produce reports to monitor compliance to training and capture safeguarding supervision.

- The development of Enhanced Risk Assessment which has been developed to support individuals to understand and identify adults who may be a risk to CYP.

- The addition of extra alerts on to PARIS to include Criminal and Sexual exploitation, Criminal Forced Labour, domestic servitude, UASC.

- Identifying the issue of adolescent to parent violence and aggression and developing training for staff following a deep dive into the use of knives.

- The update of the CAMHS Transition policy CAMHS which also including winning an award.

- The introduction of LAC practice guidance which has been cascaded, to ensure that Looked After Children remain with their team when they move around the county. A discharge checklist has also been introduced to ensure risks are shared with all agencies.

- The commencement of a CQI project working with adult mental health to improve pathways into primary and secondary care for care leavers. This will be expanded to include other agencies.

- Continuing to engage with young service users, In-patient and community youth councils are involved in interview panels and CQI projects to ensure the voice of service users are heard.

- The implementation of safety huddles and Swarms have been very successful to improve learning from incidents and support staff.

- The development of a simulation facility to provide support in a live discussion around risk.

- The appointment of business and contracts manager to improve on quality and monitoring of care homes.

- The appointment of a HPFT commissioning manager to continue to improve the monitoring of quality within care homes.

- The introduction of new policies, the Recruitment and Management of Volunteers Policy and the Ex-Offenders policy to ensure robust procedures.

Appendix 2

Recommendations

- To improve Level 3 training compliance within the organisation:
  Action: – Consider alternative training methods within the scope of Level 3 learning outcomes as defined in the Intercollegiate Document (2019).

- To improve the collation of training attainment with regards to all methods of learning
  Action: To create, introduce and embed the use of the Safeguarding Training Passport across the organisation in line with the requirements of the Intercollegiate Document (2019)

- To Improve the recording of Supervision
  Action: To audit and progress action plans with regards to the recording of supervision on the clinical record and staff recording systems.

- To continue to mitigate against the coding issue at HCC of monitoring outcomes of referrals by monitoring monthly referrals and ensuring outcome data has been received by referrer.
  Action: Continue to ensure referral outcomes are monitored and allocate role to newly appointed safeguarding practitioner going forward.

  Action: CCG to work with HCC to ensure that referrals data is collated in a way that will enable referrals outcomes data to be more easily captured within HPFT.

- To increase awareness of Domestic Abuse within the organisation.
  Action: To complete a domestic abuse audit focussing on awareness and adherence to Policy and pathways in relation to domestic abuse.

- To continue collaboration with WGH and Lister ED and MH Liaison Teams to identify gaps.
  Action: Joint audit to be completed and gaps identified.

- To improve mental health training in care homes to include safeguarding.
  Action: To develop bespoke training for care homes to include safeguarding.

- To continue to raise awareness and embed a Think Family approach across all services
  Action: To embed the action plan from audits undertaken and continue to seek assurance to demonstrate that this process is embedded in practice

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 9b
Subject:	Quarter 3 Safer Staffing Report	**For Publication:**
Authors:	Jacky Vincent, Deputy Director of Nursing, Quality and Safety/DIPC	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety/Chief Nurse
Presented by:	Dr Jane Padmore, Executive Director Quality and Safety/Chief Nurse	

Purpose of the report:

This report provides the Board with the data for quarter 3, 2020/21 on nurse staffing for the Trust, which has previously been discussed at IGC. In addition, the report provides information that sets the context for the published data including recruitment, retention and vacancies of nursing staff and cross referenced with patient safety data.
The purpose of this report is to provide information and assurance of the governance processes for rostering and ensuring the appropriate level and skill mix of nursing staff.

Action required:

The Board are asked to consider and note the contents of the report and discuss any point of clarification. To also receive assurance of the governance process for rostering and safe staffing.

Summary and recommendations to the Committee:

This report details the staffing levels achieved against the safe staffing levels that were set for each in patient unit for nursing staff. Emergency alternative staffing levels were agreed for use in exceptional circumstances during the pandemic. These emergency staffing levels were not used and business as usual staffing levels were maintained throughout.

Many services used significantly higher staffing levels than usual to address higher acuity and the resulting safe and supportive observations. This quarter continued with the increased scrutiny of how staffing is managed on a shift by shift basis and *SafeCare* is utilised resulting in strengthening the processes. The *SafeCare* contract was renewed and additional functionalities will be explored in the next quarter. Bank and agency use has increased in this quarter and, as a result additional scrutiny and approval systems have been put in place to explore alternative and safe means of ensuring safe staffing levels.

The report shows that there continue to be challenges, which are reflected nationally, in the vacancy rates for nursing staff which the Trust is addressing through a multifaceted approach to recruitment, developing the pipeline (introducing multiple roots to registration) and retention of staff generally and post retirement.

Relationship with the Business Plan & Assurance Framework:

Relation to the Trust Risk Register:
Workforce: The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services (Risk 657)
Workforce: The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff (Risk 215)
Relation to the BAF:
1. We will provide safe services, so that people feel safe and are protected from avoidable harm.

4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment

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

This report is primarily about staffing but also has financial implications.

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

There are no implications arising from this report.

Seen by the following committee(s) on date:

QRMC 18th February 2021 IGC 8th March 2021

Quarter 3 Safer Staffing Report 2020/21

1. Introduction

1.1 This report serves to provide the information and analysis of the quarter 3 nurse staffing data to enable the Board of Directors to receive assurance in relation to the nurse staffing in the Trust's inpatient services.

1.2 The reports starts by detailing the Trusts expectations in terms of inpatient nurse staffing levels and then moves on to detail generally, and by Strategic Business Unit (SBU), the staffing levels and challenges in this quarter.

1.3 Ensuring safe staffing levels can be achieved is only possible if there is the workforce in place therefore the report concludes with details of the vacancy and retirement data, the work to recruit staff and develop a strong pipeline of future registered nurses and retain staff generally and those that have retired.

2 Trust expectations in relation to inpatient nurse staffing levels

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

2.2 As part of the pandemic, the Trust approved emergency staffing levels that could be used if required. These approved levels were not required but remain in place for the second phase of the pandemic, should they been needed.

2.3 Where the skill mix and the numbers of staff who actually work is lower than planned, this may indicate a safety concern. There is an agreed escalation process for reporting any safety concerns associated with nurse staffing, as detailed in previous IGC reports.

2.4 In the event that a shift remained unfilled, this is reported to the Heads of Nursing and recorded as a safety incident on Datix, again as detailed in previous reports.

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

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

2.7 Outliers (wards with fill rates below 80% and in excess of 120%) continue to be discussed at the Safe Staffing meeting and also the Strategic Business Unit's (SBU) governance meetings.

2.8 *SafeCare* continues to be used in the inpatient services with daily *SafeCare* calls held to ensure safe staffing and identifying any hotspots. This allows for effective use of our staffing resource across the Trust.

3 Summary of findings for quarter 3 nurse staffing data collection

3.1 The analysis from the safe staffing returns has been broken down by month to provide detailed information about the services; detailed analysis is provided on services with fill rate under 80% in red and those over 120% in purple.

3.2 Care Hours Per Patient Day (CHPPD) data submitted by the Trust, reflects the increased staffing utilised in many of the services as a result of increased acuity and also the stand alone units where CHPPD is high. **Appendix 1** provides detailed data for each inpatient unit for quarter 1, including the Registered Nurse Associates (RNA). There are a number of shifts which were over 120% and none below 80%. The Heads of Nursing are continuing to focus their weekly scrutiny meetings on ensuring close monitoring and management of the skill mix and staffing levels.

3.3 An interim SafeCare Lead was appointed to oversee safe staffing across the Trust during the COVID-19 pandemic, with a remit to:

- Use the SafeCare system and Health E-roster to understand the safe staffing picture across the Trust

Work with the local matrons and teams to understand their hotspots and needs

- Manage locally where possible
- Report into the daily SitRep for Incident Command any hotspots.

3.4 Plans for a one year post to lead on both SafeCare and Health Roster and embed into the service areas as well as review and recommend on future resource to ensure the continual and consistent use..

Essex and IAPT SBU

3.5 The use of bank and agency in Lexden remained high in consideration of the high acuity with individuals as well as staff sickness, staff members required to shield and also vacancies.

3.6 Three individual service users with complex behaviours which were challenging were supported by two staff members on a continual basis at all times. There were 54 reported incidents of service user assaults to staff in October, reducing to 38 in November and then a significant increase to 74 in December. These continued to be reviewed on a weekly basis and also as part of the service's Reducing Restrictive Practice strategy.

3.7 This remains an area of concern and, following a review from colleagues in the Learning Disability and Forensic SBU as well as the Practice Development and Patient Safety Team, a number of supportive actions are in place and being implemented to support the service provision, reporting in to the Trust's Restrictive Practice Committee.

East and North SBU

3.8 The overall number of inpatient beds in the older aged adult services reduced during the pandemic. In consideration of the vulnerability of individual services users, there were a number of prescribed 1:1 safe and supportive observations. A high level of acuity on both Seward Lodge and Logendene were noted, as well as cohorting on admission, both of which had an impact on staffing levels.

3.9 The use of agency at Forest House Adolescent Unit (FHAU) continued to be monitored by the SBU, having used high numbers. This was reflective of the need for increased staffing levels to support individual young people who were awaiting transfer to a Psychiatric Intensive Care Unit (PICU). FHAU continued with their recruitment to enable a multidimensional skill mix and establishment in the unit.

West SBU

3.10 The West SBU also noted an overall increase in safe and supportive observations and staffing levels exacerbating challenges with covering the additional staffing. The impact of the pandemic on staffing has been felt during the three months across the SBU.

3.11 A Continuous Quality Improvement (CQI) project regarding observation levels and Safewards commenced, in consideration of the Delivering Value programme. Three sessions were held with the multi-disciplinary team (MDT) and people with lived experience focusing on building the leadership aspect of the project and agreeing its parameters.

Learning Disability and Forensic SBU

3.12 All services in the SBU continued to run at safe staffing levels with Dove ward and Astley Court requiring additional staffing to manage safe and supportive observations. The pandemic impacted on staffing levels in consideration of isolation as well as an outbreak on both the Specialist Residential Services (SRS) and the Broadland

3.13 Face to face training compliance remained a significant risk including manual handling, Intermediate Life Support (ILS), Basic Life Support (BLS) and RESPECT and remains on SBU risk register.

4. Bank and Agency

4.1 The overall bank and agency usage for quarter 3 is provided as a total number of shifts, over a 5 year period, as shown in **table 1.** Furthermore, **graphs 1** and **2** shows the bank and agency use month on month for this financial year.

		October	November	December
2016	**Bank**	5388	5320	5081
	Agency	2017	2144	1894
2017	**Bank**	5702	5502	5645
	Agency	1742	1659	1545
2018	**Bank**	5448	5325	5334
	Agency	1174	1204	1080
2019	**Bank**	6047	5994	6030
	Agency	1174	1099	1247
2020	**Bank**	7059	6996	6761
	Agency	1305	1273	1343

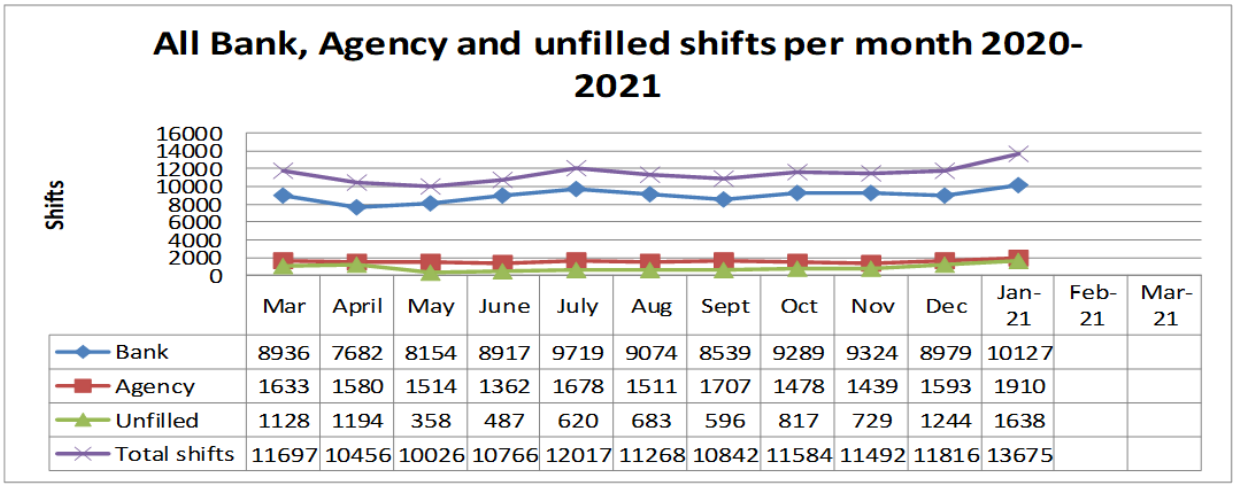
Table 1

4.2 The bank and agency shifts reduced during month 1 and 2 of the quarter, with some reduction in December. The usage also remains higher in comparison to the same quarter in the last financial year.

4.3 The highest 3 reasons remained Covid, safe and supportive observations and vacancies. With the tighter governnace and scrutiny, led by the Heads of Nursing, and revised establishments to absorb a number of safe and supportive observations in the service areas, there continues to be an expectation this will change.

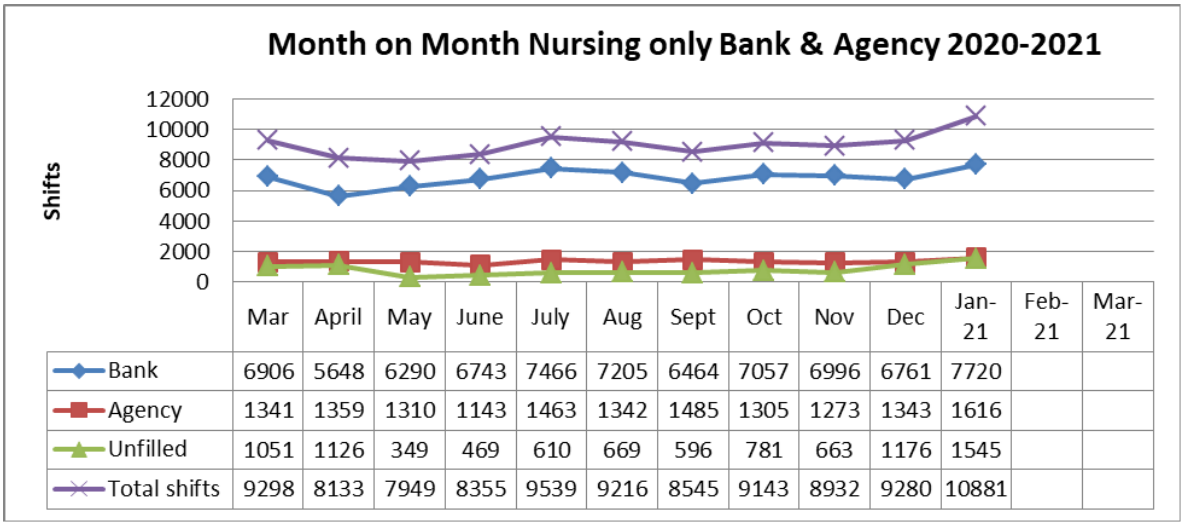
4.4 The actions previously discussed at the Safer Staffing Group meetings continue and have been reinforced at both the Trust's Recruitment and Retention Group meeting and the Trust Management Group. These include:

- Keeping agency use to an absolute minimum and ensuring that all agency use goes through the correct authorisation process
- Ensuring all agency shifts are confirmed on a weekly basis to ensure clear sight of usage
- Reviewing processes to ensure that the potential to convert agency to permanent staff is maximised.



	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-21	Feb-21	Mar-21
Bank	8936	7682	8154	8917	9719	9074	8539	9289	9324	8979	10127		
Agency	1633	1580	1514	1362	1678	1511	1707	1478	1439	1593	1910		
Unfilled	1128	1194	358	487	620	683	596	817	729	1244	1638		
Total shifts	11697	10456	10026	10766	12017	11268	10842	11584	11492	11816	13675		

Graph 1



	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-21	Feb-21	Mar-21
Bank	6906	5648	6290	6743	7466	7205	6464	7057	6996	6761	7720		
Agency	1341	1359	1310	1143	1463	1342	1485	1305	1273	1343	1616		
Unfilled	1051	1126	349	469	610	669	596	781	663	1176	1545		
Total shifts	9298	8133	7949	8355	9539	9216	8545	9143	8932	9280	10881		

Graph 2

4.5 The Trust continues to emphasise that safety comes first and should come with the appropriate scrutiny to ensure the financial impact is kept to a minimum. Scrutiny continues across the SBUs and reports to the Safe Staffing Group.

4.6 During quarter 2 and continued into this quarter, the Safer Staffing Group agreed key areas for SBUs to focus on, including:

- The effective scrutiny of e-roster shift patterns and the number of staff on shift being appropriate for the needs of the service users
- Ensuring all substantive staff have their hours allocated before any bank or agency use
- Ensuring any owed hours, by substantive staff, are used before any bank or agency use
- Annual leave is planned and covered within substantive staff before any bank and agency use
- Agreed levels of observations are covered within the approved establishment before bank and agency use.

5. Recruitment, Pipeline and Retention

5.1 Having successfully appointed over 50 newly registered nurses at the end of the previous quarter and the individuals commenced their employment during this quarter across the service areas. Work continues with recruitment to fill vacancies - detailed in **Table 3** - which remains a focused priority with the SBUs and the corporate nursing services.

5.2 The vacancies are being addressed through recruitment, pipeline initiatives, such as multiple roots to registering as a nurse or nursing associate and retention of staff, generally or post retirement.

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Essex & IAPT	13.00	9.69	3.31	25
LD & F	181.71	146.77	34.94	19
East & North	124.71	105.71	19.00	15
West	125.57	103.44	22.13	18
Total	**444.99**	**365.61**	**79.38**	**18**
Unregistered Nursing				
Essex & IAPT	17.80	20.23	-2.43	-14
LD & F	227.71	192.82	34.89	15
East & North	203.08	165.66	37.42	18
West	139.99	112.25	27.74	20
Total	**588.58**	**490.95**	**97.63**	**17**

Table 3

5.3 The Trust continues to work with the local universities ensuring that student nurses feel part of the Trust family at the start of their training and meeting senior nurse leaders during their training. The Deputy Director of Nursing and Quality/DIPC meets monthly with the University of Hertfordshire's Head of Nursing, Health and Wellbeing to build on the work with the students' placements, ensuring regular contact, as their future employee, and enabling a smooth transition from student to RN, with the Trust being their employment area of choice.

5.4 Six monthly meetings with all learning disability and mental health student nurses continue with the Deputy Director of Nursing and Quality/DIPC and the Heads of Nursing to maintain contact with them, discuss their opportunities and also ensure they feel welcomed and part of the Trust.

5.5 **Appendices 2** and **3** provide a breakdown of vacancies in the inpatient and community services respectively.

5.6 A significant risk remains regarding the profile of RNs who are able to retire, detailed in **Table 4**. Work continues to support them and explore their options to remain in the workforce.

Area	55-59			60-64			65+		
	HCA	RN	Total	HCA	RN	Total	HCA	RN	Total
Essex and IAPT	2	3	5	1	0	1	1	0	1
LD and F SBU	34	20	54	22	9	31	5	1	6
E and N SBU	27	17	44	18	12	30	7	2	9
West SBU	21	10	31	11	3	14	5	6	11
Total	**84**	**50**	**134**	**52**	**24**	**76**	**18**	**9**	**27**

Table 4

5.7 The Trust has signed a Memorandum of Understanding (MoU) with HEE for the next quarter to progress with both the recruitment of HealthCare Support Workers (HCSW) and aim to reduce to zero vacancies by the end of this

financial year. Also to work with the international recruitment programme to recruit RNs from overseas.

5.8 Progress with the Health and Care Academy continued, aimed at supporting and developing young people and encouraging them into health-related careers, supporting the pipeline of individuals joining the NHS. The Academy concept allows the Trust to 'grow its own staff', linking with colleges and schools to recruit local people/students who may not have previously considered careers in healthcare.

5.9 Following the launch for the first cohort of 12, the programme will continue into quarter 3, working with key stakeholders and the universities. Increased work and focus has taken place recruitment across the ICS with the Nursing Associate web pages on the Health and Care Academy website, linking to expression of interest forms which are then forwarded onto partner organisations' websites.

5.10 The Trust continues to lead on the Student Nursing Associate (SNA) working, on behalf of the STP and is supported by the SNA Pipeline Manager. Recruitment campaigns and promotional materials have been created and virtual career events planned.

5.11 There are 41 students confirmed in the September 2020 cohort and up to 50 students are viable for January's intake. Furthermore, the estimated numbers for 2021 are at 100. The Trust currently has 10 RNAs all of whom plan to top up to an RN to continue with their career progression in the Trust.

5.12 The self-rostering pilot initiative, to implement a team-based rostering system for nursing staff, plans to be reinstated having been postponed due to the pandemic. This pilot is aimed at increasing nurses' input into their working patterns and improving work-life balance in the Trust and provides the nursing team with autonomy and permission to negotiate the e-roster, in the context of being open and transparent. Inpatient services from each of the SBUs are participating in the pilot.

5.13 Actions for the pilot moving forwards include:

- Review of the roster rules
- Review of flexible working requests
- Full evaluation of the project and the impact of self-rostering on retention of staff and running of the wards.

6. Conclusion

6.1 This report sets out to brief the Board of Directors in relation to the quarter 3 position for safe nurse staffing within inpatient services, which has previously been received and discussed at the Integrated Governance Committee. The report also includes community nursing staffing and the vacancy rate.

6.2 The report has described how many services used significantly higher staffing levels than usual to address higher acuity and the resulting safe and supportive observations. This quarter also saw increased scrutiny of how staffing is

managed on a shift by shift basis and *SafeCare* is utilised resulting in strengthening the processes, feeding into Incident Command at the peak of the pandemic.

6.3 The report shows that there continue to be challenges, which are reflected Nationally, in the vacancy rates for nursing staff which the Trust is addressing through a multifaceted approach to recruitment, developing the pipeline (introducing multiple roots to registration) and retention of staff generally and post retirement.

6.4 Targeted work in the SBUs continues for quarter 4 includes:

- Ensuring best practice is applied in the review and management of therapeutic engagement and observation levels on the wards (for example, reviewing in each shift to ensure the level of observation is in line with the level of risk presented by the service user
- Use of alternative interventions including SafeWards to be relaunched and refreshed in all inpatient wards – as part of the MOSS*together* Strategy
- eRoster management of bank bookings, management of annual leave and ensuring staff working to contracted hours and ensuring fairness
- Ensuring all RNs are conversant with the dependency levels in utilising SafeCare census to enable consistency in its application
- Team Leaders and Matrons aware of budgets and spending on additional shifts (and attending the training sessions on offer from Finance)
- Ensuring unutilised hours are addressed.

6.5 There is also a more targeted focus for month 3 of the next quarter (and having seen a further increase in bank and agency usage in months 1 and 2) on the use of agency, the scrutiny of the rosters and the associated KPIs including additional duties and owed hours.

6.6 The Board is asked to note this report and discuss any point of clarification.

Appendix 1 - Nurse Staffing fill rate data

Month	October													
SBU	**Service**	RN Day fill rate (%)	HCA Day fill rate (%)	RNA fill rate (%)	NNA fill rate (%)	RN Night fill rate (%)	HCA night fill rate (%)	RNA Night fill rate (%)	NNA Night fill rate (%)	CHPPD RN	CHPPD HCA	CHPPD RNA	CHPPD NNA	Overall CHPPD
LD&F	Gainsford House	102	99	-	-	98	105	-	-	4.4	2.2	0.0	0.0	6.6
	Hampden House	100	112	-	-	102	119	-	-	4.9	2.8	0.0	0.0	7.7
	Warren Court	98	102	-	100	101	106	-	100	3.8	6.5	0.0	0.4	10.6
	4 Bowlers Green	99	101	-	-	100	101	-	-	5.0	0.0	0.0	0.0	8.8
	Beech	107	99	-	-	103	118	-	-	3.7	6.0	0.0	0.0	9.7
	Dove	115	140	-	-	92	170	-	-	3.6	7.7	0.0	0.0	11.3
	SRS	99	98	-	-	100	89	-	100	3.4	10.6	0.0	0.1	14.1
	Astley Court	102	194	-	-	106	124	-	-	6.6	15.1	0.0	0,0	12.7
	Broadland Clinic	102	99	100	100	87	123	-	-	3.8	8.2	0.1	0.3	12.7
	The Beacon	103	100	-	100	103	100	-	100	3.4	2.2	0.0	0.3	5.9
Essex & IAPT	Lexden	107	215	100	100	105	164	-	-	10.2	24.3	0.5	0.4	35.4
West	Swift	120	164	-	100	100	265	-	-	4.6	6.3	0.0	0.3	11.2
	Robin	127	192	-	100	100	265	-	-	2.6	7.1	0.0	0.0	9.7
	Owl	111	155	-	100	98	215	-	-	2.9	6.0	0.0	0.4	9,2
	Oak	96	186	-	-	100	152	-	-	4.4	11.5	0.0	0.0	16.0
	Thumbswood	151	114	-	-	100	137	-	-	8.6	15.3	0.0	0.0	24.5

	Albany Lodge	108	151	-	100	100	183	-	100	2.7	5.6	0	0.1	8.4
	Aston	104	120	-	100	100	140	-	100	2.9	4.6	0.0	0.2	7.7
E&N	Victoria Court	97	111	-	100	95	115	-	100	3.0	10.6	0.0	0.3	14.0
	Forest House	139	148	-	-	139	198	-	-	4.6	15.3	0.0	0.0	20.0
	Wren	100	89	-	-	100	106	-	-	3.3	7.1	0.0	0.0	10.4
	Lambourn Grove	129	105	-	100	100	155	-	100	2.9	8.6	0.0	0.5	12.0
	Logandene	101	97	-	100	100	118	-	100	3.7	8.6	0.0	0.4	12.7
	Seward Lodge	105	103	-	-	100	139	-	-	3.2	8.1	0.0	00	11.2

Month	November												
SBU	**Service**	RN Day fill rate	HCA Day fill rate	RNA fill rate	NNA fill rate	RN Night fill rate	HCA night fill rate	RNA Night fill rate	NNA Night fill rate	CHPPD RN	CHPPD HCA	CHPPD RNA	CHPPD NNA	Overall CHPPD
LD&F	Gainsford House	108	100	-	-	96	103	-	-	4.8	2.4	0.0	0.0	7.3
	Hampden House	97	104	-	-	100	103	-	-	4.9	2.5	0.0	0.0	7.4
	Warren Court	88	100	-	-	99	98	-	100	4.0	7.4	0.0	0.1	11.5
	4 Bowlers Green	98	100	-	-	100	100	-	-	4.2	5.5	0.0	0.0	9.6
	Beech	112	101	-	-	105	105	-	-	3.5	5.5	0.0	0.0	9.0
	Dove	121	128	-	-	100	168	-	-	3.8	7.5	0.0	0.0	11.3
	SRS	97	97	-	100	102	102	-	100	3.3	10.7	0.0	0.2	14.3
	Astley Court	100	196	-	-	110	116	-	-	7.5	17.0	0.0	0.0	24.5
	Broadland Clinic	104	101	100	100	88	127	-	-	3.4	7.8	0.1	0.2	12.1
	The Beacon	107	141	-	100	105	197	-	100	3.3	3.2	0.0	0.2	6.7
Essex & IAPT	Lexden	96	230	100	100	93	170	-	-	9.1	25.4	0.1	0.8	35.4
West	Swift	118	137	100	-	99	213	-	-	4.1	5.8	0.2	0.0	10.1
	Robin	120	146	-	-	100	162	-	-	2.7	6.6	0.0	0.0	9.3
	Owl	116	128	-	100	105	154	-	-	3.0	6.7	0.0	0.1	9.8
	Oak	106	158	-	-	95	154	-	-	4.8	13.8	0.0	0.0	18.6

	Thumbswood	186	96	-	-	104	142	-	-	11.0	15.9	0.0	0.0	27.7
	Albany Lodge	101	97	-	100	97	117	-	100	2.5	4.6	0.0	0.1	7.2
	Aston	105	135	-	100	100	139	-	-	2.9	4.9	0.0	0.2	8.0
E&N	Victoria Court	97	106	100	-	100	102	-	-	2.8	9.3	0.3	0.0	12.4
	Forest House	157	156	-	-	138	194	-	-	4.4	13.9	0.0	0.0	18.3
	Wren	100	92	-	-	102	117	-	-	3.3	7.6	0.0	0.0	10.8
	Lambourn Grove	144	95	-	100	102	129	-	100	3.1	7.9	0.0	0.2	11.1
	Logandene	100	95	-	100	98	126	-	100	3.8	8.8	0.0	0.4	13.1
	Seward Lodge	110	107	-	-	100	134	-	-	3.3	8.3	0.0	0.0	11.6

Month	December													
SBU	**Service**	RN Day fill rate	HCA Day fill rate	RNA fill rate	NNA fill rate	RN Night fill rate	HCA night fill rate	RNA Night fill rate	NNA Night fill rate	CHPPD RN	CHPPD HCA	CHPPD RNA	CHPPD NNA	Overall CHPPD
LD&F	Gainsford House	102	115	-	-	100	-	100	105	4.7	2.6	0.0	0.0	7.3
	Hampden House	104	113	-	-	100	119	-	-	4.5	2.5	0.0	0.0	7.0
	Warren Court	96	102	-	100	105	97	-	100	4.3	7.3	0.0	0.2	11.7
	4 Bowlers Green	109	96	-	-	100	100	-	-	4.4	5.2	0.0	0.0	9.6
	Beech	136	91	-	-	104	107	-	-	3.8	5.0	0.0	0.0	8.9
	Dove	146	109	-	-	86	168	-	-	4.0	6.8	0.0	0.0	10.9
	SRS	110	86	-	100	103	99	-	100	3.8	10.3	0.0	0.2	14.3
	Astley Court	96	159	-	-	101	103	-	-	9.0	18.2	0.0	0.0	27.2
	Broadland Clinic	93	96	100	100	83	134	-	-	3.5	7.7	0.2	0.3	11.7
	The Beacon	132	125	-	100	102	217	-	100	3.6	3.3	0	0.1	7.1
Essex & IAPT	Lexden	100	192	100	100	92	166	--	-	9.3	23.6	0.4	0.3	33.6
West	Swift	127	105	100	-	100	151	-	-	3.,7	4.5	0.3	0.0	8.5
	Robin	129	116	-	-	100	129	-	-	2.6	6.0	0.0	0.0	8.7
	Owl	98	117	-	100	100	128	-	-	2.7	7.2	0.0	0.2	10.1
	Oak	94	139	-	-	90	132	-	-	6.1	13.6	0.0	0.0	19.7
	Thumbswood	167	87	-	-	135	110	-	-	11.4	13.0	0.0	0.0	25.1

	Albany Lodge	97	105	-	100	102	137	-	100	2.6	5.1	0.0	0.1	7.8
	Aston	108	165	-	100	102	158	-	100	2.9	5.7	0.0	0.1	8.7
E&N	Victoria Court	99	108	-	100	94	108	-	-	2.7	9.2	0.0	0.2	12.0
	Forest House	162	157	-	-	184	200	-	-	4.9	13.4	0.0	0.0	18.3
	Wren	116	81	-	-	94	120	-	-	3.3	6.8	0.0	0.0	10.2
	Lambourn Grove	140	87	-	100	105	109	-	100	3.1	7.1	0.0	0.3	10.6
	Logandene	90	100	-	100	94	108	-	100	3.6	9.4	0.0	0.4	13.4
	Seward Lodge	98	94	-	-	97	135	-	-	4.1	10.0	0.0	0.0	14.1

Appendix 2 - Vacancies breakdown by in-patient services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Essex and IAPT SBU				
Lexden	13.00	9.69	3.31	25
Total	**13.00**	**9.69**	**3.31**	**25**
Learning Disability and Forensic SBU				
4 Bowlers Green	9.00	7.80	1.20	13
Beech Ward	14.20	11.00	3.20	23
Broadland Clinic	24.70	11.00	3.20	23
Dove Ward	12.00	11.13	0.87	7
Gainsford House	10.80	10.20	0.60	6
Hampden House	10.80	10.28	0.52	5
Astley Court	12.00	9.60	2.40	20
Warren Court	27.80	20.80	7.00	25
SRS Bungalows	18.00	13.00	5.00	28
The Beacon	11.31	11.28	0.03	0
Total	**150.61**	**122.31**	**28.30**	**19**
West SBU				
Albany Lodge	13.50	10.50	3.00	22
Aston Ward	15.00	12.59	2.41	16
Oak Ward	14.00	10.82	3.18	23
Owl Ward	11.00	8.00	3,00	27
Robin Ward	11.60	11.40	0.20	2
Swift Ward	18.00	18.00	0.00	0
Thumbswood	7.67	7.00	0.67	9
Total	**90.77**	**78.31**	**12.46**	**14**
East & North SBU				
Forest House	14.00	10.64	3.36	24
Lambourn Grove	11.04	12.77	-1.73	-16
Logandene	12.01	10.08	1.93	16
Seward Lodge	12.00	12.80	-0.80	-7
Victoria Court	12.64	10.50	2.14	17
Wren	11.14	10.61	0.53	5
Total	**72.83**	**67.40**	**5.43**	**7**
Overall Total	**327.21**	**277.71**	**49.50**	**15**
NON-REGISTERED NURSING				
Essex and IAPT SBU				
Lexden	17.80	20.23	-2.43	-14
Total	**17.80**	**20.23**	**-2.43**	**-14**

Learning Disability & Forensic SBU				
4 Bowlers Green	11.02	9.71	1.31	12
Beech Ward	16.00	12.63	3.37	21
Broadland Clinic	44.60	37.07	7.53	17
Dove Ward	13.89	14.89	-1.00	-7
Gainsford House	5.40	5.40	0.00	0
Hampden House	5.00	5.00	0.00	0
Astley Court	11.40	10.61	0.79	7
Warren Court	37.00	33.67	3.33	9
SRS Bungalows	61.00	44.24	16.76	27
The Beacon	8.00	7.00	1.00	13
Total	**213.31**	**180.22**	**33.09**	**16**
West SBU				
Albany Lodge	23.00	18.60	4.40	19
Aston Ward	16.08	13.60	2.48	15
Oak Ward	18.00	12.00	6.00	33
Owl Ward	15.53	14.53	1.00	6
Robin Ward	17.40	14.13	3.27	19
Swift Ward	17.40	10.40	7.00	40
Thumbswood	9.60	8.00	1.60	17
Total	**117.01**	**91.27**	**25.74**	**22**
East & North SBU				
Forest House	24.50	13.67	10.83	44
Lambourn Grove	33.15	26.03	7.12	21
Logandene	27.72	24.19	3.53	13
Seward Lodge	22.13	18.97	3.16	14
Victoria Court	34.90	31.15	3.75	11
Wren	20.80	18.67	2.13	10
Total	**163.20**	**132.68**	**30.52**	**19**
Overall Total	**511.32**	**424.39**	**86.93**	**17**

Appendix 3 - Vacancies breakdown by Community Services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	0.00	0.00	0.00	0
Continuing Care & Placement Team	2.60	2.60	0.00	0
Criminal Justice & Forensic	1.00	0.00	1.00	100
Criminal Justice Mental Health	10.50	7.50	3.00	29
LD SLDS A&T E/N Team	8.00	7.36	0.64	8
LD SLDS A&T West Team	9.00	7.00	2.00	22
Total	**31.10**	**24.46**	**6.64**	**21**
East & North SBU				
AMHCS Centenary & Jubilee	14.10	9.91	4.19	30
AMHCS Cygnet House	10.40	8.60	1.80	17
AMHCS Holly Lodge	5.00	4.00	1.00	20
AMHCS Saffron Ground	8.34	4.20	4.14	50
AMHCS Oxford House	3.04	2.00	1.04	34
AMHCS Rosanne House	11.00	9.60	1.40	13
Total	**51.88**	**38.31**	**13.57**	**26**
West SBU				
AMHCS NW Herts Dacorum	8.20	7.80	0.40	5
AMHCS NW Herts St Albans	6.98	6.73	0.25	4
AMHCS SW Herts	1.40	1.40	0.00	0
AMHCS SW Herts Borehamwood	7.10	2.60	4.50	63
AMHCS SW Herts Watford	11.12	6.60	4.52	41
Total	**34.80**	**25.13**	**9.67**	**28**
Overall Total	**117.78**	**87.91**	**29.87**	**25**
NON-REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	0.00	0.00	0.00	0
Continuing Care & Placement Team	0.00	1.00	-1.00	0
Criminal Justice & Forensic	0.80	0.00	0.0	100
Criminal Justice Mental Health	4.00	4.00	0.00	0
LD SLDS A&T E/N Team	4.00	2.00	2.00	50
LD SLDS A&T West Team	5.60	5.60	0.00	0
Total	**14.40**	**12.60**	**1.80**	**13**
East & North SBU				
AMHCS Centenary & Jubilee	8.44	7.36	1.08	13
AMHCS Cygnet House	7.06	6.36	0.70	10
AMHCS Holly Lodge	4.50	5.50	-1.00	-22
AMHCS Saffron Ground	7.19	5.40	1.79	25

AMHCS Oxford House	3.69	2.35	1.34	36
AMHCS Rosanne House	9.00	6.00	3.00	33
Total	**39.88**	**32.97**	**6.91**	**17**
West SBU				
AMHCS NW Herts Dacorum	5.89	5.29	0.60	10
AMHCS NW Herts St Albans	6.40	5.40	1.00	16
AMHCS SW Herts	3.00	3.00	0.00	0
AMHCS SW Herts Borehamwood	1.49	1.49	0.00	6
AMHCS SW Herts Watford	6.20	5.80	0.40	6
Total	**22.98**	**20.98**	**2.00**	**9**
Overall Total	**77.26**	**66.55**	**10.71**	**14**

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 9c
Subject:	People and Organisational Development Report, Quarter Three: October – December 2020	**For Publication: Yes**
Author:	Louise Thomas, Deputy Director of People and OD	**Approved by:** Karen Taylor, Deputy CEO & Executive Director Strategy & Integration
Presented by:	Louise Thomas, Deputy Director of People and OD	

Purpose of the report:

To provide an update on the People and OD activities during Quarter 3 and key metrics/outcomes achieved during that Quarter.

Action required:

To receive the report

Summary and recommendations to the Board:

The People and OD Q3 Report sets out the key workforce metrics and activities that flow from the Trust's annual plan, our People Plan Priorities and the NHS People Plan.

The key headlines are as follows:

- Our vacancy rate has increased from 10.81% to 12.27%, however, this has been artificially inflated due to newly qualified nurses awaiting registration before being put into post and posts created in the establishment prior to onboarding new staff. The vacancy rate is expected to reduce as a result of significant work to reduce our registered and non-registered nursing vacancies. Bank and agency fill rates remain above 90% for our registered and non-registered nursing shifts, which ensures that we can maintain safe staffing levels and great care. Our unplanned turnover (8.41%) and stability rate (89.58%) have both improved and remain within target.
- Sickness absence increased from 3.36% in Q2 to 4.14% in Q3, but remains significantly lower than in Q3 of the previous year.
- Appraisal compliance has increased from 74.69% in Q2 to 85.53% in Q3. We had expected to achieve full compliance by end December, however, this was disrupted as a result of the increased pressures arising from the pandemic during December. We successfully piloted our new strengths based appraisal conversation tool in Q3 and received very positive feedback and approval to launch this fully in Q4.
- Mandatory training compliance has reduced from 90.21% in Q2 to 86.07% in Q3. Compliance has been impacted by increased pressures, with face to face training (apart from Respect training) stepped down in December. All in person training has been reinstated and recovery plans are in place to achieve compliance during 2021/22.
- Staff engagement was a particular focus during Q3, with our 19th Big Listen taking place virtually for the first time and participation having increased to over 350 staff members. In addition, we held our annual staff award ceremony via livestream and we conducted our annual staff survey. We achieved a final response rate of 52%, against a national median of 49%. During Q3, we fed back to staff the actions being taken as a result of the Big

Listen and our Q2 Pulse Survey.

- We refreshed and implementation of our Health & Wellbeing Strategy, launching a winter wellbeing programme, wellbeing action plans and conversations and a wellbeing induction for new staff. We also finalised preparations to launch in Q4 our new Here for You service for all health and social staff across the Herts and West Essex ICS.
- We continue to support leadership development and to engage with teams using the Great Teams framework to bring about positive culture change and team development.

Overall, our people metrics continue to be positive. However, a particular focus for us is appraisal and mandatory training compliance and continuing to reduce vacancy rates, particularly amongst our registered and non-registered nursing workforce. We are on track to deliver against the HPFT People Priorities, the Annual Plan and the NHS People Plan. Our main focus in Q4 will remain on health and wellbeing, engagement and our people recovery strategy. In addition, we will be undertaking further work with regards our just and inclusive culture.

The Board is asked to note the Q3 position and the work that is being undertaken to support delivery against the annual plan, HPFT People Priorities and the NHS People Plan, as well as the actions being taken to improve the position moving forward.

Relationship with the 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:

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

IGC – 8 March 2021
Executive team – 3 March 2021

Hertfordshire Partnership University NHS Foundation Trust

People and Organisational Development Report
Quarter Three: October – December 2020

1.0 Introduction

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

2.0 Executive Summary

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

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

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

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

The NHS People Plan identified the following four key themes:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on the discrimination that some staff face
- **New ways of working** – capturing innovation, much of it led by our NHS people
- **Growing for the future** – how we recruit, train and keep our people, and welcome back colleagues who want to return

And the following People Promises:

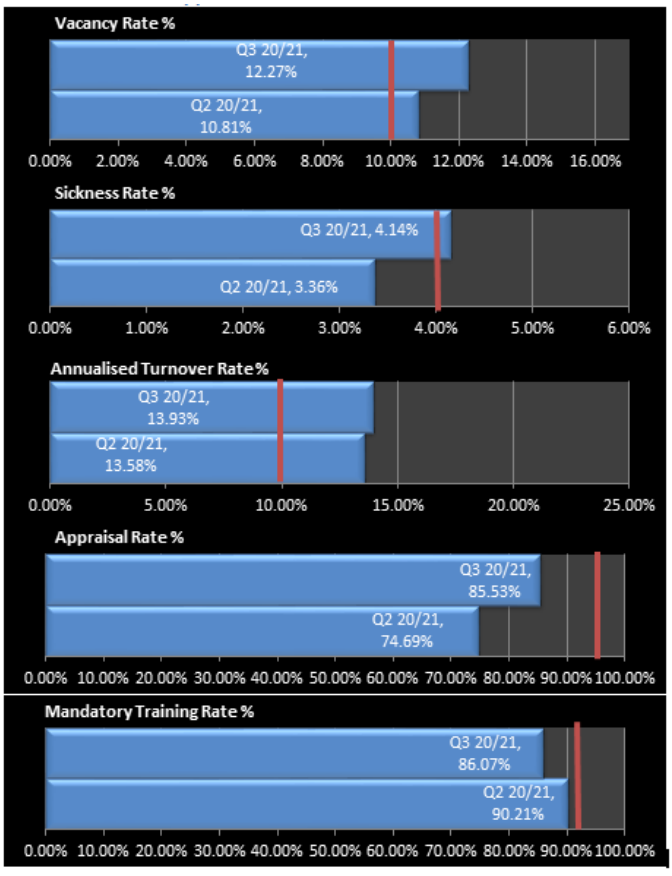
Our HPFT people and OD priorities for Q3 and the remainder of this financial year are, therefore:

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

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

3.0 Summary Position

Detailed below is the Q3 summary position:



3.1 Vacancy Rate

The vacancy rate has increased since Q2, standing at 12.27% and above our target rate of 10.5%. This figure was temporarily artificially inflated by the addition of new posts to the establishment prior to the start date of new staff and newly qualified nurses awaiting their NMC registration and therefore not appearing against their established post. We anticipate that this will reduce in Q4, as the anomaly in Q3 is resolved and as a result of heightened recruitment activity, in particular to the mass recruitment of Healthcare Support Worker (HCSW) posts. The overall turnover rate includes both planned and unplanned turnover, for example, fixed term contracts and rotational staff. The unplanned turnover rate remains healthy at 8.41% in Q3 (a reduction from 8.56% at the end of Q2 and below our target of 9%), as does our stability rate of 89.58%.

3.2 Sickness Absence

The sickness absence rate had been at the lowest for many years, at 3.36% in Q2. This increased in Q3 to 4.14%, however remained significantly lower than the same period of the previous year (5%) and was only slightly higher than our target of 4%.

The reasons behind this are as follows:

- At the end of Q3, instance of coronavirus in the community were rising and this was mirrored in an increase in staff absence due to Covid-19;
- Whilst the top reasons for absence were gastrointestinal and colds/flu and historically absence increase significantly during Q3 as a result of colds/flu, our continuing stringent infection, prevention and control (IPC) measures within the workplace and the national Hands, Face, Space drive has reduced the prevalence of colds/flu and infectious gastrointestinal complaints; and
- Whilst absence due to anxiety, depression and other mental ill health is one of the top three reasons for absence, we have undertaken significant work across the Trust regarding health and wellbeing to promote self-care and support staff, which has kept absence due to mental ill health lower than might otherwise be expected. Our people have consistently reflected back to us in our pulse surveys that the overwhelming majority (90%) believe that the Trust takes positive action in relation to staff health and wellbeing as result of the comprehensive package of support we have put in place.

3.3 Appraisals

The appraisal rate had been gradually decreasing for some time up to the end of Q2; the coronavirus pandemic undoubtedly contributed to a more significant decline in compliance. This has now increased from 74.69% at the end of Q2 to 85.53% at the end of Q4. We launched our pilot of a refreshed approach to appraisal conversations during Q3. The new approach is a strengths based appraisal conversation, which research tells us leads to more effective appraisals, which in turn lead to better outcomes for service users. The refreshed approach also offers a simplified form so that the length and complexity does not not act as a barrier to compliance, nor the quality of the conversation. The aim is to ensure a positive, constructive conversation that recognises the contribution of each of our people, thanks them and leaves them feeling valued, with a clear set of objectives, clear support and development in place to help achieve their work objectives and their

career aspirations and ensure clarity on how each individual can continue to contribute to the Trust and our equality and inclusion agenda. Feedback from the pilot has been overwhelmingly positive and we will fully launch the new appraisal conversation tool in Q4.

Significant work was undertaken during Q3 to improve appraisal compliance levels, however, heightened activity due to the changing nature of the pandemic from late November meant that we did not achieve our target of full compliance by the end of Q3, albeit that a compliance rate of 85.52% was achieved.

3.4 Mandatory Training

The mandatory training rate for the quarter has decreased from 90.21% in Q2 to 86.07% in Q3. Compliance has been affected by the pause in training delivery during the first wave of the pandemic. Whilst many training course moved online and additional face to face training was put in place to address the backlog, this was not fully resolved and was further impacted by the next phase of the pandemic during December. As a result of the changing context, face to face training, except for Respect training, was paused during the course of December. All training has resumed during Q4 and robust plans are in place to ensure we meet full compliance during 2021/22.

3.5 Establishment Data

The establishment data as at 31 December 2020 is as follows:

Funded Establishment =	3808.98
Staff in post =	3341.65
Vacant posts =	467.33
% Trust Vacancy rate =	12.27
% Total Turnover rate =	13.93
% Planned Turnover Rate =	5.52
% Unplanned Turnover Rate =	8.41
% Stability rate =	89.58

3.6 Key Recruitment Activity

At the end of Q2 the vacancy rate was 10.81%, which has increased to 12.27%. Whilst nursing vacancy rates have reduced since Q2 from 21% to 17.5% as a result of our newly qualified nursing campaign, our HCSW vacancies remain high, with 116.4 FTE vacancies (24% vacancy rate). Work commenced during Q3 to address these vacancies, following receipt of central funding from NHSE/I. We are implementing a robust and comprehensive plan to recruit to these HCSW posts and reduce our vacancy rate to zero by the end of Q4. We are currently on track to achieve this. In addition, during Q3, we recruited additional newly qualified nurses who will graduate and receive their nursing registration and therefore start employment as registered nurses during Q4. Finally, we successfully bid for funding during Q3 to support 11 of our HCAs who are registered nurses overseas to gain registration in the UK.

At the end of Q3, we had 467.33 vacant posts and 258 new starters in the recruitment pipeline.

Tables and graphs showing recruitment and vacancy information can be found in appendix 1, section 2 – Recruitment.

3.7 Junior Doctor Rotations

The December rotations were successfully managed in Q3 and preparatory work for the next rotation is being undertaken.

We also streamlined the junior doctor starter process for the December 2020 cohort to ensure they had all relevant access on their first day. In addition, we worked with Health Education England to improve the quality of trainee data and ESR positions, to enable a successful go live of the ESR Person Updates capability in October 2020 and support the national implementation of the Streamlined Doctors in Training Interface.

3.8 Consultant Recruitment

In Q3, one Advisory Appointment Committees (AAC) took place in November 2020 and one successful job offer was made. Further AAC panels are planned for Q4.

The Agency Locum usage as at the end of Q3 was seven, compared to 6 at the end of Q2 This is predicted to reduce to 4 in Q4, due to staff returning from long term sick leave and a new appointment taking up post in January 2021 and scheduled interviews in Q4.

3.9 Temporary Staffing

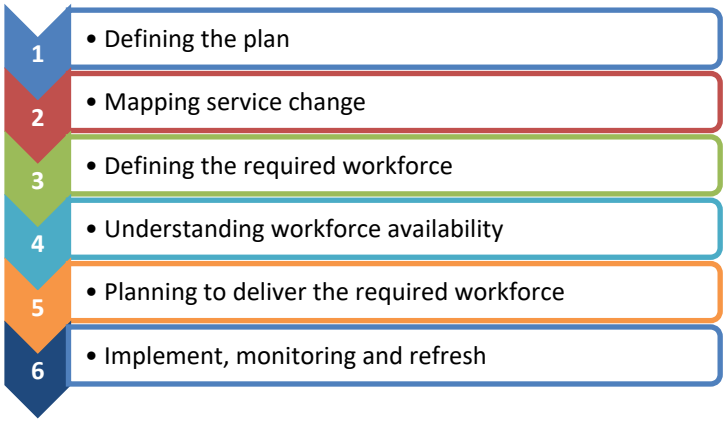
During Q3, 27,355 bank and agency shifts for registered nursing and HCA posts were requested across the Trust. 20,814 shifts were filled by bank workers and 3,921 were filled by agency workers. This is a total fill rate of 90.42%, which consists of a 76.09% bank fill rate and a 14.33% agency fill rate.

Further tables and graphs showing bank and agency information can be found in appendix 1, section 5 – Temporary Staffing

3.10 Workforce Planning

During Q3, an audit was commissioned to ensure workforce and business planning is aligned to finance and resources are being used efficiently. The audit considered the Trust's approach to workforce planning including the production of local Service Business Unit (SBU) workforce plans, how workforce plans aligned to wider financial plans and recruitment and retention strategies, and the governance arrangements in place to monitor performance of these strategies.

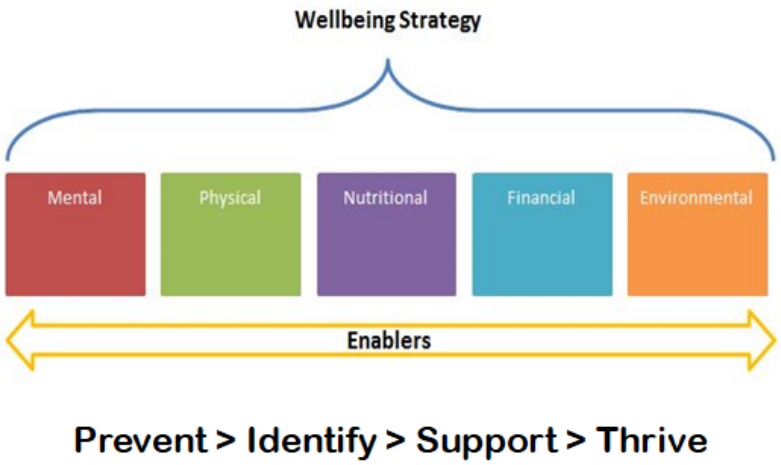
Whilst the audit provided partial assurance, it enabled us to develop a detailed action plan based on the audit's findings and best practice. The action plan is based on the NHSE/I 6 step methodology for workforce planning, as follows:



The action plan was received by the People and OD Group on 1 March and reflects the two high priority actions to take during Q4, in order to enable a robust approach to workforce planning to be fully embedded by October 2021. Further updates will be provided to the Committee in our Q4 report and progress will be monitored via the People and OD Group.

4.0 Health and Wellbeing

During Q3, we refreshed our Health and Wellbeing Strategy, which sets out the Trust's approach to supporting the health and wellbeing of our people, focused around 5 key pillars (mental, physical, nutritional, financial and environmental) and underpinned by a number of cultural enablers, as follows:



As part of implementing the strategy, we also launched our Winter Wellbeing Programme during Q3, with the following key themes:

- Be Energised
- Stay Nourished
- Refresh, Refocus & Rebalance
- Stay Connected & Be Inspired.

The programme comprises a comprehensive series of weekly activities, which were promoted via the Supporting You bulletin, HPFT News bulletin, the Hive and other all staff communications. 266 staff attended the virtual sessions, with 107 attending the exercise sessions, 98 attending the craft sessions and 61 attending the other sessions. The activities under each theme are summarised as follows:

4.1 Be Energised

A series of online activities took place each week, including Pilates, sessions from Jump n Juice, yoga, sessions on sleep and exercise and Tai Chi. In addition, staff continued to have free access to Apps such as Headspace and Sleepio and webinars from IAPT in relation to supporting healthy lifestyles and sleep.

4.2 Stay Nourished

Weekly activities included webinars on healthy eating to promote wellbeing and vitality. In addition, we recommenced regular delivery of snacks to inpatient sites.

4.3 Refresh, Refocus and Rebalance

Emotional wellbeing remained a particular focus and we provided a comprehensive offer to staff:

- Some units (particularly older peoples) have support from the psychological services team who are running pause spaces and providing 1-1 emotional drop in support.
- All staff have access to the emotional wellbeing hotline, Occupational Health and the Employee Assistance Programme.
- All staff who test positive are receiving a wellbeing call to ensure they are supported following their positive swab test.
- All Team Leaders and managers are invited to a weekly support call with Andrew Nicholls, Head of Psychology.
- All staff have access to a range of webinars from IAPT and the New Leaf College.
- Free access to the national support lines and Apps continues.
- We are running sessions on mindfulness, resilience, positivity and emotional intelligence.

- The staff resilience hub will also make an important contribution to the wellbeing offer to staff.

4.4 Stay Connected & Stay Inspired

As part of our Winter Wellbeing Programme, we ran craft sessions and sessions on communication. In addition, our staff networks continued to be supported to meet regularly, with Exec and SLT support. We launched a fortnightly check in "How are you?" virtual space for all staff, including shielding staff. The live Q&A sessions with Tom and the Executive Team, Inspire Awards, HPFT News and Supporting You bulletins also continued. The individual risk assessment reviews and appraisals also remained valuable check in points to enable supportive conversations to take place. In addition, we launched our wellbeing conversations and action plans for all staff during Q3 and launched the Health and Wellbeing Induction for all new staff. The Five Questions: Supporting each other through exceptional leadership were resent to the Senior Leaders Forum group as a reminder to keep checking in with people so we can make sure they are fully supported.

4.5 Here for You Service

During Q3, we prepared for the January launch of the Herts and West Essex ICS wide psychological support service 'Here for You'. This is a joint collaboration between the Trust and EPUT, which is now available to all health and social care staff across the ICS. The funding was secured via a joint bid, with services being jointly provided between HPFT and EPUT.

4.6 People Recovery Strategy

As we look towards a new phase in the pandemic and in the context of over 80% of our staff having been vaccinated at this point, we also look to our recovery strategy. The recovery of our people after a year of working in the Covid-19 pandemic is significant. Our recovery strategy is based on a person-centred and values driven approach that supports Great People, Great Organisation, Great Care and Great Outcomes. There are five key pillars to the strategy:

- Paying witness to what's happened
- Rest and recuperation
- Reward and recognition
- Health and well-being
- Keeping our people

We have engaged with the senior leadership forum to sense check these areas and to gain early thinking on the work that might support each pillar. In addition, Staffside colleagues have shared their early thinking on recovery. A theme common to all the feedback so far is that one size does not fit all and each person will have different needs, hence the need for a person-centred approach. This early feedback also informs our proposed next steps, which are to consult widely with staff and staffside representatives to co-design our approach. This work is being taken forward during Q4.

5.0 Great Teams, Great People

We are engaging with 22 teams as part of our Great Teams work. However, engagement has been impacted by heightened activity due to the pandemic towards the end of Q3. More frequently, an OD consultancy approach within the framework of the Great Teams model has been needed by teams and we have adopted a flexible approach to engaging with teams to ensure they receive the support they need in their specific circumstances to become high performing 'Great Teams'.

We continue to support leadership development, having moved some leadership training online and created new virtual leadership development training and moved our senior leaders forum to an online format. In addition, we have produced guidance that links to bite-sized video based training resources which managers can access on demand, linked to our values. We have also co-led at ICS level on the development and launch of a compassionate Leadership Development offer to improve positive leadership behaviours at all levels in HPFT and within the ICS. This launched during Q3.

6.0 Engagement

Three Inspire Award presentations took place this quarter. We also held our first virtual, livestreamed Annual Staff Award Ceremony in December, which was an emotional and incredibly well received event to celebrate and take pride in our staff.

We also held our first Virtual Big listen week-long event in October 2020, comprising of:

- An Opening Session from the Chief Executive and Director of People and Organisational Development, sharing their thoughts and reflections on the past year and why the Big Listen is so important at HPFT.
- Listening Sessions hosted by members of the Executive Team - focussed on listening to staff. Staff discussed their priorities and concerns with Executive Team helping them to understand how to improve and support our teams.
- Wellbeing Wednesday was dedicated to supporting staff wellbeing and taking time out to reflect and learn. Workshops included four Mindfulness sessions, an HPFT Network Session, Schwartz Round – Let's talk about Race.
- On Friday we also held a special Ruby Wax Frazzled Café.
- Question Time and Summary with the Executive Team & a message from Ruby Wax. Closing the week, the Deputy Chief Executive, summarised the themes from the week. The session also saw the Executive Team answering live questions from staff about a number of different topics.

Although the event was our first virtual event, it was our 19th Big Listen and we achieve far greater engagement through the virtual medium and having sessions spread over a week, with over 350 staff participating. Some of the feedback we received about the Virtual Big Listen included:

> "Due to pressures of work, sometimes I cannot usually attend the Big Listen. Having it take place virtually over a week was great; it allowed me to attend different sessions at my convenience"

> "I enjoyed the intimacy of the Listening Sessions. My concerns were listened to and taken on board by the executive team member"

"Meeting with the executive team and discussing issues that matter to me. Along with interaction with other staff from different teams"

We published our Autumn You Said We Did quarterly staff feedback update, setting out the feedback received from our Q2 pulse survey and the Virtual Big Listen and the actions we are taking as a result of the feedback.

Finally, we achieved a 52% response rate in the annual staff survey, against a median national response rate of 49%. The results are reported to Board separately, however, the key headlines are as follows:

- Overall, our results are overwhelmingly positive, with 57 of 78 questions higher than the national average.
- The questions are grouped together to provide 10 key themes. Over the 10 themes, 7 were higher than the national average, with health and wellbeing, safety culture, support from immediate managers, morale, engagement and quality of care being most notable.
- 92% of people said their roles made a positive difference to service users (the 3rd highest score in the country)
- 88% of people said that care of service users was HPFT's top priority (the 2nd highest score in the country)
- 76% of people would recommend us as place to work to their friends and family (again the 2nd highest score in the country)
- 76% of people would recommend us to their own friends and family if they needed care (ranking well within the top 10 in the country)
- There are always areas we can improve on and strengthen. Of the 10 themes, the three areas we need to strengthen are:
    - Equality, diversity and inclusion – in particular this relates to fairness in career progression/promotion and discrimination experienced from service users/carers/the public;
    - Bullying & harassment; and
    - Violence – in particular, violence experienced from service users/carers/the public.

We are now talking to all our people about the results and engaging on the areas staff believe we should focus on and co-producing action plans at team, SBU and Trust level to continuously improve the experience of our people.

7.0 Conclusion

Overall, our people metrics continue to be positive. However, a particular focus for us is appraisal and mandatory training compliance and continuing to reduce vacancy rates, particularly amongst our registered and non-registered nursing workforce.

We are on track to deliver against the HPFT People Priorities, the Annual Plan and the NHS People Plan. Our main focus in Q4 will remain on health and wellbeing, engagement and our people recovery strategy. In addition, we will be undertaking further work with regards our just and inclusive culture.

8.0 Recommendation

The Board is asked to note the Q3 position and the work that is being undertaken to support delivery against the annual plan, HPFT People Priorities and the NHS People Plan as well as the actions being taken to improve the position moving forward.

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 9d
Subject:	Guardian of Safe Working Hours Quarterly Report (Q3) October – December 2020	**For Publication:** yes
Author:	Dr Snehita Joshi, Consultant Psychiatrist and Guardian of Safer Working	**Approved by:** Dr Asif Zia, Director of Quality and Medical Leadership
Presented by:	Dr Asif Zia, Director of Quality and Medical Leadership	

Purpose of the report:

To present the Quarterly Guardian Report, covering October to December 2020 to the Board

Action required:

To note the report

Summary and recommendations to the Board:

Summary

uring this quarter there have been 11 exception reports raised by our trainees and Trust doctors. There has been a decrease in locum spend since the previous report, this is as a result of further cross cover being implemented. During this reporting period the sickness absence for junior doctors was 3%, in addition 9% of absence was due to self-isolation following symptomatic /positive COVID test, this did result in on-call rota gaps. There were also a number of vacant rota slots due to LTFT(less than full time) trainees however there is a plan in place to reduce reliance on locums to cover these LTFT slots from December 2020, which has now been introduced.

Relationship with the Business Plan & Assurance Framework:

BAF assurance framework

Summary of Implications for:

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

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

Seen by the following committee(s) on date:

Considered by QRMC at its meeting on 24 February 202, IGC 8 March 2021

Guardian of Safe Working Hours Quarterly Report (Q3) October – December 2020

1) Executive summary

- This is the Quarterly Guardian Report, covering October to December 2020.
- During this quarter there were 11 exception reports raised by our trainees and Trust doctors.
- There has been a decrease in locum spend since the previous report, this is as a result of further cross cover being implemented. During this reporting period the sickness absence for junior doctors was 3%, in addition 9% of absence was due to self-isolation following symptomatic /positive COVID test. This resulted in on-call rota gaps. There were also a number of vacant rota slots due to LTFT(less than full time) trainees however there is a plan in place to reduce reliance on locums to cover these LTFT slots from December 2020, which has now been introduced.
- The Guardian of Safe working delivers a presentation at each junior doctor induction to ensure that the trainees are aware of exception reporting process. In addition, emails have recently been sent out to trainees to remind them of the processes involved in Exception reporting.

2) Time allocation for Guardian of Safe Working Role

- Amount of time available in job plan for guardian to do the role: 2 PA's
- Admin support provided to the Guardian (if any): Medical Staffing
- Amount of job-planned time for clinical supervisors: 0.25 PAs per Trainee

3) High level data for Junior Doctor posts

- Data below gives the number of trainees of different grade working for the organisation. There are separate arrangements between HPFT and local trusts around core trainees rotating through psychiatric posts in Buckinghamshire, Norfolk and Essex.
- All training posts (junior doctor posts) except trust doctor posts are part funded by the Deanery and the Regional Post Graduate Dean, Health Education East of England has oversight of their training and education.

- There are currently 72 doctors of different grades in training in the trust. Most of the trainee posts are in Hertfordshire. Trust Doctors posts have been recruited from overseas against posts that were left vacant after national recruitment.

- The time that each grade spends within the trust varies considerably. Core psychiatric trainees and Specialist trainees are training grades for psychiatrist and spend between 3-6 years respectively completing their psychiatrist training. Other grades work for up to 4 months in psychiatry and then rotate between different hospitals/ specialties and primary care.

October 2020

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	27	1	0	0	28
Specialist Registrars	11	1	0	1	13
FY2 trainees	8	0	0	0	8
FY1 trainees	8	0	0	0	8
GPST	15	0	0	0	15
Innovative GPST	2	0	0	0	2
Trust	14	0	0	1	15
Total	85	2	0	2	89

November 2020

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	Number of Doctors on 2016 contract
Core trainees	27	1	0	0	28
Specialist				1	13

Registrars	11	1	0		
FY2 trainees	8	0	0	0	8
FY1 trainees	8	0	0	0	8
GPST	15	0	0	0	15
Innovative GPST	2	0	0	0	2
Trust	14	0	0	1	15
Total	85	2	0	2	89

December 2020

No. of Trainees	**Hertfordshire**	**Buckinghamshire**	**Norfolk**	**Essex**	**Number of Doctors on 2016 contract**
Core trainees	29	1	0	0	30
Specialist Registrars	9	1	0	1	11
FY2 trainees	7	0	0	0	7
FY1 trainees	8	0	0	0	8
GPST	14	0	0	0	14
Innovative GPST	2	0	0	0	2
Trust	15	1	2	1	19
Total	84	3	2	2	91

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

October 2020 – 89 Junior doctors (including Trainees/ LTFT/ Trust doctors)

November 2020- 89 Junior doctors (including Trainees/ LTFT/ Trust doctors)

December 2020- 91 Junior doctors (including Trainees/LTFT/ Trust doctors)

4) Vacancies

- The number of vacancies in this quarter is lower than in the last quarter. Stats are as follows:
- **October 2020- 4 WTE**
- 1 Specialty Trainee – Herts
- 1 Specialty Trainee- Norfolk
- 1 Trust Doctor- Norfolk
- 1 Specialty Trainee- Bucks

- **November 2020-4 WTE**
- 1 Specialty Trainee- Herts (undertaking acting up role as Locum Consultant)
- 1 Specialty Trainee- Norfolk
- 1 Trust Doctor- Norfolk
- 1 Specialty Trainee- Bucks

- **December 2020 - 3 WTE (5 WTE until 14/12/20- Bucks and 21/12/20- Norfolk)**
- 2 Specialty Trainee- Herts (both trainees undertaking acting up roles as Locum Consultant)
- 1 Trust Doctor- Norfolk

- The issue mentioned in previous reports of a number of specialist trainee posts that are being filled by a junior doctor of a lower training grade continues to present challenges. However we are due to receive 4 new Specialty Trainees from February 2021 as well as a returning Specialty Trainee from maternity leave. Since the previous report 1 Specialty Trainee has commenced maternity leave as well as 2 acting up as Locum Consultant.

5) Exception reports (with regard to working hours)

- As part of Junior Doctor Contract review process, in 2016, DoH and BMA agreed that junior doctors who are asked to work outside their work schedule (e.g. Work carried out after working hours) and or when asked to cover additional work (e.g. cover for sickness or rota gaps) would be able to raise an Exception report. A secure electronic portal system was set up for the reporting purposes and role of Guardian of Safe Working was established to monitor and report to the trust Board on number of exception reports being raised.

- There were 11 exception reports raised by the junior doctors in this Quarter. Below tables provide the breakdown by department and grade of junior doctors.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General adult psychiatry	0	9	9	0
Learning disability and forensic	0	2	1	1
Old age psychiatry	0	0	0	0
Child and adolescent psychiatry	0	0	0	0
Total	**0**	**11**	**10**	**1**

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1/F2	0	1	1	0
GPST	0	0	0	0
CT1-3	0	2	1	1
ST4-6	0	8	0	0
Trust	0	0	0	0

- The main themes from these exception reports were to do with additional hours worked.

- All exception reports from previous quarters have been reviewed by the Guardian of Safe Working. All Junior doctors who still have open exception reports have been contacted for further update for their exception report now being resolved.

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

6) Work schedule reviews

- During this quarter there were no recorded requests for work schedule reviews by either trainees or clinical supervisors. One clinical supervisor was advised to consider a work schedule review in response to a series of exception reports. This remains outstanding at the time of this report.

7) Fines

- No fines were issued during this period.

8) Locum spend

- During this quarter the total cost for bank locums for the 1st on call rota was £32,886 and £14,007 for the second on call.

- Out of a total of 163 gaps on the rota, 101 were successfully covered by using bank & Agency locums, 58 were covered by cross covering with other on-call doctors and there were 3 instances where step down was required.

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

9) Locum work by HPFT doctors for other NHS Trusts
(Did any HPFT doctors do locum shifts for other organisations?)

There were no other shifts that we are aware of declared at different organisations.

Summary

- This quarterly report provides data on the safe working hours for junior doctors.
- The 1st on call rota is currently 1:15 and 2nd on call was 1:10 with 6 SAS doctors underpinning in October and November which then increased to 1:13 with 5 SAS doctors underpinning from December.
- There have been 11 exception reports in this quarter.
- Sickness absence has slightly increased in this Quarter. Medical staffing are liaising with clinical supervisors and trainees to ensure accurate reporting as well as return to work interviews taking place robustly. Covid19 risk assessments are also being completed to ensure junior doctors are supported.
- Most of the gaps have been covered by Bank locums with some agency bookings.
- The Guardian of Safer working co-chairs a monthly Junior doctor forum that is run virtually. In addition there is also a weekly meeting held with Junior Doctor Reps, Guardian of Safe working, DME's and Medical Staffing in order for any concerns or questions to be raised and resolved in a timely manner.

Dr Snehita Joshi

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 10
Subject:	2020 Annual Staff Survey Results	**For Publication:** Yes
Author:	Louise Thomas, Deputy Director of People and OD	**Approved by:** Karen Taylor, Deputy CEO & Executive Director Strategy & Integration
Presented by:	Louise Thomas, Deputy Director of People and OD	

Purpose of the report:

To present the 2020 annual staff survey results.

Action required:

To receive the report.

Summary and recommendations to the Board:

The 2020 annual staff survey was undertaken between 30 September and 27 November 2020. We achieved a response rate of 52%, compared to a median response rate of 49% among all other 52 Mental Health and Learning Disability Trusts which comprises a total of 52 trusts.

This report sets out the high level results, which are overwhelmingly positive, with the following key headlines:

- 57 of the 78 questions scored more highly than the national average;
- Over the ten themes into which questions are grouped, seven were higher than the national average, with health and wellbeing, safety culture, support from immediate managers, morale, engagement and quality of care being most notable;
- 92% of people said their roles made a positive difference to service users (the third highest score nationally);
- 88% of people said that care of service users was the Trust's top priority (the second highest score nationally);
- 76% of people would recommend us as place to work to their friends and family (the second highest score nationally); and
- 76% of people would be happy with the standard of care we provide if their own friends and family needed our care (the seventh highest score nationally).

Although the results are positive, there are areas we can improve on and these are detailed in this report. The three areas in particular we will focus on in order to improve staff experience across the Trust are:

- Equality, diversity and inclusion, especially in relation to career progression/promotion and as experienced from service users/relatives/the public;
- Bullying & harassment, especially as experienced from service users/relatives/the public.; and
- Violence experienced by staff from service users/relatives/the public

The staff survey results are being widely shared and discussed across the team to enable engagement at team, strategic business unit (SBU) and Trust level, in order to co-design action plans at each level which are meaningful and which will genuinely improve staff experience across the Trust.

Recommendation to the Board

The Board is asked to note 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:

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

Executive Committee 17 March 2021

Preliminary 2020 Annual Staff Survey Results

1. Introduction

1.1 This report provides a high level analysis of the 2020 staff survey based on the information received by the NHS Staff Survey National Coordination Centre, which was published on 11 March 2021.

1.2 The report sets out the methodology used for the 2020 staff survey and our response rate.

1.3 The results of the 2020 staff survey are overwhelming positive. The areas of strength, where we achieved better results than our comparator group or our 2019 results are detailed in this report, together with detail of the areas we will focus on in order to continue to improve staff experience.

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

2. Participation and Methodology

2.1 There are two staff survey providers which NHS trusts can commission to carry out the NHS annual staff survey so that individual responses are anonymous and confidential. The Trust opted to engage Picker, as we have in previous years. Picker surveyed 27 of the 52 Mental Health and Learning Disability trusts this year. In 2019, this figure was 17.

2.2 The annual staff survey launched on 30th September 2020 and closed on 27th November 2020. The survey was sent to staff via email; however, staff without easy access to IT equipment were also sent paper surveys.

2.3 All teams who achieved a response rate of 75% and over were entered into a prize draw to win a hamper of goodies for the team. 17 teams attained at least a 75% response rate and the Safer Care Team won the prize draw.

2.4 Overall, we achieved a 52% response rate against a median of 49% and a 2019 response rate of 57%. The actual number of responses we received however was greater this year (1803 compared to 1786 in 2019). This provides a healthy sized, representative sample of views to help inform our knowledge of staff experience.

2.5 The Staff Survey Coordination Centre has now sent our final results, compared against the 52 other Mental Health and Learning Disability Trusts nationally. Whilst this does not include statistical significance data at question level, it does include our final Workforce Race Equality Standard and Workforce Disability Equality Standard data.

3. Overview of Results

3.1 Of the 78 questions asked, 58 were above the national average. Whilst Picker provides statistical significance at individual question level, the NHS

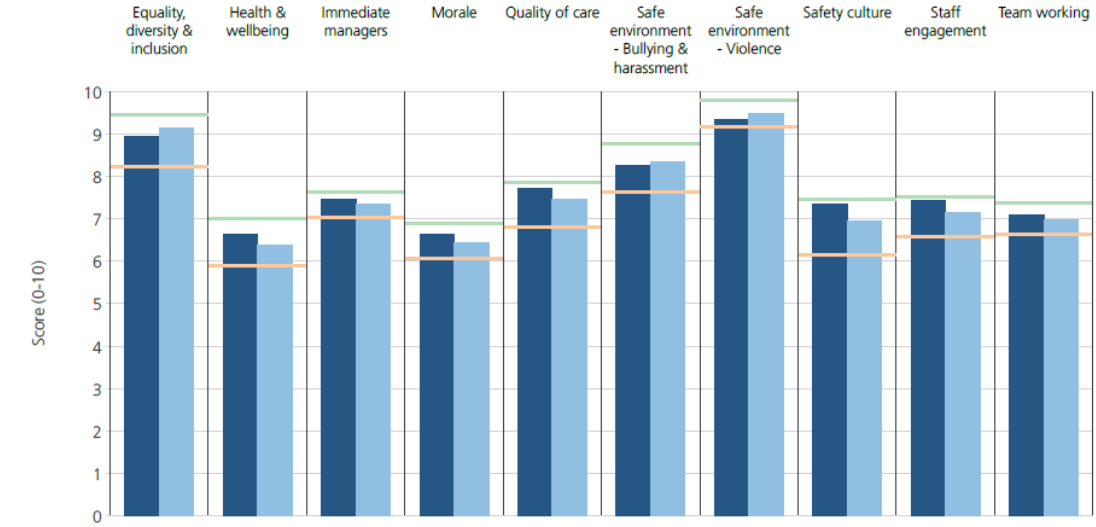
National Coordination Centre provides this only at thematic level. The Coordination Centre collates questions into 10 themes, as shown below in Figure 3. Overall, our Health and Wellbeing score shows a statistically significant improvement since 2019.

Figure 3: Significance testing: 2019 v. 2020 results

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.9**	1757	**8.9**	1770	Not significant
Health & wellbeing	**6.3**	1766	**6.6**	1773	↑
Immediate managers †	**7.4**	1765	**7.4**	1772	Not significant
Morale	**6.5**	1734	**6.6**	1758	Not significant
Quality of care	**7.7**	1533	**7.7**	1533	Not significant
Safe environment - Bullying & harassment	**8.1**	1748	**8.2**	1707	Not significant
Safe environment - Violence	**9.3**	1752	**9.3**	1765	Not significant
Safety culture	**7.2**	1755	**7.3**	1767	Not significant
Staff engagement	**7.4**	1776	**7.4**	1786	Not significant
Team working	**7.1**	1756	**7.1**	1765	Not significant

3.2 Each of the 10 themes are also compared against the national average scores, as shown in Figure 4, below.

Figure 4: Thematic comparison with national averages



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	8.9	6.6	7.4	6.6	7.7	8.2	9.3	7.3	7.4	7.1
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	1,770	1,773	1,772	1,758	1,533	1,707	1,765	1,767	1,786	1,765

3.3 Across the following seven themes, the Trust's score was higher than the national average:

- Health and wellbeing

- Immediate managers
- Morale
- Quality of care
- Safety culture
- Staff engagement
- Team working

3.4 The following three themes scored lower than the national average, albeit not significantly so. These are:

- Equality, diversity and inclusion;
- Bullying and harassment; and
- Violence

3.7 The scores in relation to the questions categorised under each of these three themes are set out in more detail in the following section.

4. Detailed Results

4.1 Health and wellbeing

4.1.1 Under the theme of health and wellbeing, the Trust scored higher than national average (6.6 compared to a national average of 6.4). Our score on this theme was also statistically significantly improved since 2019.

4.1.2 The follow questions are aggregated to determine our score under health and wellbeing. The colour of the 2020 score denotes whether this is higher than (green), similar to (amber) or worse than (red) the national average score. The direction of the arrow denotes whether the score has improved compared to 2019:

2020 Score	2019 Score	Nat. Ave.	Survey Question
72.2%↑	67.8%	66.2%	Q5h. Satisfied with opportunities for flexible working patterns
45.4%↑	37.6%	38.6%	Q11a. Organisation definitely takes positive action on health and wellbeing
29.2%↑	23.2%	26.9%	Q11b. In last 12 months, have experienced musculoskeletal (MSK) problems as a result of work activities
38.6%↔	38.8%	43.2%	Q11c. In last 12 months have felt unwell due to work related stress
43.4%↓	56%	45.6%	Q11d. In last 3 months, have come to work when not feeling well enough to perform duties

4.2 Immediate managers

4.2.1 Under the theme of immediate managers, the Trust scored higher than national average (7.4 compared to a national average of 7.3).

4.2.2 The following questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
76.3%↑	76%	76.1%	Q5b. The support I get from my immediate manager
69.9%↓	71.2%	69.9%	Q8c. My immediate manager gives me clear feedback on my work
65.3%↑	64.3%	63.7%	Q8d. Immediate manager asks for my opinion before making decision that affect my work
79.9%↑	77.4%	77%	Q8f. Immediate manager takes a positive interest in my health and wellbeing
80.1%↑	79.6%	78.8%	Q8g. My immediate manager clause my work

4.3 Morale

4.3.1 Under the theme of morale, the Trust scored higher than national average (7.4 compared to a national average of 7.3g).

4.3.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
54.7%↔	54.9%	55.5%	Q4c. I am involved in deciding on changes that affect my work area/team/department
76.9%↔	76.7%	75.7%	Q4j. I receive the respect I deserve from my colleagues at work
26.9%↑	23.1%	26.9%	Q6a. I have realistic time pressures
64.9%↑	64%	63.8%	Q6b. I have a choice in deciding how to do my work
58.5%↑	56%	53.6%	Q6c. Relationships at work are unstrained
78.5%↑	↔77.9%	77.3%	Q8a. My immediate manager encourages me at work
21.2%↓	23.9%	24.9%	Q19a. I often think about leaving this organisation

18.3%↓	21.2%	19.2%	Q19b. I am likely to look for a job at a new organisation in the next 12 months
11.8%↓	12.8%	12.6%	Q19c. As soon as I can find another job, I will leave this organisation

4.4 Quality of care

4.4.1 The Trust scored higher than national average (7.7 compared to a national average of 7.5) in relation to the quality of care theme. This score is fourth best nationally, compared to a national best score of 7.9.

4.4.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
85.3%↔	85.3%	82.3%	Q7a. Satisfied with quality of care I give to service users
91.7%↑	90.3%	89.4%	Q7b. Feel my role makes a difference to service users
74.6%↑	71.9%	68.8%	Q7c. Able to provide the care I aspire to

4.4.3 The score for the question “My role makes a difference to service users” is the third highest nationally and is 0.1% lower than the national best score.

4.5 Safety Culture

4.5.1 The Trust scored higher than national average (7.3 compared to 6.9 nationally) in relation to the safety culture theme. This score is third best nationally, against a national best score of 7.5.

4.5.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
62.9%↔	63.2%	60.7%	Q16a. Organisation treats staff involved in errors/near misses/incidents fairly
82.5%↑	78.4%	73.9%	Q16c. Organisation takes action to ensure errors/near misses/incidents are not repeated
73.7%↑	70.5%	64.7%	Q16d. Staff given feedback about changes made in response to reported errors/near misses/incidents
78.8%↑	78.1%	75.7%	Q17b. Would feel secure raising concerns about unsafe clinical practice

71.4%↑	69.8%	63.1%	Q17c. Would feel confident that organisation would address concerns about unsafe clinical practice
84.6%↔	84.5%	77%	Q18b. Organisation acts on concerns raised by service users

4.6 Staff engagement

4.6.1 The Trust scored higher than national average (7.3 compared to 6.9 nationally) in relation to staff engagement. This score is fifth best nationally, compared to the national best of 7.5.

4.6.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
63.8%↓	64.9%	61.1%	Q2a. Often/always look forward to going to work
76.3%↔	76.8%	74.7%	Q2b. I am enthusiastic about my job
80.7%↑	80%	78.5%	Q2c. Time often/always passes quickly when I am working
75.9%↑	75.2%	75.6%	Q4a. There are frequent opportunities for me to show initiative in my role
77.9%↔	77.7%	78%	Q4b. I am able to make suggestions to improve the work of my team / department
62%↑	60.2%	61.1%	Q4d. am able to make improvements happen in my area of work
87.7%↑	85.8%	80.5%	Q18a. Care of service users is organisation's top priority
76.1%↑	73.7%	67.7%	Q18c. Would recommend organisation as place to work
75.9%↑	75.6%	70.4%	Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation

4.6.3 There are several highlights to note in relation to staff engagement:

- 88% of staff stated that care of service users is our top priority at HPFT. This is the second highest score nationally.
- 76% of staff would recommend us to family and friends as a place to work. This is the second highest score nationally.
- 76% of staff would be happy with the standard of care provided by us if their own family or friends needed care. This is another score in the national top 10.

4.7 Team working

4.7.1 The Trust scored higher than national average (7.1 compared to 7.0 nationally) in relation to team working.

4.7.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
75.2%↑	75.9%	74.6%	Q4h. The team I work in has a set of shared objectives
69.8%↑	69.2%	69.8%	Q4i. The team I work in often meets to discuss the team's effectiveness

4.8 Equality, diversity and inclusion

4.8.1 The Trust scored lower than national average (8.9 compared to 9.1 nationally) in relation to equality, diversity and inclusion.

4.8.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
84.6%↓	86.5%	86.6%	Q14. Organisation acts fairly with regard to career progression/promotion regardless of protected characteristics
9.7%↓	11%	6.7%	Q15a. Experienced discrimination from service users/relatives/other members of the public in last 12 months
8.3%↓	8.4%	7.1%	Q15b. Experienced discrimination from manager/team leader or other colleagues in last 12 months
86.8%↑	80.2%	81.2%	Q26b. Disability: organisation made adequate adjustment(s) to enable me to carry out work (New)

4.8.3 10% of our staff report experiencing discrimination from service users/relatives/the public, compared to 7% nationally.

4.8.4 8% of staff reported experiencing discrimination from their colleagues or manager, compared to 7% nationally.

4.8.5 63% of staff who reported experiencing discrimination stated that it was on the grounds of their ethnicity (this figure was 40% nationally).

4.9 Bullying and harassment

4.9.1 The Trust scored lower than national average (8.2 compared to 8.3 nationally) in relation to bullying and harassment.

4.9.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
28%↓	29.3%	26.7%	Q13a. Experienced harassment, bullying or abuse from service users, relatives or the public in last 12 months
10.2%↓	11.5%	10.5%	Q13b. Experienced harassment, bullying or abuse from managers
14.4%↓	15.8%	15.5%	Q13c. Experienced harassment, bullying or abuse from other colleagues

4.10 Violence

4.10.1 The Trust scored lower than national average (9.3 compared to 9.5 nationally) in relation to violence.

4.10.2 The follow questions are aggregated to determine our score:

2020 Score	2019 Score	Nat. Ave.	Survey Question
18.3%↓	20.1%	14.9%	Q12a. Experienced physical violence from service users, relatives or the public in the last 12 months
0.7%↑	0.1%	0.4%	Q12b. Experienced physical violence at least once from managers in last 12 months
1.4%↑	1.1%	1%	Q12c. Experienced physical violence at least once from colleagues in last 12 months

5. Workforce Race Equality Scheme and Workforce Disability Equality Scheme

5.1 26% of respondents reported a BAME ethnic background.

5.2 25% of respondents stated that they had a physical or mental health condition or illness lasting or expecting to last for 12 months of more.

5.3 In relation to the Workforce Race Equality Scheme questions:

- Three questions have improved since 2019 and are better than the national average score, however, there remains a significant difference in experience between BAME and white staff;

- Our score in relation to fairness of progression/promotion was 5% lower than in 2019, albeit that this was the same as the national average.

5.4 The four Workforce Race Equality Scheme question scores were as follows:

2020 Score		2019 Score		Nat. Ave.		Survey Question
White	BAME	White	BAME	White	BAME	
91%	73%↓	91%	78%	89%	73%	Q14. Organisation acts fairly with regard to career progression/ promotion regardless of protected characteristics
6%	12%↓	6%	14%	6%	15%	Q15b. Experienced discrimination from manager/team leader or other colleagues in last 12 months
18%	20%↓	20%	25%	20%	25%	Q13b. Experienced harassment, bullying or abuse from manager/team leader or other colleagues in last 12 months
25%	29%↓	26%	36%	25%	32%	Q13a. Experienced harassment, bullying or abuse from service users, relatives or the public in last 12 months

5.5 In relation to the Workforce Disability Equality Scheme questions:

- Two questions showed an improvement since 2019 and no difference in treatment between staff with a long term condition/illness and staff without;
- Six questions showed an improvement since 2019 and were better than the national average score, however, there continues to be a difference in experience;
- The question relating to the extent to which staff feel valued by HPFT, however, showed a decrease of 5% compared to 2019 and a difference of 9% between staff with and staff without a long term condition or illness.

5.6 The Workforce Disability Equality Scheme question scores were as follows:

2020 Score – with a LTC or illness?		2019 Score – with a LTC or illness?		Nat. Ave. – with a LTC or illness?		Survey Question
Yes	No	Yes	No	Yes	No	
85%↔	86%	85%	88%	82%	89%	Organisation acts fairly with regard to career progression/ promotion regardless of protected characteristics
31%↓	25%	36%	27%	32%	25%	Experienced harassment, bullying or abuse from service users, relatives or public in last 12 months
13%↓	8%	14%	10%	15%	9%	Experienced harassment, bullying or abuse from manager in last 12 months
18%↓	12%	21%	14%	21%	13%	Experienced harassment, bullying or abuse from colleagues in last 12 months
63%↑	57%	58%	59%	59%	61%	They/colleague reported the harassment, bullying or abuse the last time it was experienced
18%↓	17%	19%	14%	24%	17%	Felt pressure from manager to come to work when not well enough to perform their duties
52%↓	61%	57%	60%	45%	55%	Satisfied with extent the organisation values their work
87%↑	-	81%	-	81%	-	Employer has made adequate adjustments to enable them to carry out their work
7.3↔	7.5	7.3	7.4	6.8	7.3	Staff engagement score

6. Next Steps

6.1 An overview of the staff survey results, together with detailed heatmaps of the theme and question level results have been shared with the Executive and Senior Leadership Team. The Senior Leadership Team have been asked to engage with their people at team and SBU level to ensure that action plans are co-created with staff at all levels.

6.2 We have shared the headlines and detail of our staff survey responses with all our people and staffside representatives. We are also actively engaging

with the staff networks and at Trust level to co-create a meaningful staff survey action plan. Whilst we will celebrate the overwhelmingly positive staff survey results, our action plans will focus on improving staff experience in relation to equality, diversity and inclusion, violence and bullying, harassment and abuse.

6.3 We will finalise and communicate our action plans by the end of April 2021 and we will monitor progress against the plans to continue to improve the experience of all our staff at team, SBU and Trust level.

7. Conclusion

7.1 The staff survey results are overwhelmingly positive: 57 of the 78 questions are above the national average and we score higher than the national average in seven of the ten themes. Several questions under the quality of care and morale themes are amongst the highest nationally.

7.2 In line with our Annual Plan, we continue to aim to improve the employment experience of all of our people. We will engage with staff to identify team, SBU and Trust level areas for improvement and co-design with staff plans to act on these in order to continuously improve staff experience.

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

NHS
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Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 11
Subject:	Report from Finance & Investment Committee – 16 March 2021	**For Publication:** Yes
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** David Atkinson, Non-Executive Director, Chair – Finance & Investment Committee
Presented by:	David Atkinson, Non-Executive Director Chair – Finance & Investment Committee	

Purpose of the report:

This paper provides a summary report of the items discussed at the Finance & Investment Committee meeting on 16 March 2021.

Action required:

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

Summary and recommendations:

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

Recommendation:
To receive and note the report and to note that there is two items to be escalated to the Board, namely:

To receive and note the report and to note that there is five items to be escalated to the Board, namely:

a. Approval of the Annual Plan for 21/22, noting that there is separate paper on the Board agenda
b. Approval of the Financial plan for 21/22, noting that there is separate paper on the Board agenda.
c. Approval of the proposal for next stage of the process for East and North Herts inpatient unit, noting that there is separate paper on the Board agenda
d. Approval of the Albany Lodge Business Case, noting that there is separate paper on the agenda
e. Recommend to Board that they approve the Terms of Reference for the Committee, noting that there is separate paper on the Board agenda

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

Controls & Assurance – reporting key matters considered by the Finance & Investment Committee to the Trust Board.

Summary of Financial, IT, Staffing & Legal Implications:

Finance – achievement of the planned surplus and Use of Resources Rating.

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

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

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

1. **Introduction**

1.1 The latest Finance and Investment Committee (FIC) was held on the 16 March 2021 in accordance with its terms of reference and was quorate.

1.2 The meeting welcomed one new member, Kush Kanodia who has joined the Trust as an Associate NED.

2. **Deep Dive – Update on Annual Accounts 2020/21**

The Committee received a comprehensive presentation that detailed the expected position with regard to the end of year accounts. The Committee noted the exceptional nature of 2020/21 and the impact this had had. It was noted that the Trust expected to meet its agreed control total of £1.2m deficit. The Committee considered the position with regard to provisions, accruals, deferred income and impairments. It was noted that initial feedback from external audit with regard to their interim audit and Value for Money work was positive.

Committee members emphasised that the presentation had built on the updates they had received throughout the year. It was confirmed that the finance team were in a strong position to support the end of year process. Catherine Dugmore offered her appreciation to the teams who, despite the last year had ensured systems of control were in place that meant Trust were likely to have a positive Value for Money and Head of Internal Audit opinion. The need for a strong balance sheet and prudent approach to provisions was discussed and the need to work with external audit to ensure they supported the Trust's approach.

3. Quarter Three Performance Report

The Committee received a report that detailed the performance of the organisation during Quarter 3 against 67 national, regional and local indicators. The report summarised that overall underlying performance had remained strong, during a period of challenges. It was noted that Phase 3 of the COVID-19 pandemic had seen the Trust prioritise core services and focussing resources on underpinning direct care as a result some of the transformation and improvement initiatives had been delayed.

The Committee noted the areas of strong performance with regard to access and waiting times; provision of alternatives to admission considered by our Crisis Assessment and Treatment Teams, acute inpatients reporting that they felt safe and Carers reported feeling valued by staff. Areas of focus for next quarters relate to Out of Area Placements, IAPT, CPA reviews and PDP rates. Referrals into the Single Point of Access service are at a similar level to referrals in Quarter 3 2019; however, overall referrals, including trusted assessors and crisis team referrals are tracking above last year's rate for the same period. Demand and capacity modelling and forecasting continues to develop and provide clear insights for operational teams.

The Committee also received an update on the first two months of quarter four, where performance continued to be strong and the Trust maintain performance levels across services.

The Committee discussed ongoing issues with high levels of bed occupancy and length of stay. It was noted that this continued to be focus for operational teams.

4. Planning 2021/22

4.1 Draft Annual Plan

The Committee received a report and a presentation on the Annual Plan for 2021/22. It was noted that the key priorities of Annual Plan 2020-21 remained relevant and were the starting point for the 2021-22 Plan. This was in line with the agreed "light touch" approach to planning, working on the basis that the Trust is aware of the items that need to be delivered and is a pragmatic approach in the absence of planning guidance.

In particular the Committee consider the high level priority areas, over and above Business as Usual, under the headings of: our service users (experience, effectiveness and safety); our people; managing with Covid; partnerships and joined up care; organisation infra structure. In developing the detail priorities and metrics consideration has been given to: Demand; Covid; NHS Long Term Plan; priorities outstanding from 20/21; changes in policy and the financial picture.

Committee members supported the priorities and confirming they were in tune with areas the Board had discussed. They were assured that the Plan would include the areas that needed to be delivered as part of the Mental Health Investment standard. It was agreed that a future FIC meeting would receive an update on the transformation programme. It was noted that the full Annual Plan including metrics would be considered at the March Board meeting.

4.2 Draft Financial Plan

The Committee considered the draft financial plan for 21/22. The report built on the initial projections for the year and provided a range of scenarios. It was noted that the scenarios depend on a range of external factors; the timing and extent of the withdrawal of the COVID funding, whether funding was provided to meet additional demand and the allocative decisions made by the ICS. Also internal factors such as COVID costs, workforce challenges of recovery, recruitment and retention and the success in mobilising the annual Delivering Value Programme would have an impact. It was noted that more specific details on requirements of financial plans are expected to be announced later in March. Some broad headlines had been confirmed such as: finance arrangements for the last two quarters for 20/21 would roll over for quarter 1 for 21/22; additional £500m MH/LD investment announced in the November spending review has been confirmed and exit position from 20/21 is showing some signs of improvement.

In response to Anne Barnard's question there was a reasonable level of confidence that Trust would be able to recruit the additional staff indicated based on past success. It was also emphasised that the Trust was undertaking workforce planning to align with Annual Plan and finance planning.

5. Capital Programme

The Committee received an update on the progress with the capital programme for 2020/21, detailing the current forecast of a £0.8m underspend, a significant achievement considering the impact of Covd-19.

The Committee considered and approved the Capital Programme for 21/22. The Plan shows: the completion of a number of projects from 2020/21, namely the safety suites, Forest House and Albany lodge; significant refurbishments of Oak ward and Lexden; one further safety suite investment and investment in CCTV; continuation of

digital investment and number of other investments to support the estate programme. The Programme also set out a number of high level outline costs for a further 3 year period (FY 23 to FY25) through to the expected completion of the East & North Inpatient Unit to support planning assumptions for CDEL. It was noted that the Trust has applied the Regional prioritisation framework to its programme; this would enable the Trust to evaluate any ICS requests to amend its capital plan in year due and will ensure a transparent consistent approach within the ICS.

In response to Anne Barnard's question it was clarified that schemes at Lexden elated to refurbishment and longer term plan to re provide facilities.

6. East and North Herts Inpatient Unit

The Committee received an update with regard to the proposed inpatient unit in East and North Herts. The Committee considered the proposal with regard to progressing with planning consent and discussions with the land owner. It was noted that both commissioners and the NHSE regional office are supportive of the scheme but that there is no immediate source of capital loan finance available. The Committee supported the proposal to develop the Business Case for approval, commit funds to secure planning consent and enter in negotiations with the land owner and agreed to make a recommendation to Board on this basis.

David Atkinson as Committee chair and other committee members supported the proposal noting that the discussed financial risk was outweighed by the risk of not progressing, as the new unit was a significant strategic priority for the Trust and of key importance to service users.

7. Albany Lodge Business Case

The Committee considered and approved the Business Case for the refurbishment of Albany Lodge. The capital investment required is £1,221,000 across both 2020/21 and 2021/22 financial years and forms part of the Trust's capital programme. It was noted that the building opened in 1995 and whilst it has had some investment to address environmental risks and damage sustained, the ward needs investment to improve the overall experience of the service users who are treated there and staff who work there as well as address some safety concerns. It was noted that longer term there is a clear plan to relocate the inpatient provision but this may take between 3 and 5 years as a minimum to complete and therefore this upgrade will provide a much needed improvement over the period of continued occupation. It was noted that the proposed investment seeks to strike a balance on the likely length of further use of the facility and suitability of the accommodation.

Committee members supported the business case noting that due to the value it would be recommended to the Board for approval. In response to Tim Bryson's question it was confirmed that the scheme does not plan to make all room en-suite and that the work would happen while the unit stayed open. Anne Barnard's query regarding length of depreciation period and impairment was clarified. The Committee asked that the operational team also consider if there were other improvements that would benefit the unit.

8. Public Dividend Capital Drawdown

The Committee noted that there had been a significant change to the financial rules under which Foundation Trusts work regarding the amount of annual capital expenditure that can be made by the Trust. This is now determined by the ICS

allocation of the capital department resource limit (CDEL). In addition to this capital limit there are other additional capital sources that are accessible from time to time. The Committee were updated on the additional capital finance in 20/21 the Trust had secured to fund specific capital investments over and above those funded within the CDEL. These comprised of: Critical Infrastructure Risk funding; Electronic Prescribing funding and Remote Working Devices

9. Outline Proposal for sale of Stewarts Property

The Committee received a report that detailed that a key priority for the Connected Lives programme, a scheme to support the delivery of social care functions for working age adults with functional mental ill health is the expansion of the Intensive Enablement service. Locally there is a desire to secure a unit in the West of Hertfordshire to compliment the unit based in Stevenage. The Committee were informed that a property search across the public sector estate and private market has determined that The Stewarts is the most suitable property. The Stewarts is currently owned by HPFT and identified for disposal. Following the consideration of the available options it is proposed to sell The Stewarts to Hertfordshire County Council at market value and to contribute towards the costs of refurbishment to provide the new facility. The Committee supported the proposal.

10. Review of Terms of Reference

The Committee reviewed its Terms of Reference, in line with the annual requirement and good governance. No changes were identified and following consideration of the feedback from the self-assessment the Committee recommended that the Board be asked to approve the reviewed Terms of Reverence.

11. Items to Note

a. Financial summary- period to end of February 2021 and outturn 20/21

The Committee noted the report that set out the overall position was on Plan for the period to 28 February 2021. Stating a break-even for the first 6 months; a deficit of £174k for the month of February; and deficit of £937k for the year to date.

b. FIC Committee Planner

The Committee noted the planner

12. Recommendation

To receive and note the report and to note that there is five items to be escalated to the Board, namely:

a. Approval of the Annual Plan for 21/22, noting that there is separate paper on the Board agenda
b. Approval of the Financial plan for 21/22, noting that there is separate paper on the Board agenda.
c. Approval of the proposal for next stage of the process for East and North Herts inpatient unit, noting that there is separate paper on the Board agenda

d. Approval of the Albany Lodge Business Case, noting that there is separate paper on the agenda
e. Recommend to Board that they approve the Terms of Reference for the Committee, noting that there is separate paper on the Board agenda

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 11a
Subject:	Performance Report: Quarter 3 2020/21	**For Publication:** Yes
Author:	Michael Thorpe, Deputy Director of Improvement and Innovation	**Approved by:** Keith Loveman, Director, Strategic Finance
Presented by:	Keith Loveman, Director, Strategic Finance	

Purpose of the report:

To inform the Board about the Trust's performance against both the NHS Oversight Framework (NHSOF) targets and the Trust Key Performance Indicators for Quarter 3 2020/21

Action required:

To note the report.

Summary and Recommendations

This report provides a summary of the performance of the organisation during Quarter 3 against 63 national, regional and local indicators across five key groupings:

- NHS Oversight Framework (NHSOF)
- Access to Services
- Safety and Effectiveness of Services
- Workforce indicators (Pulse indicators are not included in Q3, due to the Staff Survey)
- Financial indicators

In addition the report covers:

- Service Recovery to pre-COVID Levels and in some services exceeding them.
- Forecast of expected demand over the winter period.

Quarter 3 Performance Summary

Overall, our performance has remained strong as measured by our principal KPIs. We have responded to Phase 3 of the COVID-19 pandemic by prioritising core services and focussing resources on underpinning direct care in a period of increased service pressure and high staff absence. As a result some of our transformation and improvement initiatives have been delayed, such as non-essential training.

Weekly performance reporting continues to give us timely insight and assurance about how our services are responding to the challenges posed during the COVID outbreak. Operational management have reported that this has been a valuable use of their time and has helped them to maintain focus to key areas of access and risk during this period.

Service Performance Summary & Forecast

37 of the 63 (59%) performance indicators measured in Quarter 3 are meeting or exceeding our performance standards. Of the 37, access to services remains good, safety and quality levels are maintained, and we are maintaining our levels of staff engagement in line with pre-COVID standards.

In light of COVID-19, referrals into the Single Point of Access service are at a similar level to referrals in Quarter 3 2019; however, overall referrals, including trusted assessors and crisis team referrals are tracking above last year's rate for the same period.

Our demand and capacity modelling and forecasting continues to develop and provide clear insights for operational teams. For example, our Q2 forecast proved accurate in terms of the predicting a downturn in performance for Adult Community 28 day referral to assessment. However operational teams' mitigated the impact of this by making changes to assessment protocols without drawing in additional resources from treatment. The has meant that despite increases of 19% in referral volumes I adults there has been a 3% drop in performance over the same period, and crucially activity to support initial assessments hasn't impacted the assessment to treatment timeframes which remain the same levels as performance in the same quarter of last year.

Our forward looking forecast position is for the early part of Q4 we are expecting to maintain current performance levels across services. The evidence of prevalence and incidence rates of COVID-19 across Hertfordshire and the East of England region we are seeing a reduction in current rates of infection. We expect this reduction to be reflected in reduction in COVID related pressure in the community and in our inpatient services by the end of January.

We expect the increase in levels of staff absence due to COVID to normalise in Q4 as the vaccine rollout offers protection to our staff. We also expect to see demand volumes for non-crisis services to remain in-line with previous years in all areas apart from IAPT which should continue to grow to absorb some of the generated demand from people facing the challenges of COVID-19.

Areas of Strong or Improved Performance
Despite the ongoing impact of the COVID-19 outbreak the following areas saw continued strong performance in Quarter 3:

- People with a first episode of psychosis began treatment within two weeks of referral in 93.5% of cases (target – 56%)
- Non-urgent people access to our Adult Community Mental Health Services were seen in 95.88% of cases within 28 days (target – 95%)
- All service users who needed to access our Adult Crisis Assessment and Treatment Teams in Quarter 3 were assessed within a 4 hour period (target – 98%).
- Children and Young People needing routine assessment were seen within 28 days in 98.9% of cases (target – 95%) and those needing urgent within 7 days were seen in 93.33% of cases (target – 75%)
- Children and Young People in Child and Adolescent Mental Health Targeted Services were seen within the 14 day period in 98.3% of cases and 28 day waiting period in 94% of cases (target – 85%)
- People accessing our EMDASS service received their diagnosis within 12 weeks in 88.2% of cases (target – 80%).
- Across all our services 98.5% of people received treatment within the 18 week wait standard (target – 98%)
- All of our IAPT services achieved 50% or more of their clients reaching recovery levels in Q3.
- 81% of our service users who used our acute inpatient services in Quarter 3 reported that they had felt safe whilst there (target – 80%).
- Our service users told us that they felt they had been treated in a way that reflected our trust values in 85.1% of cases (target – 80%) They also told us that in 88.8% of cases they knew how to get support at a time of crisis (target – 83%) and in 88.8% of cases they had been involved in discussions about their care (target – 85%)
- Carers told us that they had felt valued by staff in 84% of cases (target – 75%).
- Although PDP and Appraisals were below the target at 85.54% (target 95%), there was a 10% improvement over the quarter.

Areas of Concern/Focus

At the end of Quarter 3, 24 of indicators were below our performance standards. The majority of these relate to areas that were already known as underperforming and were exacerbated as a consequence of the Wave 1 COVID 19 outbreak. Operational services during this time were prioritised in accordance with our Business Continuity plans, which impacted on a range of KPIs across services. Quarter 3 saw the resumption of our services and a recovery phase, with increasing referrals into the services.

The key areas of note for Quarter 3 were:

- Inappropriate out of area placements have increased over the quarter with a total of 1,160 out of area days against a target of 30 (almost 40 times the target level). The Trust is experiencing a high demand for Adult and CAMHS beds, which reflects an increase in complexity in the community. The trust has also secured some winter discharge funding for the next 3 months which we plan to use to improve community provision to support repatriation back to area and discharge.

- Improving Access to Psychological Therapy (IAPT) Services: The gap between access targets and actual rates of access has continued across the majority of our IAPT services during Quarter 3. Under the Phase 3 plans that have been developed we have proposed that our trajectory to the end of Quarter 4 will fall in line with the expected run rate to meet our commissioner targets.

- The rate of people on CPA who have had a review in the last 12 months was 86% in Quarter 3 (target – 95%) as a result of the COVID crisis and difficulty in remotely organising larger, multidisciplinary meetings. As services moved through restoration performance improved on a month on month basis, but the current COVID restrictions are likely to hamper achievement.

- The rate of people experiencing First Episode Psychosis and received cardio-metabolic checks remains below target at 63% (target – 90%). The Trust is focusing on improving Physical Health over the current year through our Physical Health Transformation Project which has so far improved our performance from 40% in August to 63%.

- PDP and Appraisal rates remained below target in Quarter 3, but saw a 10% improvement on Quarter 2 to 85.4% (target – 95%). As part of the move to recovery of services there has been a re- launch of the appraisal requirement backed by a revised and simplified form.

Q3 Benchmarking for Inpatient Services

During Q2 we undertook a benchmarking exercise to understand inpatient performance in the context of the national system and we have continued to track and report these benchmarks for Q3 to provide ongoing perspective about our performance relative to other Mental Health and LD Trusts. This benchmarking adds useful context for our focus areas of delayed transfers of care and out of area placements. They key findings are:

- occupancy in Adult Acute beds has remained at around 100% which benchmarks HPFT in the upper quartile – indicating the need for tight bed flow management;
- We are in the lower quartile for inpatient admissions and discharges but our typical length of stay is longer – indicating high levels of acuity / complexity;
- There is an increase in the use of acute bed placements across the system in 2020/21- indicating a growing demand for inpatient admissions for the future.

We know that there are a limited number of beds available for placements for some of our most complex service users. In response our length of stay increased in Q3 as did other service providers. This will continue to put pressure on Adult Wards and PICU units during Q4.

Conclusion & Recommendation
The Trust Board is asked to:

- Note the report

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

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

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

N/A

Equality & Diversity and Public & Patient Involvement Implications:

N/A

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

All targets

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

Executive Team 20 January 2021 Finance & Investment Committee 16 March 2021

NHS
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Performance Report
Quarter 3
2020/21

Contents

1. Summary

1.1 Service Recovery

New referrals into the Trust both via SPA, trusted assessors and internal referrals, have tracked above pre-COVID averages for Q3.

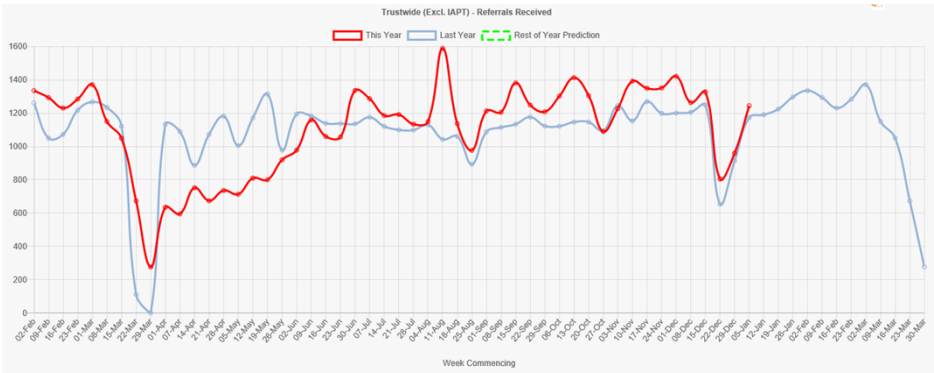


Figure 1 – Referrals into HPFT

Referrals into some services are showing an increase on this time last year, whilst others are showing a significant decrease:

- The profile of referrals into CAMHS tracked at above pre-covid rates until the last week of November, when they dipped, in a similar pattern to last year over the Christmas period.
- Adult referrals have tracked significantly higher throughout the quarter. The expected slowing down of referrals through lock down did not take place.
- SPA referrals stabilised in November, tracking approximately 5% lower than for the same period last year, and plateaued at pre-Covid rates in December.
- Older adult referrals have tracked at similar levels to last year throughout the quarter.
- IAPT referrals have tracked at a similar level to Q3 last year, but are not on track to meet the cumulative target for the year. This is known and described in our Phase III plans which forecast that IAPT referrals will meet the forecast run-rate in Q4, not the forecast volumes.
- LD referrals tracked very closely to last year's referrals during the quarter.

Table 1 - Recovery by Service

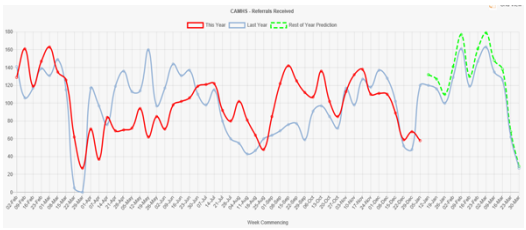
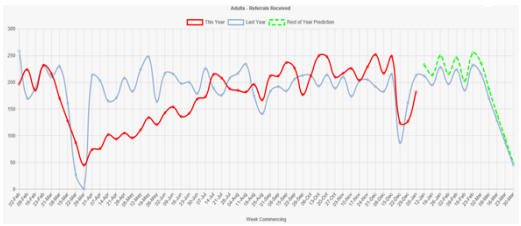
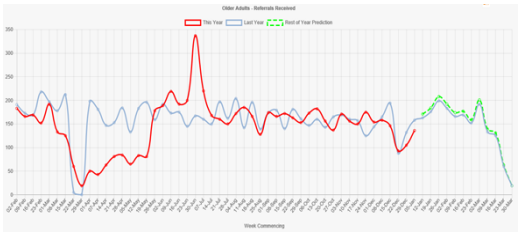
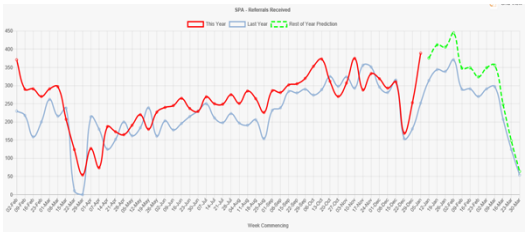
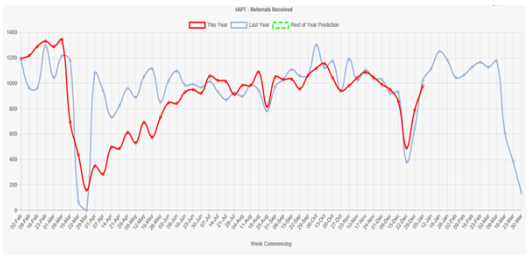
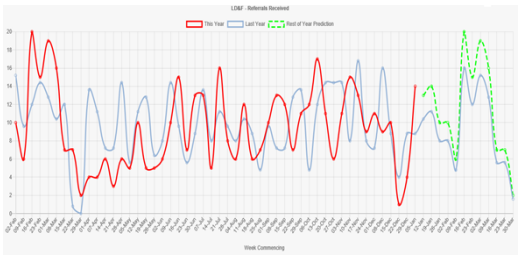
CAMHS	Adults
	
Older Adults	**SPA**
	

Table 2 - Recovery by Service c'td

IAPT	LD&F
	

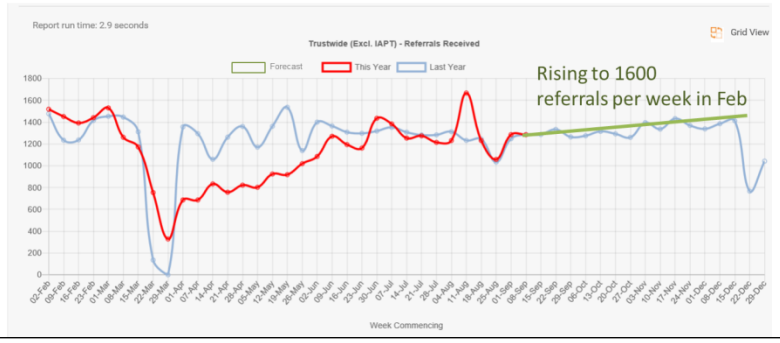
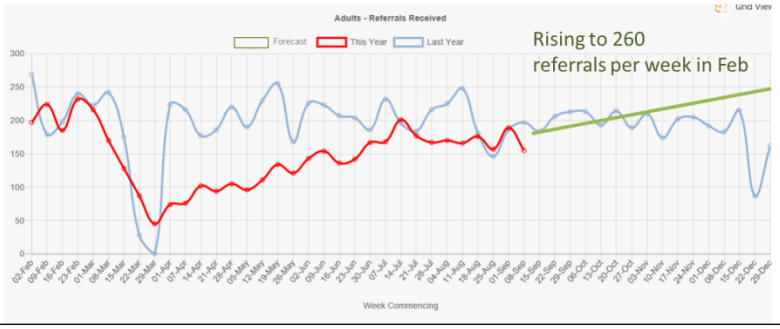
1.2 Forecast

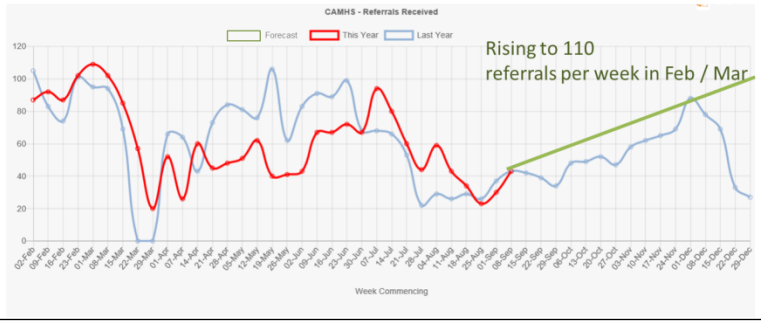
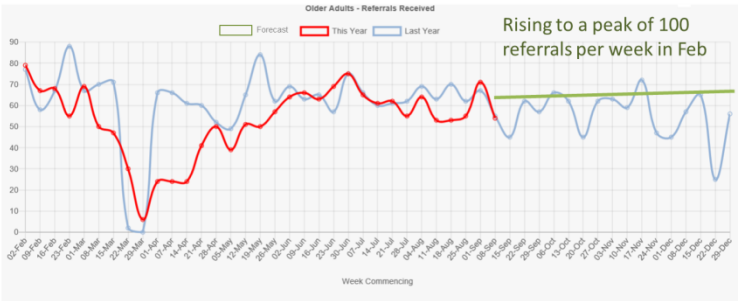
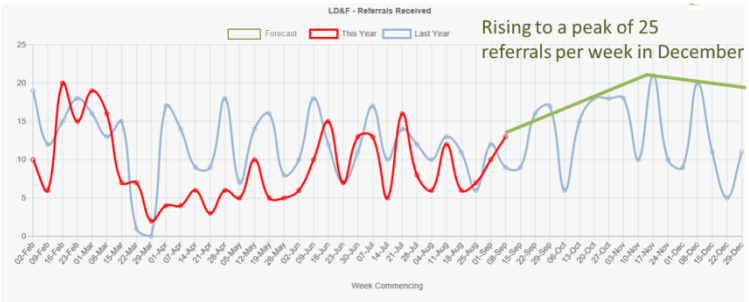
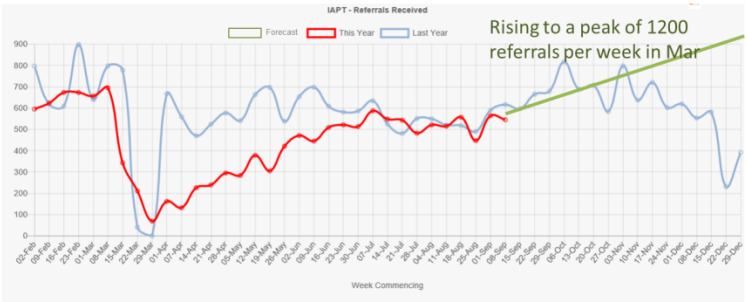
During Phase 1 of COVID-19 we saw a 25% suppression of referrals on average, which took 4-5 months to return to pre-COVID levels. As the national and regional rate of COVID infection increased above 1, regional and national responses came into effect leading to a suppression of referrals into the trust – as we saw in March to July this year. During the current COVID phase (Phase 3) we have not seen the same suppression impact we witnessed during Phase 1. Instead, and as more services across the system have stayed open and adjusted to new ways of working, we are now experiencing demand volumes in line with previous years.

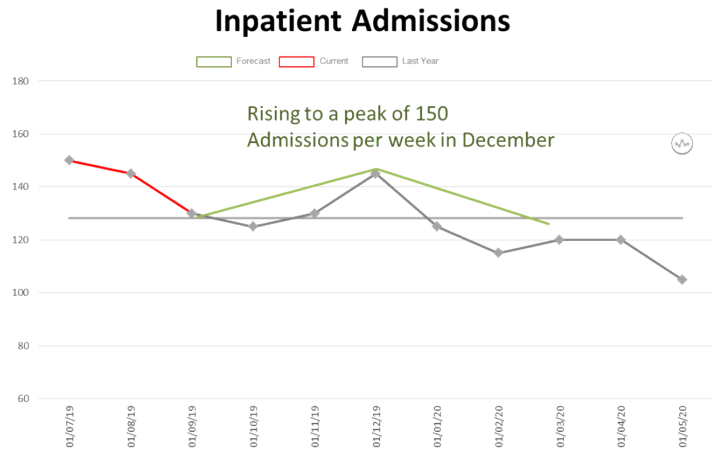
Referral volumes are not the only indictor of demand and our operational teams are reporting a rise in the complexity of presentations. This complexity is predominantly experienced as an increase of 9% in step-up referrals from IAPT and Adult Services. This matches and accounts for the pressure that Adult Community teams reported towards the end of Q2.

For planning purposes operations teams have prepared winter plans based on demand for services that is in line with the forecasts in the following charts.

Table 3 - Forecast of Winter Demand

Referral Trend Compared to Previous Year Plus Forecast	Planning Assumptions
Trustwide Referrals 	Winter Peak: Feb 2021 August Referrals: 1200 per week Peak Referrals: 1600 per week Growth rate: +75 per month from September
Adults Referrals 	Winter Peak: Feb 2021 August Referrals: 180 per week Peak Referrals: 260 Growth rate: +13 per month from September

CAMHS Referrals 	Winter Peak: Feb 2021 August Referrals: 40 per week Peak Referrals: 110 per week Growth rate: +11 per month from September
Older Adults Referrals 	Winter Peak: N/A August Referrals: 70 per week Peak Referrals: 70 per week Growth rate: Net 0 however a slight reduction anticipated up to Christmas followed by a return in January
LD&F 	Winter Peak: December 2020 August Referrals: 15 per week Peak Referrals: 20 per week Growth rate: 1 per month from September
IAPT 	Winter Peak: Feb 2021 August Referrals: 600 per week Peak Referrals: 1000 per week Growth rate: 700 per month from September Notes: IAPT demand is based on an increase of 10% above 2019/2020 based on commissioning outcomes.



Winter Peak: December 2020
August admissions: 130 per month
Peak admissions: 140 per month
Growth rate: 2.5 per month from September

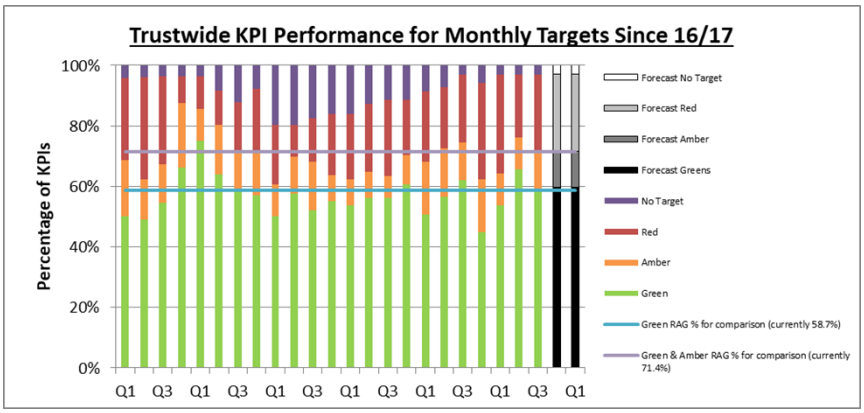
1.3 Performance Overview

Overall, underlying performance has remained strong, during a period of unprecedented challenges with the need to continue to deliver care in line with COVID 19 infection prevention and control practices. Weekly performance reporting during this period has continued to give us insight and assurance about how our services are responding to the challenges posed during the COVID outbreak and has given additional focus to key areas of access and risk during this period.

Of the 63 Key Performance Indicators monitored in Quarter 3, overall performance is as follows:

- 37 (59%) are maintaining or exceeding performance levels (on target)
- 8 (13%) are almost meeting target performance levels (close to target)
- 16 (25%) are not meeting our performance standards (underperforming)
- 2 (3%) are currently monitored but no formal performance target set

Table 4 – Comparison of Performance on KPIs by Quarter



1.4 Activity Summary

The table below provides a summary of some of the key areas of activity across the Trust during Quarter 3. It provides a sense of the volume of work and sets some of the context for the performance of the Trust over the quarter. In light of COVID-19, referrals into the Single Point of Access service are at a comparable level to 2019, with a total of 15,531 referrals received – 100 fewer than in 19/20 for Q3. However, December 2020 did see a10% increase in referrals, compared to December 2019.

Table 5 – Summary of Quarter 3 Activity

Summary of the Activity across the Trust during Quarter 3	
 257 adult acute admissions in Q3	 7,225 new spells of care in secondary mental health and LD services in Q3
 3,095 people on CPA in Q3	 111,021 secondary mental health face to face, virtual and telephone contacts Q3
 6,461 discharged from secondary mental health services in Q3	 403 inpatient beds in Q3
 152 Starters, 96 Leavers at the end of Q3	 11,607 people entering treatment in Wellbeing Services in Q3

1.5 Reporting Categories

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

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

2 NHS Oversight Framework

2. 1 Summary of Position

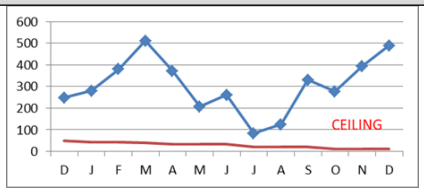
There are six Key Performance Indicators under this domain:

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

- Inappropriate Out of Area Placements (Target 30 days in Quarter 3)

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

- Inappropriate Out of Area Placements – 1,160 days against a target of 30 for the quarter.

KPI	Trend	Q3 Status/Action
Inappropriate Out of Area Placements (OAPs) for adult mental health services. (Target 30 bed days)		**Q3 Performance: 1,160** The Trust is experiencing a high demand for beds, which we believe reflects the pressure on the community teams, and the growth in complexity and demand in the community – this has largely been as a result of Hertfordshire individuals presenting elsewhere in the country and admitted locally before repatriation. **Action:** Daily oversight of individuals in out of area beds and monitoring of length of stay to continue. Winter discharge funding has been allocated to support earlier discharges.

3 Access to Services

3.1 Summary Position

In Quarter 3 the Trust, despite continued challenges faced due to COVID-19, consistently met 15 out of 24 access indicators. Accessing mental health services has been a key area during 2019 and continues in 2020. Indications are that the significant improvements that were seen in 2019 have continued to be upheld despite the COVID challenges.

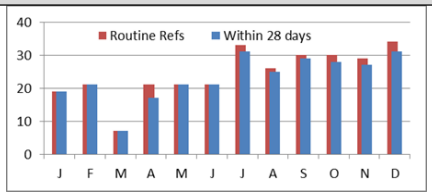
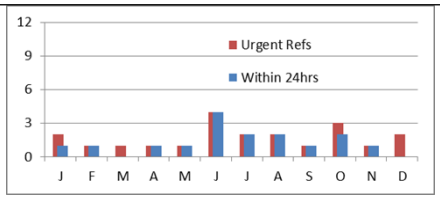
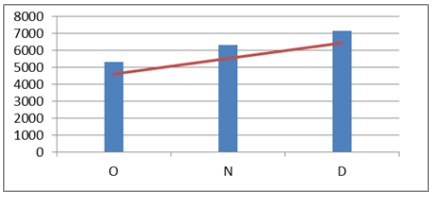
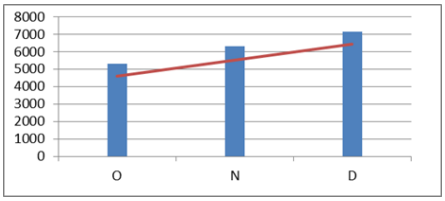
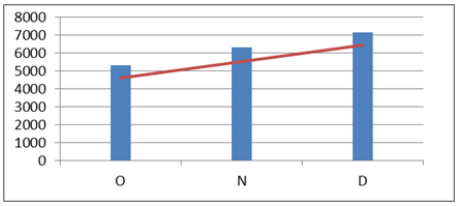
3.2 Areas of Strong/Improved Performance

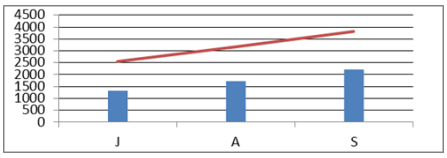
- Non-urgent people who accessed our Adult Community Mental Health Services were seen in 95.88% of cases within 28 days (target – 95%)
- All service users who needed to access our Adult Crisis Assessment and Treatment Teams in Quarter 3 were assessed within a 4 hour period (target – 98%).
- Children and Young People needing routine assessment were seen within 28 days in 98.9% of cases (target – 95%) and those needing urgent within 7 days were seen in 93.33% of cases (target – 75%)
- Children and Young People in Child and Adolescent Mental Health Targeted Services were seen within the 14 day period in 98.3% of cases and 28 day waiting period in 94% of cases (target – 85%)
- People accessing our EMDASS service received their diagnosis within 12 weeks in 88.2% of cases (target – 80%).

- Across all our services 98.5% of people received treatment within the 18 week wait standard (target – 98%)
-

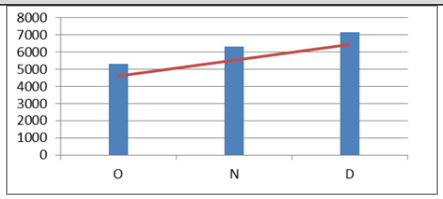
3.3 Access Indicators currently underperforming

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

KPI	Trend	Q3 Status/Action
Routine referrals to Eating Disorder Services (Target 98%)		**Q3 Performance – 92.47%** 7 service users were seen outside of the 28 day wait time, due to administration errors and some late pass ons from SPA. **Action:** Late pass on issues from SPA have been addressed and administrative staff given additional training.
Urgent referrals to ACMHS meeting 24 hour wait		**Q3 Performance – 50%** 3 service users were seen after the 24 hour period due to capacity issues. All were subsequently seen and were safe. **Action:** Service Line Lead to review administration processes with the team to ensure any urgent referrals are flagged as quickly as possible.
Number of people entering IAPT treatment (Herts Valleys CCG) (Target 8,866)		**Q3 Performance – 2,174 below target** **Action:** Under the Phase 3 plans we have proposed that our trajectory to the end of Q4 is to fall in line with the expected run rate to meet our commissioner targets, however we won't recover the cumulative volumes over that period. At the moment we are 2,174 behind and we seek to improve that position by the end of the year.
Number of people entering IAPT treatment (Mid Essex) (Target 4,825)		**Q3 Performance – 1,382 below target** **Action:** Under the Phase 3 plans we have proposed that our trajectory to the end of Q4 is to fall in line with the expected run rate to meet our commissioner targets, however we won't recover the cumulative volumes over that period. At the moment we are 1,382 behind and we seek to improve that position by the end of the year.
Number of people entering IAPT treatment (West Essex) (Target 3,417)		**Q3 Performance – 381 below target** **Action:** Under the Phase 3 plans we have proposed that our trajectory to the end of Q4 is to fall in line with the expected run rate to meet our commissioner targets, however we won't recover the cumulative volumes over that period. At the moment we are 381 behind and we seek to improve that position by the end of the year.

Number of people entering IAPT treatment (North East Essex) (Target 5,769)		**Q3 Performance – 2,184 below target** **Action:** Under the Phase 3 plans we have proposed that our trajectory to the end of Q4 is to fall in line with the expected run rate to meet our commissioner targets, however we won't recover the cumulative volumes over that period. At the moment we are 2,184 behind and we seek to improve that position by the end of the year.

3.3.1 Access Indicators – Almost Met

KPI	Trend	Q3 Status
Number of people entering IAPT treatment (East & North Herts CCG) (Target 7,207)		**Q3 Performance – 50 below target** **Action:** Under the Phase 3 plans we have proposed that our trajectory to the end of Q4 is to fall in line with the expected run rate to meet our commissioner targets, however we won't recover the cumulative volumes over that period. At the moment we are 50 behind and we seek to improve that position by the end of the year.

4 Safety and Effectiveness of Services

4.1 Summary Position

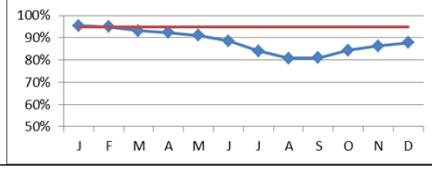
There are 24 Safety & Effectiveness Key Performance Indicators of which 15 have been fully met, 3 were almost met, and 6 where further improvement is required.

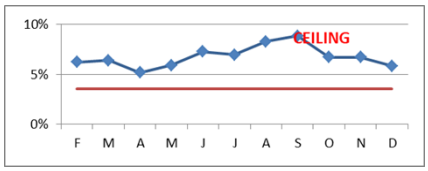
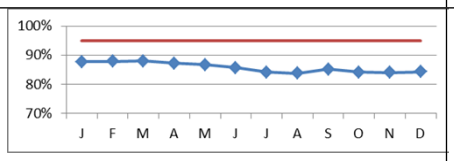
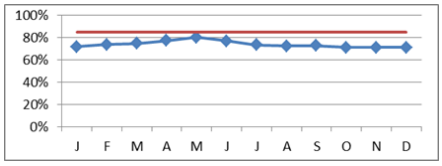
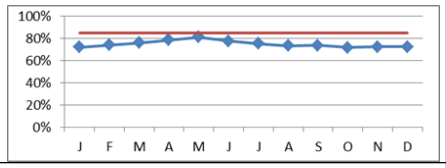
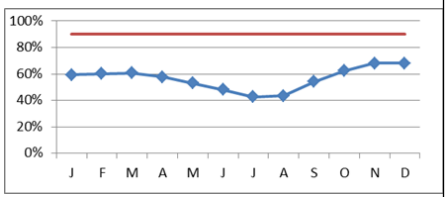
4.2 Areas of Strong/Improved Performance

- All of our IAPT services achieved 50% or more of their clients reaching recovery levels in Q3.
- 81% of our service users who used our acute inpatient services in Quarter 3 reported that they had felt safe whilst there (target – 80%).
- Our service users told us that they felt they had been treated in a way that reflected our trust values in 85.1% of cases (target – 80%)*
- They also told us that in 88.8% of cases they knew how to get support at a time of crisis (target – 83%) and in 88.8% of cases they had been involved in discussions about their care (target – 85%)
- Carers told us that they had felt valued by staff in 84% of cases (target – 75%).
- Use of the Initial Cluster Tool for those entering services is above target at 96 % (target – 95%).

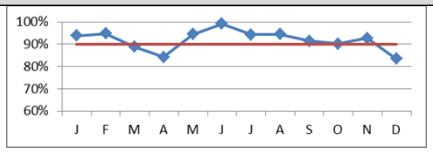
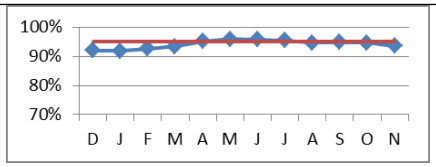
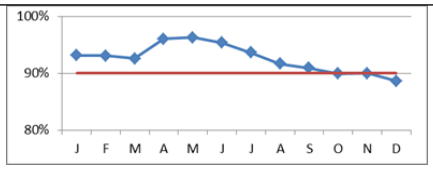
4.3 Underperforming Indicators

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

KPI	Trend	Q2 Status/Actions
The proportion of those on Care Programme Approach (CPA) for at least 12		**Q3 Performance: 85.9%** Care Programme Approach (CPA) reviews were suspended in some areas due to COVID and there were initial challenges arranging full

months who had a CPA review within the last 12 months (Target 95%)		meetings on a virtual platform. **Action:** Reviews are now back to being routinely scheduled but is expected that full recovery will take until Q4.
Delayed Transfers of Care (DTCs) (Target 3.5%)		**Q3 Performance: 7.38%** High levels of delay in Adult Acute services due to insufficient placements available for people with complex care needs. Shorter delays in older adults services, but with higher turnover – some instances of placements not being able to take older adults due to COVID outbreaks. **Actions:** Data is provided to each ward weekly on their length of stay, DTCs and discharges, and the ward leadership team is encouraged to review this to ensure effective flow. Whilst there is good engagement from community and inpatient teams, the focus is senior oversight of actions and the speed at which these are followed up. Delays are still largely due to placement providers (rather than the arrangement of placements) and transition arrangements.
Cluster Reviews (Target 95%)		**Q3 Performance 84.25%** There has been a drop in performance during COVID as risk based indicators have taken precedence, but now maintaining at a stable level **Actions:** To continue to monitor against target.
Mental Health Services Data Set submissions to NHS Digital Employment & Accommodation (Target 85%)	Employment data  Accommodation data 	**Q3 mean performance: 71.65%** Recording of employment and accommodation rose steadily with the introduction of SPIKE and the DQ initiative, peaking in May. HPFT Benchmarks extremely well against other trusts for these indicators. Historically unable to see when reviews were due on Paris. SPIKE dashboards now give this information on team and individual dashboards. **Actions:** Continue with use of SPIKE dashboards and promote recording in teams. Data Quality Officers to assist
Cardio-metabolic checks for people with psychosis (Target 90%; FEP 90%; Community CPA 65%)		**Q3 aggregate performance: 67.97%** **FEP = 62.46%** **Community CPA = 71.4%** Adult Community Teams have improved significantly since August and have a focus on completing the checks and dedicated staff to do so. FEP Performance has remained stable. **Actions:** A task and finish review has commenced and is being overseen by the Physical Health Care group.

4.3.1 Safe and Effective Indicators – Almost Met

KPI	Trend	Q3 Status/Action
Follow-ups within 72 hours of inpatient care (Target 95%)		**Q3 Performance: 89.02%** The ability to follow up people who had been discharged within 72 hours was affected by capacity issues in older people's units, due to COVID and the Christmas period. The people who we not followed up within 72 hours had go to General Hospital or residential care, were not at any immediate risk. **Actions:** Follow-ups to continue to be prioritised and reminders given to team of their responsibilities.
Rate of service users with a completed up to date risk assessment (Target 95%)		**Q3 Performance: 93.59%** Performance against risk assessments increased during the COVID outbreak, with an additional focus on reviewing risk for individuals. There has been a small drop since August which has resulted in performance falling marginally below target level. **Actions:** Continued focus on risk is expected to bring performance back on target in Q4.
Data Completeness against minimum dataset for Ethnicity (Target 90%)		**Q3 Performance: 88.66%** Target is predicted to be met on refresh of the data. **Actions:** Data Quality Officers will work with Teams to improve recording.

5 Workforce

5.1 Summary position

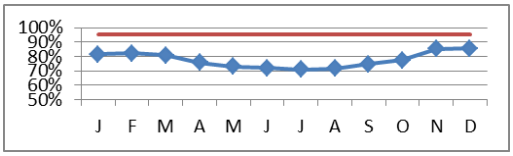
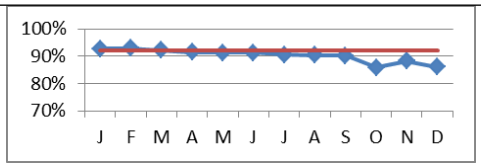
There are 4 Key Performance Indicators routinely monitored in Q3. Pulse indicators are not reported in Q3 as the Staff Survey takes its place. 2 of the 4 indicators were un-met and 2 were almost met.

5.4 Areas of Strong/Improved Performance

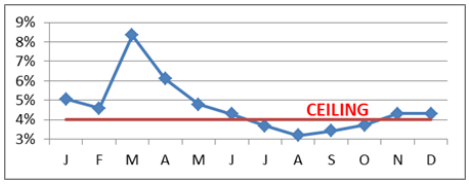
- Although PDP and Appraisals were below the target at 85.54% (target 95%), there was a 10% improvement over the quarter.

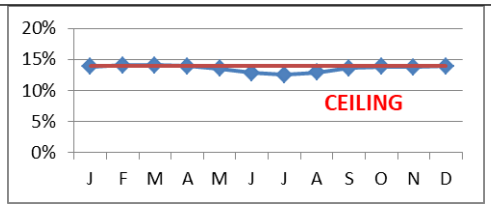
5.3 Underperforming Indicators

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

KPI	Trend	Q3 Status/Action
Rate of staff with a current Personal Development Plan and appraisal (Target 95%)		**Q3 Performance: 85.54%** PDP and Appraisals have increased by over 10% in Q3. **Actions:** The appraisal and PDP forms have been simplified. The simplified approach was launched in October in some areas of the Trust, together with training, support and clear communications. Weekly reporting is taking place to the Exec and to Senior Leaders. Our aim is for 100% compliance and we remain 9% off the KPI requirement. Therefore, work to further increase compliance will continue.
Rate of mandatory training completed and up to date (Target 92%)		**Q3 Performance: 86.07%** During the pandemic all face to face courses were cancelled and the impact of the coronavirus pandemic resulted in a reduction in the ability of staff to take time to complete their training. This has resulted in the slight drop in the level of training being completed since April to date. **Actions:** Respect Training continues and some week-end training now in place to reduce the back-log. Other face to face training has now been cancelled due to COVID 2nd wave.

5.3.1 Almost Met Key Performance Indicators

KPI	Trend	Q3 Status/Action
Sickness (Target ≤ 4%)		**Q3 Performance: 4.11% Dec 4.32%** The overall Trust sickness absence rate at the end of Q3 was 4.32%. This has increased from 3.72% in October. In comparison, however, the sickness absence rate was 5.04% at the end of Q3 2019/20. Further comparisons can be drawn from the following; at the start of Q1 the sickness absence rate was 6.10% at the start of the pandemic. **Actions:** All staff who show symptoms of COVID19 are referred for swab testing. The introduction of the LFT in Q3 is more quickly picking up asymptomatic staff and preventing further infection. All staff who test positive are offered emotional wellbeing support. Psychological support has been also put in place for all our staff and

		the full health and wellbeing offer is being significantly stepped up once more as we enter this new phase of the pandemic
Turnover (Target ≤ 13.9%)		**Q3 Performance: 13.93%** The Trust's turnover has remained within target for the last 6 months. **Actions:** The turnover rate is only marginally over the target of 13.9% and further investigation is taking place to review the cause of this.

6 Financial Resources

6.1 Finance Overview

The Trust reported an overall position on Plan for the period to December; this was break-even for the first 6 months; a deficit of £289k for the month of December; and deficit of £650k for the year to date. The deficit in Quarter 3 relates to the progressive increase in Pay costs; and to significant cost pressures within external bed costs to meet additional demand or to provide specialist care not provided within HPFT's own services; as well as provision being made for any additional costs.

Ref	Financial Indicator	Target	Current Period Performance (December 2020/21 UNLESS STATED)	Previous Period Performance (November 2020/21 UNLESS STATED)	Change on previous period	Comments and Data Quality Issues	Forecast for next period (January 2020/21)
F1	To Achieve Surplus in year (not including PSF)	**£1,190k (deficit)**	**£650k (deficit)**	**£361k (deficit)**	**£289k (deficit)**	**Trust position matches revised Plan**	↔
F2	Use of Resources (formerly Financial Service Risk Rating)	**1**	**1**	**1**		**Currently 1 and expecting to remain so**	↔
F3	To keep agency spend below the Trust ceiling of £5.8m spend for the year (NB NHSI agency spend ceiling is £7.3 million for the year)	**TBC**	**£4,983k**	**£4,440k**	**543k**	**Agency costs are higher this month, the largest increase was seen in registered nurses**	↔
F4	NHSI Agency Price Caps: (*wage caps no longer reported to NHSI) - monthly number of shifts breaching price caps reported weekly to NHSI in period	**Reduce to Zero**	**282**	**255**		Figures as per NHSI weekly submission. Figure based on full weeks that contain days in the reporting period. Current period figure includes weeks commencing; 30/11/20 07/12/20 14/12/20 21/12/20	↔
F5	Delivering Value (cash releasing efficiency savings in Financial Year)	**Annual savings requirement identified as £6m**	**Programme currently totals £4.3m of developed schemes and plans in progress with a further c. £0.9m of opportunities identified**	**Programme currently totals £4.4m of developed schemes and plans in progress with a further c. £0.9m of opportunities identified**		Schemes originally identified pre-COVID are being reassessed. There have been additional savings in areas such as staff travel and Continuing Health Care placements	↔

7. Benchmarking – Inpatient Services

Benchmarking for Inpatient Services (Source MHSDS and NHS Digital Nationally available data sets.

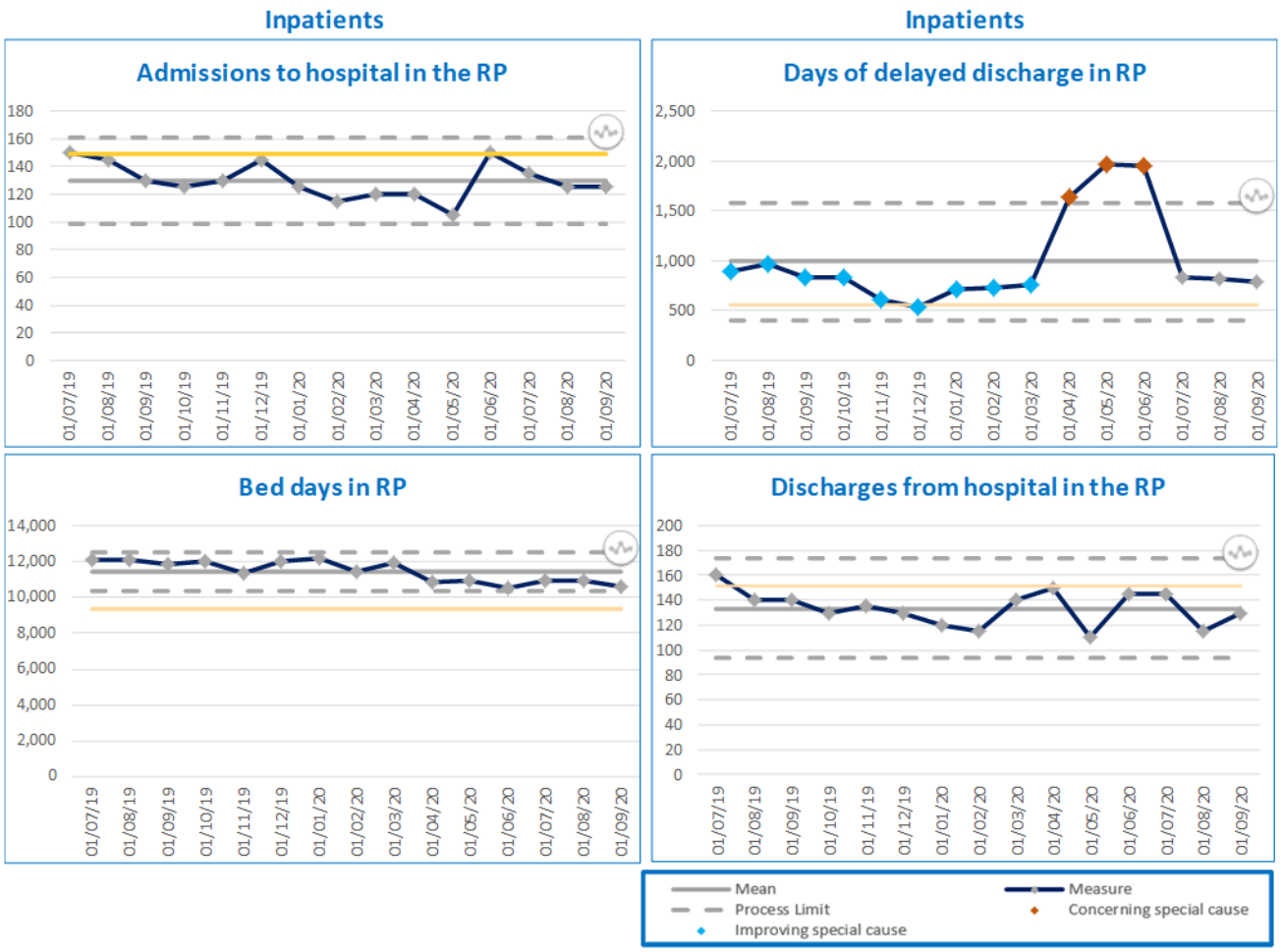
Based on current National Data sets the following conclusions can be drawn:

1. HPFT has a comparatively low rate of admission and a correspondingly low discharge rate – on average 35% lower

2. The length of stay in our services is comparatively higher than the rest of the system – an average of 48 days versus a nation mean of 34 days

3. HPFT is an outlier in delayed transfers of care at 4 times the average in the system – 2,000 versus a system of average of 500

Key metrics MHSDS Jul 2019 to Sep 2020



8. Quality Account – Priority Indicators

In Quarter 3, of the ten reportable indicators, nine were above target and one was below target. The indicator not meeting target is people on CPA having a review within 12 months, and is detailed in the main body of this report under the Safe and Effective Care section.

There are three indicators that are not reportable in Quarter 3:

- Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death – reported annually.
- Service User experience in the community – reported from annual community survey
- Social care assessments – decision to investigate within 48 hours -the development of this indicator has been delayed due to COVID-19.

Performance against these indicators can be found in Appendix 3.

9. Conclusion

This report has evidenced the performance of the Trust during Q3 2020/21. In light of COVID-19, overall performance continues to remain strong despite the challenges faced. The ability to maintain flow across our Adult and CAMHS beds remains a priority. Despite high levels of sickness amongst inpatient staff we have been able to maintain safe staffing levels on wards. The vaccination programme at the end of Q3 and across Q4 will positively improve this situation and we are working hard to identify and address the concerns of groups and individuals who are reluctant to adopt the vaccine.

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 11b
Subject:	Capital Expenditure Month 11 FY21	**For Publication:** yes
Author:	James Thackray Head of Finance Brendan Giblin Head of Capital Development	**Approved by:** Paul Ronald Director of Operational Finance
Presented by:	Paul Ronald Director of Operational Finance	

Purpose of the report:

To provide the committee with an update on the progress of the Capital Plan for the period to date and the expected position for the full year.

Action required:

Note its contents and consider the issues identified.

Summary and recommendations

The FY21 capital program is significant in terms of the level of investment and the intended disposals. The attached summarizes the Capital Investment Program, the progress to date and the key next steps. Currently the forecast net spend is shown at £14.6m against the £15.4m plan, a forecast underspend of £0.8m.

HPFT has confirmed its forecast underspend of £0.8m to the ICS and this resource has been allocated to the 3 Acute trusts within the ICS. In addition to the capital program the Trust has secured additional central funding for further estates and technology investment of circa £2.2m. These additional schemes are also being progressed in year and are expected to be completed early in Q1 FY22.

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

Summary of Financial, IT, Staffing & Legal Implications:

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

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

Seen by the following committee(s) on date:

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

Introduction

1. This paper summarises the detail in relation to the FY21 Capital Program and is based upon the ongoing Capital Program discussed and approved through the Finance and Investment Committee.

2. The capital plan progress has been positive this year with significant progress made on important key projects including the safety suites (at Dove Ward, Broadlands, Warren Court and Bowlers Green), Forest House refurbishment and HDU, and other enabling projects such as backlog maintenance, fire safety and the digital strategy.

3. The strategy has been to progress key projects with some disposals held back (The Stewarts, St Pauls and Harper Lane) to maximise revenues from sale when the Covid implications on the property market is clearer.

4. For schemes not progressed to plan in year, which include the Oak Ward refurbishment, new 54 bed East and North inpatient unit, and Albany Lodge works, progress has still been made on the scoping and design but the majority of spend is now to deferred to FY22 capital plan.

Background

5. The Trust set a draft capital plan for FY21 of circa £21m gross £15m net. The Trust has the cash to fund this from retained surpluses from prior years. Changes to the capital spending regime meant that it was possible that individual trusts plans could be altered to ensure that the overall ICS capital limits were maintained. The MoU agreed by ICS partners included the change requested by HPFT that any variation in the Capital Plan would have to be agreed by the Trust Board.

6. The Trust has applied the Regional prioritisation framework to its program which is based upon the following criteria. This assessment tool will enable the Trust to evaluate any ICS requests to amend its capital plan in year due and will ensure a transparent consistent approach within the ICS;

Criteria	Objective/Definition	Comments from Region
Patient and public safety – 60%	**Addressing current high risks relating to one or more of the following areas, which cannot be mitigated through alternative routes at lower cost**	**Examples include: -** • **Clinical safety (not clinical quality), i.e. where there is high risk of patient harm** • **Health & safety of patients, staff and/or visitors.** • **Fire safety.** • **Cyber security.** • **Regulatory instruction in relation to safe patient care, e.g. CQC 'must do'.**

30% Maintaining an acceptable level of service quality	**Addressing current high risks, for existing services, relating to one or more of the following areas, which cannot be mitigated through alternative routes at lower cost:**	**Clinical quality which adversely impact patient experience but do not carry high risk of patient harm.** • **Service continuity.** • **Regulatory instruction in relation to quality of patient care, e.g. CQC 'should do'.**
10% Business case (strategic and financial case)	**A sound case for investment based on strategic fit and financial case**	**Other considerations.**

7. The program is now being progressed as set out below.

Report Detail

8. The program forecast has been reviewed and is summarised in the table below while further detail is set out in Appendix 1. This shows an expected net spend in year of £14.6m against the envelope of £15.4m which is £0.8m less than the overall Plan in net spend terms. This represents a reduction in forecast spend of c £0.8m since last reported with the slippage on some of the Safety Suites schemes whilst there are a number of IT Projects relating to the Digital Strategy where costs will be significantly less than original plan due to successful procurement activities as well as pausing of some of the projects such as Single Person View.

NHSE/I Capital Plan FY21	Submitted Plan	Month 11 YTD Spend	Forecast 20/21 Spend	Over/(Under) spend
	£'000s	£'000s	£'000s	£'000s
Inpatient Projects				
Safety Suites	**5,000**	3,252	**5,087**	**87**
Stevenage New Inpatient Unit	**3,500**	742	**1,030**	**(2,470)**
Oak Ward Refurb & Decant	**4,000**	316	**400**	**(3,600)**
Forest House Refurb Phase 1 & HDU	**2,000**	318	**573**	**(1,427)**
Albany Lodge Works	**1,500**	44	**257**	**(1,243)**
Backlog Maintenance	**842**	646	**1,273**	**431**
IT Projects	**3,000**	1,801	**2,381**	**(619)**
Reactive Operational Capital	**1,058**	2,465	**4,101**	**3,043**
Disposals	**(5,500)**	(504)	**(515)**	**4,985**
Total spend against NHSE/I Plan (CDEL)	**15,400**	**9,080**	**14,588**	**(812)**

9. The forecast net spend of £14.6m remains subject to review and will be monitored closely in the coming weeks. The Estates team and IT Team has with SBU colleagues focussed on identifying areas where spend on the existing program can be accelerated by placing early orders or bringing forward enabling works.

10. In headline terms there has been good and continuing progress across a range of works both supporting clinical care, quality initiatives and staff welfare.

11. A number of schemes from FY20 included under Reactive Operational Capital held over have been successfully implemented. These include the works on the Colonnades, the creation of more clinical space at Waverley Road, provision of junior doctor facilities and the progression of the fire safety program.

12. A number of the areas of the program progressed at pace;
    - 12.1. Backlog maintenance Rolling Program of works already set.
    - 12.2. Laptop investment accelerated to support remote working
    - 12.3. Operational Capital Schemes being progressed.

13. In terms of the FY21 core program schemes then the current position is shown in the table below with actions being taken on each scheme.

Project	Actions
E&N New Inpatient Unit;	• Continue interest in land • Finalise OBC/FBC • Discussion with NHSE on draft business case • Finalising of the design progress. • Acoustic surveys on site have commenced. • Land topographical surveys progressing.
Safety suites; **4 suites built and in use**	• COVID19 – 19 cases have caused delays to the programme as well as unforeseen underground hazards, recent inclement weather and steelwork delivery delays. • Foundations completed and brickwork and steelwork installation has commenced. • Capital spend, with construction commencing, to increase significantly in Q4 FY21 with completion in Q1 FY22.

Oak Ward
 	
Deferred to 21/22 as decant option to be completed initially.
	• 4 Bowlers Green decant option discounted.
	• Key elements being;
	  ○ Length of any decant period
	  ○ Continuity of staff provision
	  ○ Future bed capacity requirements
	  ○ Minimise any double run/distressed cost
	• Essential works list being compiled now that COVID19 19 outbreak restrictions have been lifted.

Forest House **Refurbishment and provision of minimum of 2 HDU beds**	• Contractor WDI looking at commencing external groundwork and drainage works in March 2021. • Due to COVID19 19 positive cases, access internally for surveys is restricted. • WDI completing surveys and cost plan. Liaising with clinical operational staff.
Digital strategy **Year 1 of plan**	• Individual project streams are being progressed with the initial focus on the upgrading our Wi-Fi and network to provide an adequate and well-functioning Wi-Fi across all sites with sufficient bandwidth. This is progressing well with equipment order and discussions nearing conclusion on sourcing a partner for the configuration and installation. Further progress has been made on IAPT Chat-bot facilities, single sign on protocols, and single person view.

14. For the FY21 plan robust cash-flow forecasts are in place for the main projects which gives assurance to the planned forecast spends as set out in Appendix 1. The main risk to the delivery of the plan is now any slippage on the Safety Suites schemes and any unexpected COVID19 outbreaks that impact on the construction sites. This is mitigated wherever possible to minimise delays whilst retaining the safety of patients, staff and construction staff.
Our internal tracker for the main projects is attached as Appendix 2, together with an update on current leases and licences.

15. The additional capital finance that has been secured in addition to the current program are:
    15.1. £1m PDC has been agreed to cover the cost of the relocation of the generator, gas and water supplies onto the Little Plumstead site from its current location which is now within the land sold for building development. This has now been agreed and funding approved. Architects have been commissioned and the project is progressing at pace.
    15.2. £0.9m PDC funding has been approved by NHS England to support the implementation of an Electronic Prescribing Medicines Administration system able to manage prescriptions and medications digitally.
    15.3. £0.3m PDC funding has been approved for the funding of Remote Working Devices
    15.4. £74k has been provided through NHS X to fund a pilot for the remote care monitoring.
    15.5. A small number of COVID capital claims have been approved £390k covering some initial COVID related estate works and the purchase of digital equipment

ICS Provider Capital Working Group

16. As noted above there is an overall capital limit for the ICS and in the light of the forecast underspend of £0.8m and following requests from individual Acute Trusts HPFT's CDEL for FY21 has been reduced by £0.8m to £14.6m to enable the overall limits to be maintained.

Conclusions

17. It is recognised that the large capital program with several key schemes has been challenging in the current environment. However, whilst there has been some delay in this year's program due to the work on the emergency planning response the program is now being progressed on all fronts. The Trust has been working to maximise the amount of spend that can be capitalised this year by placing orders for furniture and equipment, mattresses, signage etc. and accelerating pipeline projects to bring the current forecast as close to the revised CDEL. This includes the bring forward the purchase of IT hardware from the FY22 program; install handrails and dropped kerbs to the SRS bungalows; change carpet flooring to vinyl at Kingsley Green; complete remedial works on Aston ward; bring forward FY22 backlog maintenance schemes where feasible, and; reconfigure storage facilities at Warren Court.

18. In relation to the impact of COVID -19 then this is being managed, with suppliers of Trust construction providing immediate notification of any issues or effect of the lockdown. Letters have been issued to construction suppliers to issue to their staff to confirm that are working on essential NHS required works.

Appendix 1 Current Capital Plan YTD Spend and Forecast

NHSI Capital Plan FY21	Submitted NHSI Plan	Month 11 YTD Spend	Forecast 20/21 Spend	Over / (Under spend)
	£'000s	£'000s	£'000s	£'000s
Inpatient Projects				
Safety Suites	5,000	3,252	5,087	87
Stevenage New Inpatient Unit	3,500	742	1,030	(2,470)
Oak Ward Refurb and Decant	4,000	316	400	(3,600)
Forest House Refurb Phase 1 and HDU	2,000	318	573	(1,427)
Albany Lodge Works	1,500	44	257	(1,243)
Trust wide Projects				
Backlog Maintenance	842	646	1,273	431
IT Projects				
Digital Strategy	2,400	1,214	1,594	(806)
App Development	100	0	0	(100)
IT allocation	500	587	787	287
Reactive Operational Capital				
Reactive Operational Capital	1,058	2,465	4,101	3,043
Disposals				
The Stewarts (NBV £1,785k)	(2,200)	0	0	2,200
St Pauls (NBV £1,460k)	(2,000)	0	0	2,000
Harper Lane Sales (£1,274k)	(1,000)	0	0	1,000
Little Plumstead Land Sale (NBV £0k)	0	(50)	(50)	(50)
Alexandra Road Sale (NBV £318k)	(300)	(454)	(465)	(165)
Total spend against NHSI Plan	15,400	9,080	14,588	(812)

Complete
On track for forecast spend
Some risk to meet forecast spend
High risk to meet forecast spend

Appendix 2 Capital projects 2020/2021 Update Report: February 2021 Stage Deliverables	Key Risks	Mitigation	This Month	Planned Comp Date	Estimated/ Actual Comp Date	Jan Risk	Feb Risk
4No Safety suites – Business Case approved, relevant planning application approved, pre start meetings completed, HPFT signed contract. Works started on site concurrently.	● Undetected underground services. • Lockdown – suppliers delay. ● Positive COVID results.	CAT Surveys. RAMS. H&S regular visits. Frequent site meetings, risk register workshops. Manage supplier timelines.	Concrete base complete, steel delivered, craned in and erected. Metal deck installed, blockwork has commenced & drainage.	4 BG Dove W Court Broadland all 10th May	4 BG 9 June Dove12 June W Court 23 June Broadland 9 June		
Forest House HDU – GMP completion and appoint WDI, internal surveys w/c 26th Oct. Business Case approved. Positive pre app meeting completed, same Planner allocated planning application.	• Planning risk validation delay. • COVID positive results. • Site welfare set up. ● GMP exceeds budget.	Regular communication with Planners, Cost advisor role, fortnightly PM update.	Validation surveys completed where feasible. Plan to commence underground works March 2021.	TBC	TBC		

Forest House Internal refurb – Pre start completed, commenced on site 2nd November 2020.	•Lockdown. • COVID positive results. • Occupied building, risk of delay due to H&S incidents.	H&S advisor role, frequent site meetings.	Completed, handed over, final account agreed.			Completed	
Albany Lodge Ward refurb – GMP completion and appoint WDI.	● GMP complete & appoint. ● Potential delay in not completing before April 2021. ● Delay in receiving scope of works from Operational colleagues.	Close communication with Operational leads and escalate if necessary.	Business Case approved at 24th Feb Exec. Delay to access site fro final surveys due to PPE protocol decision.	24th Sept	24th Sept		
Oak ward/project/decant	● Annette King completed option appraisal paper awaiting Exec decision.	Present costed options with timelines.	Decant option, 4 BG, no longer viable. Staff reported to Interserve 'essential' works. Design to be signed off by clinical stakeholders Meeting with Kier on 23rd Feb	TBC	TBC		

			to discuss next steps. Kier prog expected 8th March, potential start date mid Oct 2021				
Roseanne House 3rd Floor, Day Treatment Centre – Capital bid approved, tenders issued, anticipated commence on site 23rd November & handover 4th December 2020.	● Tenders exceed approved budget. ● Landlord prevent works.	Cost Advisor role. Properties Manager liaise with Landlord, receive Landlord formal consent.	Complete w/c 14th Dec.			Completed	
20/21 Backlog Maintenance – Tenders issued 2nd November, anticipated completion March 2021.	● Returned tenders exceed budget. ● Potential delay in not completing before April 2021. ● Delayed access. ● Supplier delay due to COVID.	Pre tender estimate completed per scheme. Monthly Design Team update meeting. Fortnightly site meetings once work commences.	Works in progress on numerous sites. Fortnightly team progress meeting established.	31st March	31st March		
Kingsley Green – Overflow car park – Planning approval and tenders received, POs raised, pre start meeting to commence November 2020.	● Potential delay in not completing before April 2021 ● Bloor Homes delay	Contact made with Bloor Homes and invite to pre start. PM to closely manage	Work progressing well, light columns in, spoil removed, tarmacing commences 1st March	31st March	26th March		

	access to site.	construction programme.	for five days, followed by line marking.				
6 Facet Surveys – Lister & Astley Court – Capital Bids to be discussed at 5th November MoE. GMP completed. P21+ contractor to receive instruction before 16th November, otherwise tender works as P21+ expires 17th November.	● Potential delay in completing before April 2021. ● Delay in giving Interserve Construction (P21+) instruction retender to take place.	P21+ complete GMP, in anticipation of Bid approval.	Astley Court & Lister, works commenced, progressing well, good liaison with E&N.	19th March	19th March		
Staff changing room & staff rest rooms – Paper presented at Exec on 28th October. 14No sites proposed Eliott external cabins, task & finish group set up, next meeting 30th October. Paper approved.	● 5No trial sites chosen: external cabins,- Bowlers Green,(shared). Warren Court, Kingfisher Court, 15 Forest Lane, Beech & Oak ward (shared) ● Risk - after 2 week trial period, cabin is not feasible option.	Task & Finish Group including Op stakeholders engagement and signoff. Pre surveys completed.	Next T&F Group 1st March to discuss lesson learned and phase 2. Chair replaced with Pauline Duffus.	31st March	TBC		

99 Waverley Road – St Peters St move - move**,** PC and handover completed.	● Final account to be agreed approx £5K overspend.	Cost advisor reviewing costs.	N/A			Completed.	
15 Forest Lane – DBT move from 1 Bowlers Green.	● Delay to CHC, Transport & Perinatal not receiving approval.	Transport bid submitted 5th Nov MoE. Perinatal bid to be completed.	Strip out and first fix completed.	29th March	29th March		
Transport move to Martinlea – Capital bid 5th November MoE. Nick Smith visited site and is in favour of move.	● Capital bid not approved. ● IT/Tel line does not meet timelines.	Nick Smith visited site and agreed option.	Stored furniture removed, deep clean and minor building works commenced. Existing BT line found on site.			Completed	
Perinatal move to Prospect House – Suzanne Gray has visited site and is in favour. Positive meeting with Suzanne and IT took place on 12th Nov.	● Capital bid not approved. ● Staff consultation not agreed.	Staff favour Prospect House option.	Staff to move in 18th Jan.			Completed	
CHC move to 1 Bowlers Green	● Not enough space at 1 Bowlers Green.	E&F discussions commenced.	Staff to move planned 12th Jan.			Completed	
Holly Lodge – side extension Planning approval received, SLA signed, Capital bid approved, PO issued awaiting start date.	● PO delayed. ● Not meeting staff expectations.	Design signed off and approved.	Works completed except snagging. Staff have started using facilities.	18th Feb	18th Feb		

Education Centre – PC and Handover	● Final account not agreed.	Cost Advisor task.	Handover w/c 14th Dec.			Completed	
Little Plumstead – Plant room relocation, finance approved, M&E and Architect appointed and received POs. Site visits completed.	● Underground hazards discovered. ● Planning refusal ● Developer Cripps prevents access to site.	Complete Pre App planning application. Close communication with Planners and Cripps.	Planning application approved, tenders to be issued early March	30th Oct	30th Oct		
Forest House – windows complete 27th Oct Oak & Beech completed.	N/A	N/A	Issue final invoice and O&M manuals.			Completed	
CCTV trial project – P22 'minor works' package with Kier Construction. Design completed awaiting stakeholder approval, estimate exceeds budget. Option - complete Warren Court only with additional circa £100K funding, or delay to 21/22 Capital Plan.	● Funding not available.	Cost advisor to review costs.	John Fanning Head of Patient Safety agreed with design. Cost Advisor issued report comparing BC with Kier costs.	21/22 Scheme	21/22 Scheme		
Lexden - A&T Project – Architect visited site and met Operational team. Architect has listed scope of works, awaiting confirmation that scope of works is agreeable.	● Not on Capital plan 2022/21, funding may not be available.	Complete & sign off design and complete costing exercise.	QS cost plan issued, based on approved design drawings. Nathan liaising with Owen, writing Business Case for 21/22 pipeline.	TBC	TBC		
CATT move from St Pauls to The Orchards – To enable St Pauls disposal from April 2021, CATT to relocate.	● Staff consultation does not go to Plan. ● The Orchards option not feasible.	Site meeting with relevant stakeholders including Owais.	Owais confirmed 'The Annexe' plus two rooms in The Orchards is suitable for CATT team. Condition survey completed, tenders in	21/22	21/22		

			progress, Owais to complete Capital Bid after 1st Mar on site meeting.				
Health & Wellbeing Team move to The Bungalow Albany Lodge.	● Staff consultation does not go to plan. ● The bungalow option not feasible.	Regular communication with Owais and stakeholders.	Kate Spokes confirmed The Bungalow is too small. Simon Whittome continuing with search.	21/22	21/22		
EMDAS move to Borehamwood CC	● Returned tenders exceed budget ● Potential delay in not completing before April 2021 ● Delayed access ● Supplier delay due to COVID. ● Heads of Terms not agreed.	Properties Manager liaising with Landlord. Pre tender estimate.	Finalise Heads of Terms, design approval, ready for 21/22 project.	TBC	TBC		
Latton Bush move to Kao Park – Capital Bid approved, positive landlord negotiations.	● Returned tenders exceed budget. ● Potential delay in not completing before April 2021. ● Delayed access. ● Supplier delay due to COVID.	Cost Advisor – Pre Tender estimate. Frequent site progress meetings. Monitor supply chain.	Works commenced on site.	12th March	5th March		

New Leaf College from St Pauls – Capital bid required.	● No feasible freehold vacant space. ● Search for private Accommodation. ● Therefore revenue funding required.	Raise at OSL meeting.	Irma Mullins has visited The Bungalow and is keen to occupy.	Q2,21/22	Q2.21/22		

LEASES & LICENCES UPDATE:					
Property	***New Lease/Renewal***	***Completion***	***Take Up Rationale***	***Cost Implications***	***Comment***
Welwyn Civic Library	Renewal	31/04/21	Small base still in use by MHSOP service.	Minor reduction in rental costs (c.£4K pa) once complete due to removing NHSPS and dealing directly with council.	Drawn out due to multiple superior landlords involved in providing agreement.
31 Hill End Lane, St Albans	Income lease	01/05/21	N/A HPFT freehold. Lease to 'New Directions'	Increase in rent income pending updated valuation.	
Midshires Business Park, Aylesbury	Renewal	30/07/21	LD Office & clinical base, required.	Possibility of negotiating zero rent uplift, pushing for this.	Terms on new lease almost set. Holding out for best terms (see previous comments).
Colne House, Watford	Renewal	11/12/21	Under investigation to ascertain usage.	Pending discussions.	
Tekhnicon House, Essex.	Renewal	08/03/21	Services still require existing space – Pol Toner, Owen Fry, Kate Spokes(Consultation required on taking on extra space at a later date).	Negotiated down to £7K pa increase from previous 2015 lease rent.	
Spinks Lane, Witham	New lease	31/03/21	Required due to transfer of LD services from ACE to HPFT	Rent of £49K pa. Costs conformed by Pol Toner as covered within service transfer.	Already in occupation due to staff TUPE. Awaiting lease engrossments from NHSPS.

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 12
Subject:	Financial Position to 28th February / Expected Outturn to 31st March 2021	**For Publication:** yes
Author:	Sam Garrett, Head of Financial Planning & Reporting	**Approved by:** Paul Ronald, Director of Operational Finance
Presented by:	Paul Ronald, Director of Operational Finance	

Purpose of the report:

To set out the financial position to 28th February 2021 as well as a forecast for the position for the full year, and a forward look into 2021/22.

Action required:

To review the detailed provided on the current and projected financial position and assess the Trust's ongoing response to the evolving financial arrangements.

Summary and recommendations

The Trust reported an overall position on Plan for the period to 28th February; this was break-even for the first 6 months; a deficit of £174k for the month of February; and deficit of £937k for the year to date. The deficit in Quarters 3 and 4 relates to the progressive increase in Pay costs; and to significant cost pressures within external bed costs to meet additional demand or to provide specialist care not provided within HPFT's own services; as well as provision being made for any additional costs expected this year.

The Trust submitted a revised forecast via the ICS in October forecasting a £1.2m deficit for the final two quarters, building progressively through the period as the Trust recruits staff to new posts funded through the new funding. The position reported therefore remains as per this forecast.

The key highlights relating to the reported position for February are:

1. Income levels better than Plan by c. £365k overall largely due to higher levels of COVID-19 related income being released in the latter months to match costs.

2. Pay costs higher than Plan by c. £75k due to agency remaining above Plan, payment of annual leave buy-back, and COVID-related Bank pay, all offset by delays in recruitment for new and expanded services.

3. Non pay costs and overheads above Plan by c. £250k due to accruing for COVID-related costs and other additional costs. Notably, Secondary Commissioning reported below Plan by c. £140k in the month, due to very low activity (in part caused by the 28 day month with most costs being driven by days rather than calendar months).

4. COVID-19 costs are in line with the fixed sum provided for the year to date.

	February Actuals	February Plan	Year to date Actuals

Income incl. Covid related	24.0	23.6	258.3
Expenditure	23.8	23.8	259.2
Surplus / (Deficit)	**(0.2)**	**(0.2)**	**(0.9)**

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

Summary of Financial, IT, Staffing & Legal Implications:

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

N/A

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

Financial Management

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

1. Summary

1.1. The Trust has reported a position on Plan for the month and year to date as at 28th February 2021. This was comprised of break-even for Quarters 1 and 2, as per the then national reporting arrangements, supported by c. £350k top-up income to achieve this in Month 6, and a deficit of £174k in month and £937k for Months 7 to 11.

1.2. As part of this position, £12.2m of COVID-19 costs and top-up has been reclaimed or released from the Quarter 3 allocation, with £1.1m remaining available for use and release in Month 12.

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

	In Month Actual	In Month Plan	Year to date Actual
Income excl. Covid-related	22.9	22.7	246.1
Pay	15.8	15.7	166.9
Secondary Commissioning	2.8	3.0	33.7
Non Pay	4.6	4.2	48.8
Financing	0.9	0.9	9.9
Total Deficit before supplementary income	**(1.3)**	**(1.1)**	**(13.2)**
Supplementary Income:			
COVID-19 reimbursement	1.1	0.9	11.3
Other Top-up	0.0	0.0	0.9
Revised Deficit	**(0.2)**	**(0.2)**	**(0.9)**

1.4. For the Month of February, compared to the Plan and reforecast submitted in October to NHSEI, main variances were:

1.4.1. Income at £365k more than Plan largely due to higher levels of COVID-19 income being released in the latter months to match costs and accruals, as well as old year transformation income and additional Education and Training income being released.

1.4.2. Pay costs at £75k more than Plan due to: agency remaining above Plan, payment of annual leave buy-back, and COVID-19 related Bank pay costs; all offset by delays in recruitment for new and expanded services.

1.4.3. Non Pay Costs and overheads above Plan by c. £250k due to accruing for COVID-19 related costs (covered by COVID-19 income released) and other additional costs expected. Notably Secondary Commissioning costs reported below Plan in the month by c. £140k, due to very low activity (in part due to reductions for Adult Acute and PICU Out of Area, in part due to there being only 28 days in the month with most costs driven by days rather than calendar months).

1.4.4. COVID-19 costs of c. £1.1m and income of the same level; this is in line with the revised amount available in the 2nd half of the year, with a similar amount available for use in Month 12.

1.5. The Trust's Use of Resources (UoR) framework rating is not being reported to NHSEI under the current financial arrangements and due to the fact that Trusts are reporting a consistent break-even position. The Trust's own assessment against the previous criteria would report as 1.

2. Background

2.1. This year saw fundamental changes to the normal contracting and financial reporting processes and is set within the context of the overarching objective of Finance to support and facilitate the clinical response to COVID-19. All NHS Organisations were directed to report a break-even position in each of the first six months with income being made available to fully match expenditure. The arrangements changed from Month 7 and now include:

2.1.1. The continuation of most elements of the Block payment with the exception of several smaller London contracts for SRS beds, meaning a reduction of c. £100k per month for HPFT.

2.1.2. Reduction of the standard top-up by £100k per month to £188k per month.

2.1.3. Additional MHIS amounts paid by Hertfordshire CCGs of c. £550k per month (with a small part of this ultimately going to other providers).

2.1.4. Additional growth monies of £150k per month.

2.1.5. COVID-19 reimbursement to be dealt with via the ICS and at a capped amount for the system, rather than full reimbursement of all costs.

2.2. Further detail on additional income available to the Trust, such as Health Education England monies for IAPT services, and release of old year SDF monies to match spend, is included below.

3. Key Variances

Income

3.1. For the year to date there is £1.2m less income than Plan, excluding the impact of COVID-19 income released and planned, this is due to the original Plan assuming release of significant amounts of deferred income which were largely not necessary in Quarters 1 and 2, though they have been released through Quarters 3 and 4. For the month, income is c. £164k more than Plan, due primarily to Winter monies being released to match spend, as well as the continued release of old year SDF income and new year HEE income for IAPT trainees.

3.2. CQUIN has been included for the year to date at 100% with no penalties, this position will continue for at least Quarter 1 2021/22.

3.3. Although the new finance regime for Month 7 resulted in some reduced income for HPFT (c. £250k per month relating to small London contracts for SRS services, reduction in the top-up paid, and New Care Models change), there was also a significant level of new investment. MHIS has been paid at c. £550k per month and growth monies at c. £150k per month. Additionally, the Trust was offered a total of £745k to make up the SRS income previously lost; though this has yet to be received.

3.4. SDF was added to the contract schedule with IHCCT and has largely now been received. In the meantime the full amount of old year SDF has now been released into the position to match spend, and the new year amounts have started to be released in Month 11.

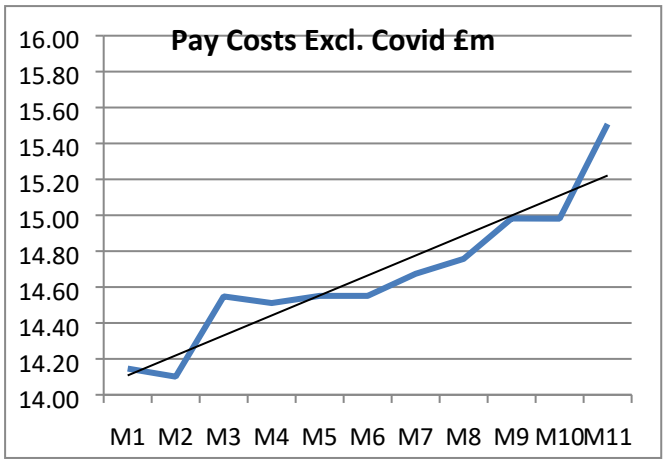
3.5. There has been some uncertainty over the exact levels of income due to the complex arrangements this year, however a contract schedule has been agreed with IHCCT and Herts Valleys CCG, and is awaiting final agreement from East & North Herts CCG, though they have in fact already made payments slightly exceeding this contract value. Herts Valleys CCG have agreed one further payment to be made on 15th March. In both cases the amounts received include non-contract items outlined below. Any further changes will not have a material overall impact on the yearend position.

3.6. Receipts from the Hertfordshire CCGs have included items not included on the contract schedule such as income for the Health and Wellbeing Hub (£219k to date), various NHSEI IT items (£499k covering Chat Bots, Remote monitoring license, and Productivity Innvovation), and Winter Discharge Planning / Pressures (£924k). These are largely neutral in effect for 2020/21, any excess amounts not spent will be deferred to match expenditure in the new financial year. Winter Discharge monies have been released into the position to a total of £195k to date to match expenditure.

Pay

3.7. For the month pay is above the revised Plan by c. £75k due to agency remaining above Plan, annual leave buy-back in month, and high bank pay costs, particularly relating to COVID-19; all offset by recruitment delays. For the year to date, pay is above Plan by £2.0m but this relates to the impact of COVID-19, without these costs it would be significantly below Plan, due to recruitment delays.

3.8. Despite being below Plan there has been a significant increase in pay spend during the year, even excluding COVID-19 expenditure, as shown in the graph below.

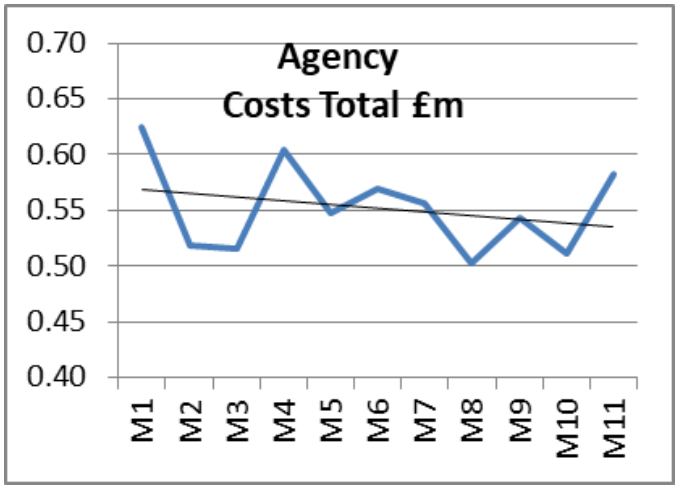


3.9. This increase in pay spend has been in part due to an increase in staff recruited, and lower levels of leavers than usual, with bank and agency spend not reducing (and in some cases continuing to increase) despite substantive recruitment. In some cases this is to be expected, such as the high numbers of IAPT trainees, which wouldn't have been covered previously, and there is some evidence that agency costs for inpatient services did start to reduce in Quarter 3 though the impact of the Pandemic Wave 2 has meant this hasn't been sustained to date. There has also been a regular accrual for Annual Leave "Buy-back" in 2020/21, and payments made with £107k paid out in February (buy-back also allowed for days carried forward from 2019/20 but this was accrued for last year).

Period	Starters	Leavers	Net	Comments
March & April	72	-65	7	
May & June	71	-36	35	
July & August	99	-99	0	Placement Student nurses started/left
September	87	-53	34	IAPT Trainees high numbers
October & November	81	-56	25	IAPT Trainees high numbers
December & January	112	-81	31	
Total	**522**	**-390**	**132**	
Expected Feb & March	110	-40	70	Including c. 40 Placement Student nurses Feb & c. 35 IAPT trainees mid-March

3.10. Pay awards have now been paid with most staff paid via Agenda for Change agreement from April, most medical staff paid in September (and backdated to April), and most other staff paid in October, with VSMs due to be paid in March 2021 (maximum cost of £20k).

3.11. Agency spend having increased during the latter part of 2019/20 did reduce a little during the early part of 2020/21, it has fluctuated since with some recent reductions and overall the linear trend line on the graph below does show a small overall reduction during the year. The highest use of agency remains qualified nursing roles in inpatient and all qualified roles in the community, in particular in CAMHS, with C-CATT in particular where a necessary expansion of the service has not yet been fully funded and so not substantively recruited to.



3.12. Part of the plan to address Bank and Agency spend is in more efficient use of the Electronic Roster and of Safe Care, a senior role to lead on this work has been agreed and it is hoped this will be appointed to soon. Additionally there has been an Internal Audit of pay costs which identified some actions relating in particular to Bank pay costs where additional controls should be implemented. This is being reviewed by a Task and Finish Group which will recommend and make changes.

Secondary Commissioning

3.13. Secondary Commissioning has overspent for the year to date and remains above the revised Plan submitted in October for the year to date, by £1.6m, however exceptionally it reports below Plan in February by £138k. This is due to reduced activity in the month primarily related to Adult Out of Area Acute and PICU, as well as there only being 28 days in the month (most costs are driven by daily costs rather than calendar month costs). It has been particularly difficult to address additional activity and spend during the Pandemic, particularly for CAMHS Tier 4 Out of Area which has seen really exceptional levels of activity and very high acuity. A snapshot of activity at the end of each month, shown alongside target numbers for the year, is shown below:

End of Month:	Target	Q1	Q2	Q3	Jan	Feb	Current
CAMHS OOA	8	12	18	22	19	19	15
Acute OOA	2	8	5	9	13	9	15
OA Acute	0	0	0	0	0	0	0
PICU OOA	2-4 avg	4	4	6	2	2	4
Health Long Term	30-32 avg	35	35	34	31	31	31

3.14. The key areas are:

3.14.1. CAMHS Tier 4 Out of Area placements which have continued at extremely high levels with a number of young people who need very specialist care and cannot be maintained at home. Recent cases include a young person who has needed multiple-level observations within the S136 suite, though part of the cost was covered by NHSEI due to the exceptional nature of this case. Staffing and skill mix of community teams is being reviewed with new roles being trialled, for instance Band 4s to provide meal support at home to prevent admission or accelerate discharge in young people with eating disorders, and a senior clinician to review young people in their placements.

3.14.2. PICU Out of Area placements have remained at a moderately high level although they have been in part contained by a lack of available beds. Acute Out of Area have continued at high levels and the need to cohort service users as a result of outbreaks has meant a difficulty in bringing service users back to HPFT resources at times. There was some reduction in February but this has not been sustained into March. All service users are reviewed by a dedicated clinician.

3.14.3. Main Health placements have remained at a high level though there has been significant activity which has netted off. There was a low of 30 in 2019/20, however with several placements being made largely due to COVID-19 issues, it has not yet proved possible to reduce back down to this level. However a return to 31 has been sustained with a plan to get to 30 or below by Quarter 1 2021/22.

3.14.4. MHSOP CHC Placements have made significant savings, of c. £1.5m to date, which has been sustained.

3.14.5. Social Care costs haven't changed significantly during the year, though a reduction for Quarter 4 is expected in line with the Connected Lives Programme. The Provider Review part of this is just starting (expected full year impact from Quarter 4 activity is c. £200k) and numbers have been held at 2019/20 levels with no growth.

Overheads

3.15. Other Direct costs and Overheads are above Plan by c. £2.8m for the year to date and £431k for the month but this is largely due to COVID-19 related costs, and provision being made for additional costs. Excluding COVID-19 impact, savings were made on travel in the early part of the year, and a number of items didn't go ahead on time due to the Pandemic. A number of one-off costs have been paid or provided for, such as external recruitment for Non-Executive Directors, potential external fit-testers (c. £50-150k depending on method chosen), and the purchase of new AEDs (c. £100k).

4. COVID-19

4.1. For Months 1 to 6 there was a COVID-19 cost reimbursement process in place via which HPFT claimed and was paid a total of £8.0m. For Months 7 to 12 income based on Quarter 1 was allocated to Trusts via the ICS, for HPFT this equates to just under £900k per month. A total of £4.2m has been released to date out of a total available of £5.3m for the 2nd half of the year, with £1.1m remaining available for Month 12, which is expected to be sufficient.

4.2. Current areas of spend relating to COVID-19 are as follows:

4.2.1. Pay and Security costs relating to PPE and the 24/7 Helpline

4.2.2. Other Pay costs particularly as relating to Incident Command, C-CATT, and weekend cover, with both Incident Command and weekend cover having been stepped back from the start of March

4.2.3. Costs relating to IPC such as deep cleaning and uniforms, other non-pay elements of incident response, accommodation costs (not funded nationally as in Wave 1)

4.2.4. Additional external bed provision / secondary commissioning costs

4.2.5. Vaccination and Lateral Flow Testing, and Aspirant Nurses, for which additional separate income will be provided

A number of costs are now starting to reduce again as Wave 2 eases and it fully expected the amount of income remaining is sufficient to cover costs in Month 12 and continue to provide for a number of items at risk.

PPE remains provided nationally and not funded by the Trust, though this will need to be accounted for at the year end.

5. Delivering Value Programme

5.1. Whilst the Trust has worked on its Delivering Value Programme throughout the year, progress has at times been mixed during 2020/21 due to the impact of the Pandemic and in particular operational availability to work on plans. However

there has been a renewed focus on the 2021/22 Programme in particular during Quarters 3 and 4.

5.2. To date £7.4m full impact and £5.5m adjusted impact for 2021/22 (based on 100% achievement of Green rated and 75% of Amber rated) schemes have been identified and developed, against an initial Plan of £7.0m, with work ongoing to identify smaller schemes or firm up less certain schemes to cover the gap. The main schemes being developed and progressed are:

5.2.1. Agency reductions Trust-wide including targeting close observation reductions and more efficient use of Health Roster
5.2.2. OOA bed reductions for CAMHS, Acute and PICU, as well as Older Adult CHC beds
5.2.3. A review of Admin staff resources
5.2.4. Connected Lives Social Care programme
5.2.5. Potential for an EUPD Unit
5.2.6. Procurement and general purchase reductions
5.2.7. Sustaining savings arising out of agile working such as room hire and travel

6. Balance Sheet and Cash Flow

6.1. The full Statement of Financial Position is set out as an appendix. Main movements in the month are as follows:

6.1.1. Receivables decreased by £1.9m predominately due to raising and payment of the Herts County Council block contract income on time following a delay post the Christmas period.

6.1.2. Payables and accruals overall stayed the same. There was a £500k increase in capital payables related to the increased capital spend, offset by at £500k decrease in non-capital payables related to clearing of invoices in preparation for the year end.

6.1.3. Deferred income increased by c. £4.0m: £2.5m relates to change in categorisation used previously; £1.1m relates to the ICS SWIM Model income where the total income for an 18 month period has been received in advance; and £600k relates to LDA income which was requested by HEE to be invoiced early and was then settled early.

6.2. Cash balances remain very positive, but these will drop in March as the final payment was received in February for March with the block payments having been made in advance throughout the financial year. This will still have a positive impact on the level of PDC for the year given the calculation looks at the net daily cash balance.

6.3. Current provision balances are shown below:

31/03/2020	Provision	Total current month 9	Movement YTD
£000s		£000s	£000s
-978	Continuing Care appeals	-944	34
-600	LTPS & Legal Claims	-421	179
-2,008	Pensions	-1,791	217
-169	Protection of Pay	-169	0
-2,679	Injury Benefit	-2,688	-9
-1,445	Dilapidations	-1,624	-180
-1,085	Oak Ward	-1,085	0
-150	SRS	-150	0
-9,113	**Total provisions**	-8,872	241

7. Capital

7.1. Cumulative net capital spend year to date for 2020/21 is £9.1m, £1.7m in the month, a significant increase as the Programme has picked up pace in recent months. Projects and spend are shown below:

NHSE/I Capital Plan 2020/21	Submitted Plan	Month 11 YTD Spend	Forecast 20/21 Spend	Over/(Under) spend
	£'000s	£'000s	£'000s	£'000s
Inpatient Projects				
Safety Suites	**5,000**	3,252	**5,087**	**87**
Stevenage New Inpatient Unit	**3,500**	742	**1,030**	**(2,470)**
Oak Ward Refurb & Decant	**4,000**	316	**400**	**(3,600)**
Forest House Refurb Phase 1 & HDU	**2,000**	318	**573**	**(1,427)**
Albany Lodge Works	**1,500**	44	**257**	**(1,243)**
Backlog Maintenance	**842**	646	**1,273**	**431**
IT Projects	**3,000**	1,801	**2,381**	**(619)**
Reactive Operational Capital	**1,058**	2,465	**4,101**	**3,043**
Disposals	**(5,500)**	(504)	**(515)**	**4,985**
Total spend against NHSE/I Plan (CDEL)	**15,400**	**9,080**	**14,588**	**(812)**

7.2. There is a further more detailed update including in a separate paper to FIC.

8. Summary and Forward Look

Summary

8.1. This paper has outlined the position currently and for the year to date, which is that a deficit position has been reported as per Plan. In completing the accounts and reaching this deficit position it should be noted that a fairly prudent approach has been taken. This is appropriate given the uncertainties around the Pandemic, both in terms of the associated potential volatility in costs, and the remaining uncertainty around exact income levels for HPFT.

8.2. Specifically, an amount of c. £400k in month and c. £1.8m year to date has been provided for in relation to accruals for COVID-19 related costs, and for any reduction in income that does emerge during the remainder of the year. This is in addition to the various specified provisions the Trust holds (referenced in Section 6), and to the specific COVID-19 costs accrual (c. £700k) and Annual Leave accruals (c. £600k remaining) held.

Quarter 4

8.3. It is expected that Pay Costs will increase further in March, by between £100-200k depending on exact levels of recruitment and annual leave buy-back requested. There is income expected to support some of this in particular in relation to HCA recruitment, though this is likely only c. £10k in year. There is a further £745k expected for “lost income” relating to SRS services and the difference between financial arrangements for Half 1 and Half 2.

8.4. Whilst directly attributable COVID-19 costs are continuing to increase, there is c. £1.1m put aside from earlier months, as well as c. £200k further income expected in relation to the Lateral Flow Testing and Vaccination Programmes in year, which form part of the increased costs. It is therefore expected that COVID-19 costs will be fully contained within the money already available to HPFT, including the ability to provide for a number of costs within this.

8.5. Secondary Commissioning Costs will increase in March which is a normal length month. There will be a number of further accruals and provisions made, taking a prudent approach due to the current risk level.

8.6. These expected changes, and a number of yearend adjustments, assuming that release of and reset of provisions are neutral, and that the impact of Winter Discharge income and costs are neutral, will result in a position on Plan at £1.2m deficit. This could increase up to a deficit of £455k should the £745k be received.

8.7. The expected full year position is shown below:

£m	Full Year Expected	Comments
Income incl. COVID related	281.9	Additional deferred income of c. £5m
Pay	184.0	c. £1m additional pay accruals / provisions
Sec Comm	37.3	c. £300k additional provision
Non Pay	52.2	Releases of net c. £500k
Financing	9.6	PDC reduction £900k & £190k profit on disposal
Total Costs	283.1	
Surplus / (Deficit)	**(1.2)**	Possibly higher if £745k "lost income" received relating to SRS

Forward Look 2021/22

8.8. It has been announced by DHSC that as for 2020/21, the planning process for 2021/22 has been delayed, and that financial arrangements for Quarter 1 and possibly Quarter 2 will be based on those during 2020/21. There is little further detail available at this time, this is expected by the end of March. In summary though it is assumed the arrangements would include:

8.8.1. Block arrangements to continue at revised levels in place for Months 7 to 12 2020/21

8.8.2. Top-up payment but at the reduced level of £188k/month in place for Months 7 to 12 2020/21

8.8.3. COVID-19 costs provided for as a fixed amount via the ICS at c. £900k per month

8.8.4. Additional ICS Growth funding of which HPFT received c. £900k for 6 months

8.8.5. MHIS and SDF funds being made available but at lower amounts than currently

8.9. Whilst this information gives some certainty in terms of funding at least for the Quarter, which is welcomed, there are risks inherent in this approach for HPFT, in particular:

8.9.1. The specific level of MHIS and SDF, given that for MHIS in particular the 12 month amount has all been received in Months 7 to 12 thus receiving 1/12 in Month 1 2021/22 would be a reduction in income.

8.9.2. Arrangements for continuation of funding for COVID-19 costs given that these are quite significant and are likely to remain so for quite some time, particularly those for enhanced IPC, and additional bed costs.

8.9.3. The application of any efficiency factor to the inflationary uplift.

8.10. To deliver a balanced position therefore in 2021/22 it will be important to ensure the following:

8.10.1. That pay controls are kept in place with only funded posts recruited to and bank and agency costs reducing as substantive recruitment takes place.

8.10.2. That external bed costs are stabilised and brought down where possible.

8.10.3. The Delivering Value Programme is progressed early in the financial year and the current identified gap fully covered.

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

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 13a
Subject:	Business case for capital Upgrade to Albany Lodge inpatient Unit	**For Publication:**
Author:	Lucy Macro/ Brendan Giblin	**Approved by:** Sandra Brookes Director of Service Delivery & Service User Experience
Presented by:	Paul Ronald Operational Director of Finance	

Purpose of the report:

To seek approval by the Trust Board on the 25 March to the proposed investment set out in the Business Case

Action required:

To review the Capital Investment proposal in terms of the nature purpose and rationale of the investment, the specific detail of the refurbishment proposed and the process deployed for the project from design through to implementation

Summary and recommendations to the Executive Team:

The purpose of this business case is to seek approval of the £1,221,000 capital investment across both 2020/21 and 2021/22 financial years in support of the refurbishment of Albany Lodge.

The approval figure is a pre-tender estimate, subject to final confirmation and a headroom percentage of 20% is requested. This is to cover any variation in the cost estimates and following discussion in the Finance & Investment Committee to identify any further enhancements to the business case. The Estates team is liaising with the Modern Matron for Albany Lodge. Items to consider include the replacement of bedroom furnishing and enhanced elements for infection control and patient safety

The building opened in 1995 and whilst it has had some investment to address environmental risks and damage sustained, the ward needs investment to improve the overall experience of the service users who are treated there and staff who work there.

Longer term there is a clear plan to relocate this inpatient provision to a new site but this may take between 3 and 5 years to complete as a minimum and therefore this upgrade will provide a much needed improvement over the period of continued occupation. The proposed investment seeks to strike the correct balance on the likely length of further use of the facility by focusing on the priority work. The specification and classification of the work required has been done with the SBU senior management team.

This will be brought back to the Board for confirmation

Relationship with the Business Plan & Assurance Framework:

Part of Capital Plan

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

Approved by Executive Team February 24th 2021 Approved by Finance & Investment Committee March 16th 2021

Capital Investment, Property, Equipment & ICT proposals

HPFT Estates & Facilities

£1m - £4m Business Justification Template

To be used for Capital Investment, Property, Equipment & ICT proposals between £1m and £4m

Sponsors and authors of documents seeking appropriate authority to fund or proceed with a scheme or project must consider whether the content or strategy to which the document applies at this stage is sensitive or may have commercial implications. If it is considered necessary, the document should be headed and watermarked appropriately.

TITLE OF SCHEME	Albany Lodge Refurbishment	
TYPE OF SCHEME	New build	N/A
	Improvement	Yes
	Equipping and ICT	N/A
If other – specify and explain		
	Reference	TBC
	Confirm the Organisation issuing the reference number.	Herfordshire Partnership University Foundation Trust
DCO	East of England	

SPONSORING NHS ORGANISATION(S) (or other such as GP)	Lead Sponsor 1:	Herfordshire Partnership University Foundation Trust
	Sponsor 2:	N/A
	Sponsor 3:	N/A

LEAD SPONSOR CONTACT DETAILS		
PROVIDE DETAILS OF LEAD OFFICER FOR THE SCHEME	Title	Mr
	Name	Brendan Giblin
	Organisation	Hertfordshire Partnership University NHS Foundation Trust
	Office tel.	N/A
	Mobile tel.	07884 547 852
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PROVIDE DETAILS OF LEAD FINANCE OFFICER FOR THE SCHEME	Title	Mr
	Name	Paul Ronald
	Organisation	Hertfordshire Partnership University NHS Foundation Trust
	Office tel.	N/A
	Mobile tel.	01707 253 854
	e-mail	paul.ronald@nhs.net

PROPOSED SOURCE OF CAPITAL In addition, explain if more than one source of funding is to be accessed, how obtained and type of funding.	

CAPITAL VALUE AND PROPOSED CASH FLOW OF FUNDING: *(add additional rows as required)*					
PERIOD *[Please enter appropriate Financial years on right]* **FUNDING SOURCE**	Current year 2020-2021	2021-2022	2022-2023	2023-2024	Total
Trust Allocation					
STP					
Other *(specify)*					
Other *(specify)*					
Total	**£96,547.65**	**£1,124,452.35**			**£1,221,000.00**

BASIC BREAKDOWN OF SCHEME CAPITAL COST: *(add additional rows as required)*						
PERIOD *[Please enter appropriate Financial years on right]* **ITEM (MONTH)**	**Group Element / Element**	Current year 2020-2021	2021-2022	2022-2023	2023-2024	Total
SEPTEMBER 2020	N/A	£18,000.00				£18,000.00
OCTOBER 2020	N/A	£0.00				£0.00
NOVEMBER 2020	N/A	£0.00				£0.00
DECEMBER 2020	N/A	£29,890.70				£29,890.70
JANUARY 2021	N/A	£13,330.31				£13,330.31
FEBRUARY 2021	N/A	£6,032.99				£6,032.99
MARCH 2021	N/A	£29,293.65				£29,293.65
2020/21 FY TOTAL	N/A	**£96,547.65**				**£96,547.65**
APRIL 2021	N/A		£410,111.10			£410,111.10

MAY 2021	N/A		£410,111.10			£410,111.10
JUNE 2021	N/A		£304,230.15			£304,230.15
2020/22 FY TOTAL	N/A		**£1,124,452.35**			**£1,124,452.35**
Total: Development Cost (incl VAT)	N/A	**£96,547.65**	**£1,124,452.35**			**£1,221,000.00**
Revenue costs (Escorting service)	N/A	**£5,950**	**£5,950**			**£11,900**
TOTAL Capital & Revenue	N/A	**£102,497.65**	**£1,130,402.35**			**£1,232,900.00**

1. BRIEF SCHEME OVERVIEW

a) What is/are the principal strategic drivers triggering the need for this business case (e.g. to enable delivery of relevant commissioning requirements, to comply with NHS policy requirements, alignment with relevant policy e.g. Five Year Forward View, Strategic Transformation Plans and Strategic Estates Plans.

b) Summarise the key dimensions of the scheme in terms of both the tangible capital asset to be delivered, and the outputs that will be enabled in service terms as a consequence of the investment. Include land and premises ownership issues, cross boundary/partnership working and impact for service users, etc.

Introduction

Albany Lodge is an acute in-patient unit of approximately 1200 square meters GFA, constructed in the mid-1990's. The building is a part single / part two story building with the ground floor area comprising the secure ward area / SU accommodation, SU activity and assessment areas outside the secure ward area, reception and other administrative space. The upper floor comprises administrative space.

The unit provides accommodation for 24 mixed gender service users, some in en-suite rooms and also provides relaxation space / lounges, a gym, activity rooms, treatment and assessment space as well as administrative space. Some rooms within the administrative side of Albany Lodge are bookable and are used by other HPFT services on an ad-hoc basis.

Sleeping accommodation within Albany Lodge is split into three areas – a female area, a male area and a 'swing' area which can be exclusively male or exclusively female as demand requires. The three areas form an 'L' shape along the northern and eastern elevations via a linking corridor with segregation provided by manually operated (lockable) fire resisting doors.

The building has only undergone required repair and minor improvement / refurbishment since construction, including the renovation and re-modelling of the reception area and provision of a new nurse's station, medicines room and treatment room in 2018.

That said, a number of concerns have been raised both by clinical, operational and managerial staff, by the CQC in their last inspection and through internal audits for ligature and fire safety.

The primary areas of concern highlighted in this report are: -

- Ligature
- Security
- Condition of SU shared facilities
- Condition of facilities / furniture in SU bedrooms
- SU room doors and risk of SU barricading themselves in
- Suitability of surface finishes in courtyard areas

This report will consider all of these issues and will propose a range of

	options designed to address one or more of the primary concerns.

2. PURPOSE **a)** State clearly what the business justification is in support of: typically – 'this is to seek approval of ..... for £ ….. on ….. in support of …..' **b)** Where funding sources are, or may be split, such as investment by the premises owner and external funding e.g. ETTF, this must be clearly defined and explained here, in the relevant subsequent sections and in the table above.	The purpose of of ths business case is to seek approval of £1,221,000 capital investment across both 2020/21 and 2021/22 financial years in support of the refurbishment of Albany Lodge. Total cost of the refurbishment will be £1,232,900 due to revenue costs of approximately £11,900 for the escorting service at Albany Lodge.

3. Strategic Context	Context
a) Provide a summary in the context of underpinning plans and key strategic drivers together with the service requirements that support the case for investment. E.g. Five Year Forward View, GP Forward View, Sustainability & Transformation Plan, Strategic Estates Plan, Devolution and New Care Models, etc. **b)** Provide confirmation of the support of all relevant stakeholders. **c)** Confirm the extent to which the scheme delivers on high priority NHS capital investment requirements, e.g. Service transformation and related infrastructure requirements as identified in the strategic drivers above, improving patient safety and the patient environment, reducing backlog maintenance (% of total); enabling QIPP delivery, etc. and other current key work streams. **d)** Confirm the support of key clinicians and the way in which the scheme supports delivery of local commissioning priorities. **e)** Confirm that any premises subject to the investment will not be disposed of within 5 years of their completion. **f)** Include how the investment will deliver the aims of the programme, etc.	**Context** To date, although Albany Lodge has had some investment to address environmental risks and damage sustained, it is the only adult ward to have not received investment to improve the overall experience of the service users who are treated there and staff who work there. The bathrooms and bedrooms have not been replaced since the building initially opened in 1995 and the past 24 years of daily use by service users and staff has seen the wear and tear within these areas reach a position which does not reflect the trust values or the quality of care that the staff on Albany Lodge strives to provide on a daily basis. **Stakeholder and Key Clinician Support** The majority of service users on Albany Lodge are transferred from Swift Ward at Kingfisher Court as per the treatment pathway. However, this leads to comments from service users about the comparative state of the two environments: *"I don't understand how both wards are even in the same trust, it makes no sense!"* *"I didn't want to move, I've been on Albany Lodge before and when the nurse told me [on swift ward] that I was being transferred I refused to go. I only agreed in the end because there was a friend of mine there".* *"I'm surprised the building is even allowed to be open!! I've heard staff saying it's sinking and things are always being broken. It's a depressing environment; I thought a mental health hospital was supposed to be nice environment to be in?"* Staff working at Albany Lodge have also expressed their concerns at the environment: *"The lines of sight are bad, I know we now have mirrors but I can't help but think we can work the environment a bit better. The corridors are so dark and the paint work is odd and random. I don't feel like I can take any of my service users in to a nice space for a 1:1. I also feel bad when bringing in friends and family of service users on to the ward, our quiet rooms aren't the best rooms to use and they really need a revamp."* Albany Lodge does benefit from input from a good MDT, with input from Occupational Therapy; recreational workers and Psychology. There is a purpose built gym; a multipurpose room for creative activities and a large activity/group room. These are currently underutilised due to the complexity of access, which is via the main reception and service users therefore not being able to freely mill in and out of activities due to staffing ratios. The ability to be able to fleetingly engage with some activity or other people is an important part of recovery, in accordance with OT Models of treatment. In addition, there is limited space within the communal areas of the ward that allows for a separate designation between day area and dining area space. This limits the ability for service users to have their own quiet time, or quality time with any visitors due to the congested nature of the space. Furthermore, it does not allow for an environment that is conducive for meal times to be a therapeutic and positive experience. Occupational Therapists on the ward have stated: *"Due to the current layout of the ward environment, the Recreational Worker is not able to regularly run activity groups in the evenings/weekends, especially during visiting hours, which can be a difficult time for those not receiving visits. This is because there is no designated activity space in the communal area, which is mainly occupied by service users and their families during this time. There is a designated activity room off the main ward,*

however this is not in close proximity to the main ward environment, and therefore an additional staff member is required to support the Recreational Worker to take service users off the ward.

Another issue that has been longstanding is no designated therapy kitchen on site. This means that any ADL assessment requests either have to be actioned at the SU's home or at Kingfisher Court. This places additional time pressures on OT staff, as an assessment which should take no longer than 1 hour, can take up to half a day or more. Also, no availability of kitchen space means that we cannot run any ADL maintenance sessions and we are not able to react flexibly with SU's if they display spontaneous interest in these sessions."

Psychology colleagues have also commented that:

"Albany Lodge needs modernisation so as to allow for an increase in therapeutic effectiveness and to reflect the value that we place on our service users' recovery. From a psychology perspective, I wish to highlight lack of therapeutic space/rooms, including calm and quiet rooms and space/room for individual 1 to 1 meetings and recommend/suggest this be considered for inclusion in future redesign/redevelopment of Albany Lodge."

In conclusion, it is evident that both service users and staff share the same concerns regarding the environment on Albany Lodge and would welcome the opportunity to be treated and work in a ward that enhances the healing environment and supports recovery through activity and psychological mindedness. A lack of therapeutic space and ability for service users to independently access the activity spaces and gym is a challenge to recovery and wellbeing. There are also further concerns highlighted in the impact that the current state and functionality is having on the service user journey and experience by delaying assessments from taking place in a timely fashion. Furthermore, the impact that the current state of Albany Lodge has on its carers who visit should not be underestimated.

Deliverables, Premises in next 5 years and Aims

Whilst it is acknowledged that it would be difficult to undertake a structural renovation of the building, the refurbishment of Albany Lodge, to include its bedrooms, bathrooms, communal areas and addressing the issue of access to assessment, treatment and activity spaces, provides the trust an opportunity to invest in to the largest standalone acute unit within the acute services portfolio and provide a therapeutic and healing environment similar to that of Kingfisher Court. Albany Lodge have recently achieved AIMS accreditation, and it is important for this recognition of quality of care to be matched with an outstanding environment. Within the acute service line, clinicians and managers would like to be in a position of confidence in relation to parity of environments across the pathway to ensure service users are receiving the right care, at the right time, in the right place within an environment that reflects the Trust's journey from good to great.

Project Business Requirements

Though a relatively new building within the context of HPFT's wider portfolio, the current layout, features and components within Albany Lodge no longer satisfactorily meet the more demanding needs and complex presentation of service users, nor the higher standards of security and fit, which a more modern unit would provide. This is particularly evident in the design of the windows, the lack of a comprehensive CCTV system, ease of movement between male / female accommodation and some of the day to day practices necessary to run the unit, for example, service users need to be escorted from the secure ward area and through the public reception area for their regular assessments. The décor and floor finishes are also dated and unwelcoming.

Ligature
The key areas of ligature identified within Albany Lodge are the windows / doors, radiator covers and lighting.

The windows are those installed at build and though they have been altered in the past in an attempt to reduce or minimise the ligature risk, however, ligature points still remain and the windows, particularly those in the service user bedrooms are not fit for purpose. Windows have also been identified as an area service users have targeted in an effort to abscond from the ward. Indeed, a number of windows have been kicked out by service users in an attempt to abscond.

The radiator covers are also those fitted at build; many are now loose and are a ligature risk for service users and require replacement.

Light fittings in the service users rooms are those installed at build, are a ligature risk and do not provide a 'night light' facility which means staff are required to open SU doors for night time observation – this not only disturbs service users but puts staff in an uncomfortable position of disturbing sleep.

Security
The nurse alarm system does not provide full coverage of all areas of Albany Lodge with some internal 'blind spots' and inadequate coverage to the courtyards and the car park area.

Ward Environment
The floor coverings and surface finishes within the ward area are aged and do not provide a welcoming and calming environment for service users.

Partial replacement / upgrade of some facilities has taken place over time but this has been piecemeal and inconsistent in specification.

Improvement to floor coverings and decorative order throughout the ward would provide a far more welcoming and calming environment for service users and staff alike.

The shared bathrooms / showers / WC's within the ward are in a poor condition and raise a number of infection control concerns. The sanitary appliances have discoloured with use and cleaning and are not welcoming.

Service User Bedrooms
The wardrobes and furniture in some of the SU rooms is now starting to deteriorate leading to new injury, ligature and security risks. Over the 2018 Christmas period, one room were rendered unusable as result of the furniture being ripped out and potentially used as a weapon.

The doors to the SU bedrooms are not designed to be anti-barricade therefore staff are unable to access a service users bedroom if they barricade themselves in or disable the lock barrel. This poses a risk to service users wishing to do harm to themselves.

Surface Finish in Inner Courtyard
The inner courtyard, which is used by services users as recreational area is surfaced in paving slabs. Many are now loose or damaged and are being used as weapons and to cause damage to the glazing which surrounds the courtyard. This area requires re-surfacing in a material less likely to be used as a weapon or a means of damaging the building.

Staffing and Re-provision Assessment
In order to deliver the project safely and with the minimum of disruption to service users or the day to day operation of the Ward, additional staffing would be required to provide an 'escorting' service.

	Based on figures provided in January 2019 by the clinical team, the weekly cost of a member of staff to act as an escort is approximately £700, based on a 17 week programme equates to a staffing cost of £11.9k. In total, to provide an escorting service for contractorsbased on a 17 week programme would require a revenue investment of circa £11.9k.

4. Economic Case

a) Confirm the options considered to achieve the scheme's objectives and provide a summary of the options appraisal process that has resulted in the selection of the preferred option. It is important that a range of viable options are considered during the appraisal process If the options were/are limited in number, please provide clear supporting rationale.

b) Confirm the scheme benefits – including financial (cash releasing and non-cash releasing) and non-financial (quantifiabl

Assessment of Options

The table below identifies the key areas of concern and indicates the preferred option(s) to address the concerns raised. We engaged Medical Architecture to develop concept designs for the safe access route. The options have been reviewed by the clinical lead and a preferred option selected.

Area of Concern	Preferred Option
Ligature	Complete replacement of all windows and doors within the secure ward area and within those spaces outside of the ward area currently utilised by (or for) service users. Replacement of all radiator covers in all areas. Replacement of lights in the service user bedrooms and shared spaces with anti-ligature lights. In addition, lights in service user bedrooms to be provided with a 'night light' facility for safe observation of service users.
Security / Blind Spots / CCTV	Upgrade of the existing nurse call system with a modern alternative which would also provide coverage to the external courtyard (3 No.) areas and potentially the car park area. Replacement of the access control system to provide enhanced security particularly between the male / female sleeping areas and the swing area.
Ward Environment	Replacement of floor coverings and redecoration of all walls and ceilings. Refitting of all shared showering / bathing and WC facilities within the secure ward area.
Service User Bedrooms	Replacement of the wardrobes, bedside cabinets and desking in all rooms. Replacement of doors and frames with anti-barricade door-sets. Replacement of lighting with anti-ligature lights completed with night light facility.
Inner Courtyard	Replacement of the existing flagged surface with a soft rubber crumb (similar to that used in play areas) finish. Cannot be lifted and provides some protection from falls.

Options Appraisal

e and non-quantifiable) and how the scheme delivers value for money. Appraisal of options on the basis of the extent to which they deliver non-financial benefits can be carried out and presented using a non-financial benefits analysis employing weighted benefits criteria and a scoring system to derive non-financial benefits points.

The review identified areas of work which could be omitted from the scope and either contained within other Trust programmes (CCTV, for example) or managed locally (anti climb gutters, for example). Further work such as the ward lighting was considered to be a very low priority and could safely be omitted from the revised scope.

The remaining elements of work were prioritised as per the table below: -

Option	Brief Description	Estimated Cost
1. Do Nothing	Business as usual	£0
2. Most Urgent Priority	This option delivers the following work and is considered to be the minimum required to address the primary areas of concern within Albany Lodge: - • Replacement (of remaining) windows and doors • Replacement of the radiator covers • Redecoration of the ward areas • Replacement of floor coverings • Replacement of lighting, furniture and anti-barricade doors to service user rooms • Refurbishment of all shared bathroom and WC facilities • Replacement / upgrade of the nurse call and access control systems • Refurbishment of the en-suite bathroom facilities • Replacement of the hard surface to the inner courtyard • Furniture to SU bedrooms • Escorting service for contractors	£1,232,900
3. Medium Urgent Priority	Option 2 works identified above are considered essential to improve the environment for service users and staff alike. In addition to the works stated in Option 2, this option delivers: -	£1,541,056

	• Provision of the safe access corridor from the existing secure ward area to the activity rooms, the gym and the proposed assessment room as well as the associated re-purposing required elsewhere on the ground floor.	

Preferred Option

Option	Brief Description	Estimated Cost
2. M ost Urgent Priority	This option delivers the following work and is considered to be the minimum required to address the primary areas of concern within Albany Lodge: - • Replacement (of remaining) windows and doors • Replacement of the radiator covers • Redecoration of the ward areas • Replacement of floor coverings • Replacement of lighting, furniture and anti-barricade doors to service user rooms • Refurbishment of all shared bathroom and WC facilities • Replacement / upgrade of the nurse call and access control systems • Refurbishment of the en-suite bathroom facilities • Replacement of the hard surface to the inner courtyard • Furniture to SU bedrooms • Escorting service for contractors	£1,232,900

Costs include fees for project design and management and VAT at 20%.

5. Financial case **a)** Confirm the recurrent revenue costs of the scheme. Where these are anything other than revenue neutral or revenue saving, confirm the availability and source of additional revenue. **b)** Confirm and demonstrate that the recurrent revenue cost of the scheme is affordable. **c)** Confirm and where necessary explain any non-recurrent (e.g. transitional costs) of the scheme. **d)** Confirm the availability and source of non-recurrent funds to meet these costs. **e)** Provide supporting income and expenditure analysis that sets out clearly the recurrent and non-recurrent costs of the scheme, the sources of funds to meet these costs, which must demonstrates clearly that the scheme is affordable. **f)** Clarify where the assets will reside in terms of ownership. **g)** Provide evidence of the proposed efficiency measures and projected outcomes and how they align with service improvements.	The scheme will improve the environment of Albany Lodge and the experience of service users, carers and staff. The building is a freehold site that is owned by the Trust. There is no expectation of revenue savings accruing from the scheme The plan is for a phased implementation of the works so that rooms can be utilised to the best effect with no reduction in bed numbers. There should therefore be no requirement for the purchase of external OOAP beds)which cost on average £4.6k per week per bed). There will be a non recurrent cost of c. £11.9k in year 1 to provide an escorting service for contractors based on a 17 week programme. The recurrent revenue costs are set out in Appendix 1 and show a net cost of £48k in year 1 and an average recurrent cost of £49k for the first five years. The total discounted cashflow cost over the 40 year effective useful life is £0.9m.
6. COMMERCIAL CASE **<u>For new build and refurbishment projects:</u>** **a)** Confirm the commercial arrangements for delivery of the proposed capital investment, e.g.	**<u>Procurement</u>** The costs in this appraisal are based on a adopting a traditional form of procurement with tendering taking place during 2020/21, work commencing Q1/2021 and practical completion Q2/2021. New framework procurement offers circa £20k saving on OH&P

procurement approach and proposed contract type (if not using NHS Procure 21+ or the subsequent P22 framework please explain why not). **b)** Confirm when any necessary full planning consent will be achieved. **c)** Confirm whether compliant with DH guidance (HBN & HTM); **d)** Where appropriate, attach site plans and design drawings for the preferred option. **e)** Identify the ownership of the land or premises to be modified, the risk this poses and how the risks are mitigated for the options. **For equipping and ICT projects** **f)** Describe the scheme: specify what equipment is being purchased and for what site(s) **g)** Describe the strategic need for the capital investment and what measurable benefits the capital investment will provide. **h)** Indicate where funding is required to support Strategic Estate Plans. For example, if a new build has been agreed and the requirements in this business case also specifically relate to another business case which has delivered or will deliver premises development, please explain and justify the links	**For equipping and ICT projects** N/A

7. MANAGEMENT CASE **a)** Confirm the arrangements for management and delivery of the scheme **b)** Provide a simple timeline with key milestones for the procurement and delivery of the scheme.	ALBANY LODGE - PCSA Programme - Dr

KEY RISKS Please provide adequate information to enable reviewers to understand the level and likelihood of risk and how it is to be mitigated. Please list any risks to delivery, for example if the spend is dependent	**Risk**	**Mitigation**
	Working in an occupied building	Phasing work, working with clinical leads, H&S consultants employed, competent design team, escorting service for contractors.

on estates investment etc.		

ENDORSEMENTS AND APPROVALS

LETTERS OF APPROVAL / SUPPORT				
Organisation	**Enclosed**		**Letter dated**	**Note**
SPONSOR ORGANISATION	**Y**	**N**		

SCHEME OR PROJECT ENDORSED BY:		
DIRECTOR/HEAD OF ESTATES or APPROPRIATE AUTHORISED OFFICER	Name	
	Signature	
	Date	
SERVICE CLINICAL LEAD	Department	
	Position	
	Name	
	Signature	
	Date	
DIRECTOR/HEAD OF FINANCE or APPROPRIATE AUTHORISED OFFICER	Name	
	Signature	
	Date	

Appendix 1. Financial case recurrent revenue costs

Cost £'000	1,232
Estimated Impairment	30%
Net Capitalised Cost £'000	862

A	B	C	D	E	F	G	H	I	J
Year	Cost/ Net Book Value b/f £'000	Depreciation £'000	NBV c/f	PDC Dividend impact £'000	Escorting service Yr1 £'000	Savings £'000	Revenue Total £'000 C+E+F+G	Discounted Cash Flow @ 3.5%	Discounted Revenue Cashflow £'000
1	862	22	841	15	12		48	1.00	48
2	841	22	819	29			51	0.97	49
3	819	22	798	28			50	0.93	47
4	798	22	776	28			49	0.90	44
5	776	22	755	27			48	0.87	42
6	755	22	733	26			48	0.84	40
7	733	22	711	25			47	0.81	38
8	711	22	690	25			46	0.79	36
9	690	22	668	24			45	0.76	34
10	668	22	647	23			45	0.73	33
11	647	22	625	22			44	0.71	31
12	625	22	604	22			43	0.68	29
13	604	22	582	21			42	0.66	28
14	582	22	561	20			42	0.64	27
15	561	22	539	19			41	0.62	25
16	539	22	517	18			40	0.60	24
17	517	22	496	18			39	0.58	23
18	496	22	474	17			39	0.56	21
19	474	22	453	16			38	0.54	20
20	453	22	431	15			37	0.52	19
21	431	22	410	15			36	0.50	18
22	410	22	388	14			36	0.49	17
23	388	22	367	13			35	0.47	16
24	367	22	345	12			34	0.45	15
25	345	22	323	12			33	0.44	15
26	323	22	302	11			33	0.42	14
27	302	22	280	10			32	0.41	13
28	280	22	259	9			31	0.40	12
29	259	22	237	9			30	0.38	12
30	237	22	216	8			29	0.37	11
31	216	22	194	7			29	0.36	10
32	194	22	172	6			28	0.34	10
33	172	22	151	6			27	0.33	9
34	151	22	129	5			26	0.32	9
35	129	22	108	4			26	0.31	8
36	108	22	86	3			25	0.30	7
37	86	22	65	3			24	0.29	7
38	65	22	43	2			23	0.28	7
39	43	22	22	1			23	0.27	6
40	22	22	0	0			22	0.26	6
		862		**589**	**12**	**0**	**1,463**		**881**

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 13b
Subject:	FY21 Public Dividend Drawdown	**For Publication:** yes
Author:	James Thackray Head of Finance	**Approved by:** Paul Ronald Director of Operational Finance
Presented by:	Paul Ronald, Director of Operational Finance	

Purpose of the report:

To provide an update to the Board on the Public Dividend Capital drawn down in FY21 to support its capital investment program. The amount has been updated since the paper to the Finance & Investment Committee to reflect the final two amounts of £451k which relate to COVID19 capital funding which have only just been notified and offered for payment.

The nature of PDC capital funding and the calculation of the PDC dividend means that it is cost neutral currently between using internal cash or drawing down the PDC dividend offered.

The PDC drawdown preserves cash levels and therefore in most cases will be the chosen option.

Action required:

To note the PDC drawdown for year 2020/21 and consider the implications for future financial periods.

Summary and recommendations to the Committee:

In a significant change to the financial rules under which Foundation Trusts work to, the amount of annual capital expenditure that can be made by the Trust is now determined by the ICS allocation of the capital department resource limit (CDEL) which is set for NHS Trusts and for the NHS as a whole. The CDEL limit for FY21 was £66m for the ICS with the Trust allocation within this £15.4m.

In addition to this capital limit there are other additional capital sources that are accessible from time to time. The Trust has secured additional capital finance in FY21 to fund specific capital investments over and above those funded within the CDEL. These comprise:

1. Critical Infrastructure Risk funding

£1,000k PDC has been approved by NHS England to cover the cost of the relocation of the generator, gas and water supplies onto the Little Plumstead site from its current location which is now within the land sold for building development. Architects have been commissioned and the project is progressing at pace.

2. Electronic Prescribing funding

£882k PDC funding has been approved by NHS England to support the implementation of an Electronic Prescribing Medicines Administration system able to manage prescriptions and

medications digitally. The business case for this proposal has been progressed to identify a preferred supplier which is Civica and the tender award will be made in 2020/21.

3. Remote Working Devices

£286k PDC funding has been approved by NHS England to support funding the purchase and deployment of Remote Working Devices; laptops and smart phones.

4. COVID Infrastructure

PDC funding has been approved by Department of Health and Social Care to support funding the delivery of the NHS COVID-19 response. This included funding improvements to ventilations systems at Forest House, Oak and Beech Unit

5. Clinical Equipment

£60k PDC funding has been approved by Department of Health and Social Care and was utilised for the set-up of Elizabeth Court in March 2020 as a potential Nightingale Ward

The Public Dividend Capital total of £2,619k (as detailed below) will be drawn down during March 2021;

	£'000s	£'000s
Critical Infrastructure Risk funding	1,000	
Electronic Prescribing funding	882	
Remote Devices funding	286	
Drawn down 15th March		2,168
COVID Infrastructure	391	
Clinical Equipment	60	
To draw down 22nd March		451
Total		**2,619**

The annual PDC charges (associated with these investments is estimated to be c. £80k

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

Summary of Implications for:

1 Finance
2 IT
3 Staffing
4 NHS Constitution
5 Carbon Footprint
6 Legal

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

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

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

Finance & Investment Committee 16th March 2021

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 14
Subject:	2020 Mental Health Community Survey Update	**For Publication:**
Author:	Sandra Brookes Director Service Delivery and Servicer User Experience	**Approved by:** Sandra Brookes Director Service Delivery and Servicer User Experience
Presented by:	Sandra Brookes, Director Service Delivery and Servicer User Experience	

Purpose of the report:

The report provides an update following the results of the Community Survey 2020 and the actions taken to address the areas requiring improvement.

Action required:

The Trust Board is requested to note the report and the actions taken forward.

Summary and recommendations

Following the results of the Community Survey 2020 the Trust focussed on six specific areas of improvement;

- Information to be sent out to each service user regarding who is leading their care, who to contact and make it a more personalised approach. Various methods will be used to provide this information.
- Reminders for appointments and reviews to include what to expect from these and support preparation.
- Initial Assessments and CPA reviews to include prompts for staff to ask questions regarding employment, meaningful activity and financial support.
- Change letters to being addressed to the service user and copied to their GP.
- Update the welcome packs currently produced and ensure packs available for all services.
- Develop new ways to collect feedback from service users and carers.

Progress against these actions has been made although not at the pace anticipated, due to the impact of Covid. These actions will now be picked up within the service recovery plan and transformation programme being monitored by the Trust Management Group and Executive Directors meeting.

The 2021 survey is now underway with service users who were receiving care from our adult and older people's services 1st September - 30th November 2020.

as One

Our Values
Welcoming Kind Positive Respectful Professional

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

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

Summary of Financial, IT, Staffing & Legal Implications:

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

The national survey includes a sample of service users from adult and older peoples community mental health services who used services between 1 Sept – 30 Nov 2019

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

The Trust is required to participate in the national community mental health survey, the basic sample of which is covered under Section 251 of the NHS Act 2006

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

1. Summary of 2020 Survey results

The 2020 Community Mental Health Survey is part of the NHS Patient Survey Programme in line with the NHS Outcome Framework and is a major source of data for the CQC under the inspection regime, via intelligent monitoring. The survey is co-ordinated by the Patient Survey Co-ordination Centre, based at the Picker Institute Europe, on behalf of the Care Quality Commission (CQC). In 2020 there was a 25.3% response rate to the survey from HPFT service users which is slightly higher than the 2019 response rate.

The sample for the survey was generated at random on the agreed national protocol from all service users aged over 18 years on the Care Programme Approach (CPA) or on non-CPA care seen by the Trust between 1st September and 30th November 2019. The survey was undertaken between February and June 2020.

The majority of scores for the Trust were in the intermediate 60% of the Trusts surveyed by Quality Health, although there were also a number that sit in the top 20% range, (particularly within the Medicines section).

Only two scores sat within the bottom 20% range of Trusts. There were some significant improvements in some scores since the 2019 survey. While many scores improved since 2019, there was a general trend downwards between 2018 and 2019, so these results represent significant recovery since then.

The overall rating of care and the respect and dignity scores improved since 2019, however a review of the longitudinal data indicated that scores within the organising care and planning of care sections have either shown decline or have stagnated over a period of time.

2. Actions agreed

Whilst a number of the transformation work-streams will support further development of community services and improvement of experience will be a key outcome of these, 6 key actions were agreed for the community teams to work on, aimed at some immediate improvement, focused on communication and the organisation and planning of care:

2.1 Information to be sent out to each service user regarding who is leading their care, who to contact and make it a more personalised approach. Various methods will be used to provide this information.

2.2 Reminders for appointments and reviews to include what to expect from these and support preparation.

2.3 Initial Assessments and CPA reviews to include prompts for staff to ask questions regarding employment, meaningful activity and financial support

2.4 Change letters to being addressed to the service user and copied to their GP

2.5 Update the welcome packs currently produced and ensure packs available for all services

2.6 Develop new ways to collect feedback from service users and carers

3 Progress to date

Unfortunately the pandemic has impacted on the progress we have been able to make in some of the above areas.

3.1 Information to be sent out to each service user regarding who is leading their care, who to contact and make it a more personalised approach. Various methods will be used to provide this information.

Communication sent out to service users as part of the second wave regarding how to access services also confirmed who their key worker was and how to get support from crisis services. This now needs further development, to work with service users on the different ways in which they would find it helpful to receive this information, on a regular basis. As part of our business continuity plans staff in the community teams took on different roles and worked with service users that were not usually on their caseloads, and so the teams had to consider an effective way to hand back the care to the key worker. The handover included the service user and summarised the support they had received and next steps. The teams are reflecting on this approach in order to improve handover of a service user's care as staff move around or leave services.

3.2 Reminders for appointments and reviews to include what to expect from these and support preparation.

All teams updated their standard appointment letters to service users with prompts about how to prepare and what to expect from reviews and why we do them. The next steps are to ensure that this is part of the plans to further roll out shared decision making and personalised care and support plans, which will hopefully be a less abstract concept than the Care Programme Approach.

3.3 Initial Assessments and CPA reviews to include prompts for staff to ask questions regarding employment, meaningful activity and financial support

Communication, including the use of screensavers has been sent to all teams to remind staff of the importance of the preparatory work with service users before reviews or appointments, including; reminders about the social and holistic elements of people's lives and ensuring this is explored either in an initial assessment or review meeting. We also linked this into post Covid messages about isolation, loneliness and the potential for increased social and health related anxiety. In addition the Individual Placement Support Service produced direct communications to care co-ordinator's reminding them to ask service users questions about employment.

Service Line Leads across adults and older adults took a role in promoting these messages through team meetings, as this was felt to be more impactful when people were working remotely, and this was done on a weekly basis, with particular focus in the weeks before the survey 2021 started.

3.4 Change letters to being addressed to the service user and copied to their GP

Whilst initial discussions has taken place this was considered to be too large a task during the pandemic but it will be a part of the service recovery plan with a view to implementing during quarter 2, 2021/2022.

3.5 Update the welcome packs currently produced and ensure packs available for all services

The pack for adult community services has been reviewed and updated and is now ready to be produced. The final amendments are being made to the older peoples community services pack. CAMHS services already have a highly regarded pack. During quarter 2 a pack for Learning Disability services will be developed. All the packs are being co-produced with service users, carers and staff. They will be available in hard copy and electronically. Work is underway to develop packs for the wards and this will be done in conjunction with Healthwatch, who have been doing a particular piece of work with us on welcome packs.

3.6 Develop new ways to collect feedback from service users and carers

A tender has been completed and awarded to Philips for their Questlink product which will provide a way to collect real-time feedback, following appointments. Deployment started in late December 2020.Currently work is underway including installations, integration with Paris and development of the forms to be used. Pilots will go-live in adult eating disorders and perinatal services, in June and PATH and CAMHS will go-live in July. This will allow care professionals, service users and carers to complete a number of different outcome and experience measures digitally across these services. The plan is then to extend this across all community services.

4 Additional actions

4.1 The feedback from the community survey has been discussed with service users and carers and it has been agreed that an area of focus for this year to work together on will be; discharge, and in particular improving communication leading up to and at the point of discharge, from community services. This will work in conjunction with work undertaken by Healthwatch with regards to discharge from in-patient areas.

4.2 The feedback has also been used by the steering group working on community transformation in order to ensure that service improvement takes into account service user views.

4.3 Each service line has identified experience champions. The champions will receive training regarding service user and carer experience during quarter 1.

4.4 A quarterly feedback group to look at themes/trends from feedback gathered through a range of methods is to be established and supported by the Experience and Inclusion team, from quarter 1.

5 Summary

Six key actions were identified following the 2020 survey. Progress against these actions has been made although not at the pace anticipated, due to the impact of Covid. These actions will now be picked up within the service recovery plan and transformation programme being monitored by the Trust Management Group and Executive Directors meeting.

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 15a
Subject:	Annual Plan 2021/22	**For Publication:** YES
Author:	Ian Love, Deputy Director, Commercial Development	**Approved by:** Karen Taylor, Deputy CEO & Executive Director, Strategy & Integration
Presented by:	Karen Taylor, Deputy Chief Executive and Executive Director, Strategy & Integration	

Purpose of the report:

To present the 2021/22 Annual Plan

Action required:

To approve the 2021/22 Annual Plan

Summary and recommendations to the Board:

Background

Our 'Good to Great' Strategy describes how we are going to deliver our vision 'Delivering Great Care, Achieving Great Outcomes – Together'. Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. Our Annual Plan describes our commitments to our service users, our staff and our partners about what we will deliver during 2021/22.

Like the rest of the NHS, and indeed the country, the last twelve months have been challenging as we have responded to the Covid-19 pandemic. We are exceptionally proud of how our people responded and continued to deliver great care for our service users during this period. As we turn our focus to the future, we recognise the world has changed and some things will need to be different in the way we deliver and provide care. However, our commitment to keep our service users and staff safe, improve their experience and provide great care and outcomes remains as strong as ever and Annual Plan for 2021/22 reflects this ambition.

Our 2021/22 plan builds on the work we have been doing during 2020/21, and takes into consideration and reflects the commitments made in the Long Term Plan and priorities across the Hertfordshire & West Essex Integrated Care System (ICS), together with local contract discussions and agreements. It has been informed by feedback and discussions from stakeholders including our staff, our senior leadership team, the Council of Governors, our service users and cares and our commissioners. Any significant changes at a national, regional or local level that may impact on this plan will be brought back to the Trust Board for consideration.

We will improve, innovate and transform our services to provide the most effective **The Annual**

Plan supports the delivery of our overall Trust 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 through the delivery of effective evidence based practice
4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment
5. , 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)

The Annual Plan is split into seven sections, one for each Strategic Objective. Against each Strategic Objective there are priorities identified for delivery in 2021-22, with the actions to be taken and the outcomes to be achieved clearly detailed.

The Annual Plan is cascaded through the organisation through the development of Strategic Business Unit Plans and corporate department/support services Annual Plans. These, in turn, are reflected in team plans through to individual Personal Development Plans. At Trust Level, progress against the detailed milestones and outcomes which underpin the Annual Plan will be formally reviewed on a quarterly basis. Progress is also monitored quarterly with the Strategic Business Units.

Recommendations:

The Trust Board is asked to approve the Annual Plan 2021-22

Relationship with the Business Plan & Assurance Framework:

The Trust's Annual Plan 2021-22 supports delivery of the Trust's Strategic Objectives

Summary of Implications for:

The Annual Plan is aligned and reflected in the Trust's finance, workforce and operational plans

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

For all new developments in the Annual Plan, Quality Impact Assessments are undertaken, with public and patient involvement taking place on service changes and developments. Addressing

inequalities is a key focus and priority within the Annual Plan.

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

N/A

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

Executive Committee (3 March 2021 & 17 March 2021) and Finance and Investment Committee (16 March)

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Annual Plan 2021-22 - Our Commitments

1. Introduction

Our Annual Plan describes our commitments to our service users, our staff and our partners about what we will deliver during 2021/22. Our ambitious plans, detailed in this paper reflect our relentless drive to improve the quality of care we provide for our service users and carers.

For the past year the Covid pandemic has dominated the world stage and our organisation itself, with the Trust in formal incident command since March 2020. During that time, we have sadly lost service users and those who are dear to us. Yet, through all this, we have continued to strive to provide great care.

Sustaining the quality of care for our service users has brought home the importance of the work we have done over recent years to embed our values, focus on great care great outcomes, build great teams; working closely with others, and developing a responsive organisation.

Our people have responded to the challenge in a way that we and the communities we serve can be proud of. However, this effort has left our colleagues physically and emotionally tired. And the Covid pandemic is not yet fully under control and continues to circulate in the wider population.

Over the coming year then, we will need to adjust how we work in a more sustained way to address this new reality as we draw this Covid incident to a close, support our people to recover from their efforts; prepare for the impact on the mental health of our communities and refocus our combined efforts on Providing Great Care and Delivering Great Outcomes, Together.

2. Background - Good to Great

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

Our 'Good to Great' triangle below depicts the key areas of focus for the Trust in terms of its people, improving the way we do things, partnerships and quality (experience, effectiveness and safety).

Figure 1 - Good to Great Triangle

3. Strategic Objectives 2016-2022

The Trust has a number of 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 will feel positively about their experience
3. We will improve the health of our service users through the delivery of effective, evidence based practice
4. We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care
6. We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners
7. We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

4. Our Commitments for 2021/22

As we look to next year's work, framed by our Good to Great strategy, towards our vision of providing "Great Care, Delivering Great Care, Together", a number of commitments emerge.

Our Service Users

A continued focus on the needs of our service users for quality (safety, outcomes, experience) services. We know that the pandemic has hit the BAME community and disadvantaged

communities the hardest. These are also communities that do not always feel able to easily access our services, so ensuring that we provide inclusive services that everyone in the communities we serve can access is a key part of our plan for next year.

We will continue to improve our services through our programme of transformation, including meeting our Long-Term Plan commitments for our Early Intervention in Psychosis; Individual Placement, Community Perinatal, IAPT and community mental health services

Carers play an important role in the support and outcomes for our service users and this coming year will see us further improve our engagement and support for them.

The pandemic has brought increased focus on our work to improve the physical health care of those suffering a mental health need or with a learning disability the coming year will see us stepping up our existing improvement work in this area.

We will continue to take a zero tolerance to suicides and work with public health & other partners to deliver the system Suicide Prevention Strategy

Supporting our people to recover

After a challenging year where our people have been outstanding in their work to maintain our services we will take time to pay witness to what has happened; provide opportunities for our people to rest and recuperate; continue with the wide range of health and wellbeing initiatives and find ways to recognise and reward their contribution.

We will continue taking further action to ensure all our people feel they are treated equally and are able to make a contribution to the care we provide to our services users.

Responding to and managing with Covid

Regrettably, we foresee Covid continuing to be a presence in our communities (at a much reduced rate) during the coming year and we anticipate seeing increased demand for our services as the effects of the pandemic, national lock downs and slowing economy have an adverse impact on people's mental health.

During the coming year we will focus rigorously on maintaining our standards of infection prevention and control to maintain the safety of our service users and our people. Through our service transformation programme and full delivery of our Long-Term Plan commitments, we will work with our commissioners to address any short term increases in demand while we better understand the medium- and long-term impacts on the demand for our services.

Partnerships & joined up care

Increasingly the Trust has been working collaboratively with other organisations to improve care. It has done this in Hertfordshire where it has worked with others to develop a joined-up approach to mental health care; across the East of England where it is working with other Trusts to transform specialist mental health care and services for those with Learning Disabilities, and in Essex, where in partnership with Essex Partnership University Trust we are working to transform learning disability services.

We see this collaborative approach accelerating during the coming year. In Hertfordshire we will, together with others, complete the work to establish an Integrated Care Partnership focused on improving outcomes for those with mental health needs and/or learning disability. In Norfolk, together with other local providers and the local commissioner we will be setting out a plan to provide improved and integrated learning disability services.

Organisational infrastructure

The Trust's digital strategy and its adoption of a continuous quality improvement approach will underpin much of what we do in the coming year. In particular the Trust's digital strategy which will; continue to improve experience and outcomes for service users; improve productivity and time to care for our workforce; drive quality improvements across our health networks; and improve safety and effectiveness of our services and support integrated pathways.

These plans mean we are confident that 2021-22 will see us making significant strides along our journey to achieve 'Great Care, Great Outcomes – Together'.

5. Development of the Plan

Our 2021/22 plan has been produced ahead of national planning guidance and the creation of the Herts and West Essex Integrated Care System operational plan for 2021-22. Due to the impact of Covid it also comes ahead of our contract discussions with our commissioners.

However, it continues to align with our well established Good to Great Strategy, both completing and building on the priorities we set during 2020-21, recognising the significant impact of the Covid pandemic during that time, while continuing with our Long Term Plan commitments as described in the national Mental Health implementation Plan.

It was also informed by feedback and discussions from stakeholders including our staff, as part of discussions with the Hertfordshire Integrated Care Partnership, our Council of Governors, our commissioners and our senior leadership team. This updated plan has also taken into consideration the recent COVID-19 pandemic requirements going forward, and revised our underpinning activities and focus.

6. 2021/22 Priorities, Actions and Outcomes

The Annual Plan is split into seven sections with priorities identified for each Strategic Objective (see Table below). The actions to be taken and outcomes are clearly defined (See Appendix 1). The Annual plan is underpinned by a detailed set of milestones and outcomes by quarter for each priority.

Strategic Objective	Our 2020/21 Commitments – We will ….
We will provide safe services, so that people feel safe and are protected from avoidable harm	• Continue to work with system partners to prevent suicides • Keep service users and staff physically and mentally safe, reducing the avoidable harm they experience • Ensure the least restrictive practice is appropriately used to support service user recovery • Implement and follow best practice infection prevention & control practice across our services
We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	• Improve service user experience of accessing our services and receiving treatment • Involve our service users and carers in the design and delivery of services and their care • Provide safe, high quality environments where our service users are cared for and our staff work
We will improve the health of our service users & support recovery through the delivery of effective evidence based practice	• Improve the care, support and outcomes for service users who are in need of additional support or at risk of admission • Support our service users to be physically healthy by improving the physical health support, intervention and care available • Support our service users to live their lives as independently as possible
We will attract, retain and develop all our people with the right skills and values to deliver consistently great care, support and treatment	• Improve the employment experience of all of our people, including support to improve their health & wellbeing and to help them to rest and recover post Covid 19 • Ensure all our people feel valued, included and able to fulfil their potential through the development of our just & inclusive culture • Develop our collective leadership culture to support all of our staff to feel empowered and engaged
We will improve, innovate and transform our services to provide the most effective, productive and high quality care	• Support, enable & encourage our people to continuously improve the care and services we provide • Continue to introduce new digital capabilities that will enable teams to innovate and improve service user, carer & staff experience as well as the safety and effectiveness of our services • Release time to care by supporting staff to work more effectively and flexibly, including providing better and simpler access to information
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	• Improve community adult and older peoples' services and care aligned with Primary Care Networks • Improve access and delivery of care for those people with a learning disability across the Trust • Improve the range and access to crisis services in conjunction with Hertfordshire partners • Work with partners across Hertfordshire to deliver earlier intervention and support for Children and Young People
We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our populations	• Lead the development of the Hertfordshire Mental Health & Learning Disabilities Integrated Care Partnership (MH & LD ICP) • Advocate for and ensure mental health & learning disability services are developed across populations we serve • Work with regional partners to develop and deliver New Models of Care for those with specialist mental health and learning disabilities

7. Monitoring and Review

The Annual Plan priorities are cascaded via the development of Business Plans for the Strategic Business Units and Corporate Services. These, in turn, should be reflected in team plans through to individual Personal Development Plans. At Trust Board Level, progress against milestones and outcomes will be reviewed on a quarterly basis. Progress is also monitored quarterly with the Strategic Business Units.

In the event of changing factors (internal or external to the Trust) the plan may need to be adjusted/updated to ensure delivery of the required outcomes. This reflects the need to ensure the plan, although produced at the beginning of the year, remains a 'live' reflection of our work and priorities across the Trust.

8. Conclusion

2021/22 is the sixth year of our 'Good to Great' journey and our Annual Plan describes the commitments we have made to our service users, our carers, our staff and our stakeholders. It documents the key actions we will take this year to further develop our services and to ensure we are able to provide the highest quality care for those individuals with a mental health illness and/or learning disability.

Like the rest of the NHS, 2020-21 has been a challenging year. We are exceptionally proud of how our people responded and continued to deliver great care for our service users during this period. As we turn our focus to the future, we recognise the world has changed and some things will need to be different for us in the way we deliver and provide care. However, our commitment to keep our service users and staff safe, improve their experience and provide great care and outcomes remains as strong as ever and we hope you will agree our revised Annual Plan for 2021/22 reflects this.

Hertfordshire Partnership University NHS Foundation Trust

APPENDIX 1

OUR REVISED ANNUAL PLAN 2021-22

Our Commitments

Strategic Objective 1 - We will provide safe services, so that people feel safe and are protected from avoidable harm

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our service users and staff)	Measurement (how we will know)
Continue to work with system partners to prevent suicides	• Work with public health & other partners to deliver the system Suicide Prevention Strategy, including awareness of 'Stay Alive' suicide prevention App • Strengthen care plans using shared decision making with service users and carers and plans for crisis management and relapse prevention	• Service users will not feel that suicide is their only option • Service users will feel more confident about their recovery • Staff will feel confident in assessing and managing risk	• Reduction suspected suicides • < suicides by service users known to the Trust • Care plans for all service users show shared decision making and plans for crisis management and relapse prevention (demonstrated via audit)
Keep service users and staff physically and mentally safe, reducing the avoidable harm they experience	• Introduce the "Just Culture Guide" to support teams to embed our Just and Learning culture • Review & strengthen the approach and role of peer experience listeners on inpatient units • Review the approach to managing violence and aggression to develop and implement the best evidence based approach • Review & fully implement MOSStogether, including embedding safety huddles for service users	• Service users will feel safe when they use our services • Service users and staff will experience less incidents of violence and aggression on our wards • Staff will feel safe when they are working on our wards • Staff feel confident to speak up when things go wrong, rather than fearing blame	• < in harm as result of Service user to service user violence & aggression • < in harm as result of Service user to staff violence and aggression • > staff reporting feeling safe • 98% SI action plans - Day 60 post SI • 95% SI actions implemented by date set in action Plan (audit) • 85% service users report feeling safe across all adult & CYP inpatient units
Ensure the least restrictive practice is appropriately used to support service user recovery	• Adopt new approaches to engage service users ensuring the appropriate, least restrictive practice, is used across all areas through regular, real time monitoring and support to local teams. • Continue opening best in class new seclusion/safety suites	• Service users supported with the least restrictive practice to recover & move quickly & safely out of seclusion • Staff have capability & confidence to enable & use least restrictive practice	• Reduction in the length of time spent in seclusion per episode. • Roll out of safety suites • Least restrictive practice audit Experience of people experiencing seclusion will improve
Implement and follow best practice infection prevention & control practice across our services	• Ensure rigorous application of existing Infection Prevention & Control policies and behaviours by providing increased support & training to staff • Continue to update all policies to ensure they fully reflect best practice Infection Prevention and Control	• Levels of incidents of all infections are sustained at a low level • Staff will understand & feel able to follow best IPC practice across the Trust, wherever they are working	• HCAIs are 0 over Quarter 2-4 • No member of staff contracts Covid19 as a result of their work • No new "outbreaks" declared

Strategic Objective 2 - We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our service users or staff)	Measurement (how we will know)
Improve service user experience of accessing our services and receiving treatment	• Reach out to BAME and disadvantaged communities to ensure they have the access to the services they need • Respond to the changing demand post Covid to ensure timely access to our services • Implement our approach to recovery and personalisation through our 'connected lives' programme supporting service users to live as independently as possible • Increase access to psychological therapies, developing a 'psychologically minded' workforce • Bring care closer to home by eliminating inappropriate out of area placements	• Service users will have improved outcomes and less reliance on crisis services • More people who need our services will be able to access EIP, Community Perinatal and IAPT services • Those who have found it difficult to get the services they need will increasingly find then easier to find and access • Fewer services users will see their care provided away from where they live	• Able to demonstrate access by geography & demographics • IAPT Access KPIs met • <wait to treatment/follow-up (Baseline tbc) • < social care placements made (tbc) • Care and support plans in place • > service users in employment • < Out of Area Placements
Involve our service users and carers in the design and delivery of services and their care	• Coproduce and put in place a new trust-wide approach to service user and carer engagement • Ensure service user & carer feedback informs service improvements and developments • Further embed Shared Decision making to support the way we involve our service users in decisions about their care • Increase the number of carers assessments undertaken across the Trust • Implement the Care and Support Plan	• Staff will be able to describe how service user and carer feedback has informed service changes and developments • Service users will feel informed, safer and have a better experience • Carers will feel their needs have been assessed and will feel supported	• >Service user rating in 'Having Your Say' • >positive Community Survey feedback • Shared decision making captured on Paris • SU/carers able to provide feedback through multiple avenues including digital • Staff trained in shared decision making • > staff completed "carer awareness training" • >carers assessments completed
Provide safe, high quality environments where our service users are cared for and our staff work	• Upgrade our inpatient facilities including Oak Ward, Forest House and Albany Lodge • Complete the development of the business case for the re-provision of adult acute beds for E&N Herts through to final Board Approval	• Staff able to access the clinical space needed to work effectively • Service users will have a better experience of their care environment	• Oak ward & Albany Lodge refurbishments • Forest House development completed • E & N Herts bed re-provision, final business case approved by Trust Board • Lexden refurbishment started

Strategic Objective 3 - We will improve the health of our service users through the delivery of effective evidence based practice

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our service users and staff)	Measurement (how we will know)
Improve the care, support and outcomes for service users who are in need of additional support or at risk of admission	• Provide additional support & improved community interventions for those service users who are frequent users of our inpatient services • Implement a new integrated CYP crisis service • Functional model implemented as an alternative to outpatient clinics • Engage service users in research activity across the Trust, focusing on specific clinical pathways • Consistently apply evidence-based care across services to support improved outcomes • Review the effect on service users' recovery of moving to remote care during the pandemic	• Service users will have an improved and more consistent experience of high quality care • Our staff will be able to see more clearly how to positively impact on the outcome for our service users • Children and young people will have improved access to the care they need when in crisis • Staff will use consistent pathways and measurement of outcomes	• 20% reduction in readmission rates for service users with a Personality Disorder • 20% <Section 136 attendances by those known to us by Q4 • Maintain inpatient ALOS & DTC at 2019/20 level • Social care and wellbeing plans in place and outcomes recorded • Demonstrate improved outcomes for new functional community model • > service users participating in research
Support our service users to be physically healthy by improving the physical health support, intervention and care available.	• Ensure all service users receive physical health checks appropriate to their protected characteristics, co-morbidities, and medications • Deliver consistent high standards of physical healthcare through support/training front line staff. • Develop pathways to prevent avoidable acute trust attendances / admissions • Improve recording & use of physical health data • Support service users to reduce tobacco dependence and nicotine addiction	• Service users supported to work towards their own physical health goals • Improved quality & consistency of physical care for our service users • Our staff will have the support and skills to better care for the physical health needs of our service users	• 95% CPA physical health checks • 90% service users (defined by a set criteria) have had a physical health check and a trajectory set for 2021/22 • Improved physical health outcomes – demonstrated through PACE audit • Inpatient Services & Community Simulation Training programme • <10% service users who smoke cigarettes
Support our service users to live their lives as independently as possible	• Work with partners to support service users to gain employment & accommodation to support their recovery • Use our new social care and wellbeing plans to enable better planning and shared decision making with service users	• Service users will feel better supported in their recovery • Staff will have a fuller picture of how to support service users in their recovery	• 85% settled accommodation for adults with a severe and enduring mental illness (SMI) • > service users supported into employment or to retain employment

Strategic Objective 4 - We will attract, retain & develop people with the right skills and values to deliver consistently great care & treatment

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for our staff or service users)	Measurement (how we will know)
Improve the employment experience of our people, including support to improve their health & wellbeing and to help them to rest and recover post Covid 19	• Support our people to 'pay witness' to the pandemic, to rest and recuperate. • Continue to develop and provide a broad range of wellbeing activities & approaches across the organisation • Increase opportunities for reward & recognition across the Trust • Work with our staff networks to continue to address differences in employee experience	• Our staff will feel refreshed and ready to continue improving the care we provide and the outcomes we achieve for our service users • People will actively want to join the Trust & will chose to stay working in the Trust • Our staff will have more opportunities for flexible working	• Staff Survey Health & Wellbeing score > 6.6 • My immediate manager takes a positive interest in my health and wellbeing > 80% • Unplanned turnover rate < 9% • Trusts stability rate >90% • Vacancy rate < 10.5% • Equality Impact Analysis - improving position for elements of Inclusion Agenda
Ensure all our people feel valued, included and able to fulfil their potential through the development of our just & inclusive culture	• Refresh our EDI Plans, focusing on our just & learning cultural programme • Develop our approach to talent & promotion to ensure fairness of promotion opportunities across all groups including BAME • Continue our campaign to eliminate bullying & harassment across the Trust • Improve our recruitment approaches to attract high calibre people reflecting local communities	• Our staff will recommend HPFT as a great place to work and develop, regardless of ethnicity, gender or other protected characteristic • Our staff will benefit from a reverse mentoring programme • Our staff will be able to make recruitment & development choices • BAME staff will report an improved employment experience within the Trust	• <Reduction in staff reporting bullying/harassment by a manager • >80% staff recommend place to work • 9+ Equality, Diversity & Inclusion score • Relative likelihood of BAME staff entering formal disciplinary, appointed from shortlisting, access to training and reporting fairness with regard to career progress **all equal to that of white colleagues** • Improve representation of staff with protected characteristics across all bands/ role. Including BAME
Develop our collective leadership culture to support all of our staff to feel empowered and engaged	• Ensure we have the right people with the right skills through more effective workforce planning • Support teams to develop through fully implementing our Great Teams model • Further develop our staff engagement activities across the Trust	• Our people feel the Trust is the place they can develop their career • Staff feel enabled to make decisions & supported to learn from mistakes • Staff feel they can share feedback with leaders of the Trust	• >7.4 Team working score (Staff Survey) • >82% I can make suggestions to improve the work of my team • >80% 'there are frequent opportunities for me to show initiative in my role' • Staff Survey engagement score > 7.6 • Staff Survey return rate >60% • Big & Little Listen events well attended

Strategic Objective 5 - We will improve, innovate and transform our services to provide the most effective, productive and high quality care

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for service users or staff)	Measurement (how will we know)
Support, enable & encourage our people to continuously improve the care and services we provide	• Use CQI methodology to support teams to improve services • Use CQI across our Transformation Programme, identifying and coproducing improvements with our service users and carers • Adopt a CQI assessment tool to demonstrate improvements made • Harness the skills of our CQI leaders & coaches to target further quality improvements	• Our people will feel supported to develop their CQI skills and knowledge • Our people will be supported to generate & test improvement ideas • Improved safety, outcomes, effectiveness of inventions, timeliness to access service	• >180 staff trained in CQI • Improvements - 6 CQI focus areas • 20 EBE trained in CQI • 2 IHI Fellowships or equivalent programme • West and E/N main CQI hubs in place • CQI forum established in each SBU and one external QI forum event
Continue to introduce new digital capabilities that will enable teams to innovate and improve service user, carer & staff experience as well as the safety and effectiveness of our services	• Use electronic communications & real time online feedback to empower service users & carers • Implement digital solutions to improve effectiveness, safety & experience including video consultations, ePrescribing and Medicines Administration (ePMA) in inpatient services, observations and safety dashboards • Continue to improve infrastructure, software & access controls to support our workforce including Office 365 deployment • Enable information sharing for care professionals working with our partners	• Service users & carers will receive correspondence more quickly in the format they prefer • Outcomes reported by service users & carers will guide care • Staff will have the right equipment & systems to deliver great care • Staff will notice improved speed and ease of access to information • Staff will have more time to care and a better experience of work	• Tbc % letters & discharge notifications delivered digitally to GPs & service users • Tbc % service users empowered to complete outcomes online • Tbc % MS Teams Virtual Visits • Tbc % migrated to Office 365 • Improved staff survey / Pulse survey results re: equipment, access to information, experience of work • Digital solution for inpatient ward observations in place • Controls on key data across systems to improve data quality in place
Release time to care by supporting staff to work more effectively and flexibly, including providing better and simpler access to information	• Further develop demand, activity & capacity modelling capacity across the Trust • Implement a Trust productivity, quality and pathway dashboards • Deliver our 'Time to Care' programme • Align estate with new agile working culture • Design and implement the 'corporate services' transformation programme	• Staff will more easily identify opportunities to improve productivity • Staff will have more time for direct service user care • Service Users will report they have more time to discuss their care • Corporate services demonstrate best practice & support to frontline	• Have your say and Pulse survey • Feedback survey following Time to care masterclass • Staff and services will report high quality customer experience with improved accessibility and responsiveness

Strategic Objective 6 - We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for service users or staff)	Measurement (how we will know)
Improve community adult and older peoples' services and care aligned with Primary Care Networks	• Continue to pilot and evaluate, taking a CQI approach, a new community model for adult & older people (in Watford & Lower Lea Valley) to inform the future community model for the Trust • Continue to develop (adopting a CQI approach) our Primary Mental Health model with PCNs	• Service users able to access the right care and support at the right time, in the right place to support recovery • GPs and other primary care workers will feel able to support service users • Staff will feel able to deliver great care	• <crisis presentations • <inpatient admissions • >Improved service user and carer experience • Personalised care plan approach in place
Improve access and delivery of care for those people with a learning disability across the Trust	• Continue transformation of Essex LD Services including the potential bed reconfiguration • Work with partners to review & improve Assessment & Treatment pathways across all LD services • Specialist Residential Services - co-produce future care with service users, their families and commissioners to meet ongoing care needs. • Develop a new approach to Learning Disability Services in Norfolk in conjunction with partners	• Service users will experience more joined up care & have better access to services • Service users will have high quality care and better outcomes • Staff will feel supported & able to make improvements	• Essex Local integrated teams in place • Access to service improved through new 'Way in' service • > Service users reporting satisfaction • < Crisis admissions • <inpatient admissions
Improve the range and access to crisis services in conjunction with Hertfordshire partners	• Broaden the range of crisis interventions available and evaluate their impact • Develop an all age adult crisis service to meet the diverse needs and support for service users	• Service users will have improved access to local services & improved outcomes • Service users will experience reduced waiting times to access crisis support	• %<1 hour access in crisis • < Inpatient including out of area placements • <repeat readmissions by service users (Baseline t.b.c)
Work with partners across Hertfordshire to deliver earlier intervention and support for Children and Young People	• Ensure Mental Health Support Teams in schools are fully operational (first wave) • Develop an integrated crisis model in conjunction with system partners • Coproduce and remodel our CAMHS community services to offer earlier intervention and support wider system integration	• Children & Young people (CYP) will experience better access to services • CYP will report being satisfied with the services available • Staff will report being able to make improvements & provide high quality services as part of a CAMHS system	• 95% CAMHS access <28 days • < CYP present in crisis in A&E • <CYP known to CAMHS presenting in crisis (Current 29%)

Strategic Objective 7 - We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)

What are the key priorities?	Actions we will take (what we will do)	Outcome (what will be different for service users or staff)	Measurement (how we will know)
Lead the development of the Hertfordshire Mental Health & Learning Disabilities Integrated Care Partnership (MH & LD ICP)	• Drive and oversee restoration & transformation of care pathways across the system in line with Long Term Plan • Work with local partners to establish the governance and organisational structures to support inclusive decision making • Work with partners to address inequalities in access and outcomes across Hertfordshire, by working with voluntary and community sector partners	• Service users will experience more joined up care, • Service users will experience better outcomes • Staff will feel motivated and able to deliver great care	• Delivery of LTP/Operating Plan commitments for 2020/21 • Agreed transformation programme in place with partners engaged • Delivery new Community model including PCNs • Delivery of new crisis pathway & CAMHS pathways with partners across Hertfordshire
Advocate for and ensure mental health & learning disability services are developed across populations we serve	• Support development of Herts & West Essex Integrated Care System • Ensure the needs of those with mental illness & learning disabilities are included within system plans and developments • Continue to lead the ICS mental health and LD work stream by actively engaging with other place based parts of the Herts and West Essex local system	• Service users will experience more joined up care • Service users will receive care that meets their needs • Staff will feel able to contribute to service developments	• HWE ICS continues to prioritise & invest in Mental Health & Learning Disabilities (LD) • HWE ICS population health model continues to develop • Mental Health Investment Standard is met within 2020/21 • MH & LD is overtly prioritised within the ICS strategy and delivery work streams • Place based ICPs focusing on, and including MH & LD in future delivery models
Work with regional partners to develop and deliver New Models of Care for those with specialist mental health and learning disabilities	• Work with partners across East of England to establish a strong provider collaborative • Lead the delivery of the CAMHS new model of care across the East of England • Advocate for and develop our Adult Mental Health & LD Secure services, Eating Disorder and CAMHS services to improve care and outcomes	• Service users will have increased local choice and provision to support them at home and in their community • Staff will be involved and feel able to shape improvements in care	• East of England (EOE) Provider Collaborative established • < Out of area placements for service users requiring specialist beds • Plans for development of services across EOE under development • <number of inpatient stays for an Eating Disorder

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 15b
Subject:	FY22 Financial Plan	**For Publication: yes**
Author:	Paul Ronald Director of Operational Finance	**Approved by:** Paul Ronald Director of Operational Finance
Presented by:	Paul Ronald Director of Operational Finance	

Purpose of the report:

To set out for the Board the FY22 financial plan for review and approval. As previously advised there remains several key national policy matters and specific financial details which are still to be determined. Therefore, this plan is based on a number of key assumptions which are our best estimate at this time. The report identifies those key assumptions and their rationale, setting out key areas of risk and the associated mitigations.
These planning assumptions will be refreshed and evaluated when the full policy and framework details are published with the current expectation that the national planning submissions for FY22 will be late June 2021. If required, an update to this financial plan will be made at that time and presented for approval.

Action required:

To: -

1. Review the detail provided, noting in particular the risks and the mitigating actions identified to manage these.
2. Note the key assumptions and the basis of their determination
3. Critically appraise the information provided
4. Advise any further information required

Summary:

Background

The initial FY22 projections (December Workshop) gave a likely position of a (£5.8m) deficit. The projected range of deficit was between (£1m) and (£13m) and identified several key dependencies relating to range of both ***external factors***; the timing and extent of the withdrawal of the COVID funding, whether funding was provided to meet additional demand and the allocative decisions made by the ICS and the ***internal factors*** of; the time line in managing down the COVID cost increases particularly on external beds and bank costs, the workforce challenges of recovery, recruitment and retention and the success in mobilising the annual Delivering Value Program which is currently assessed as a £7m program (FYE).

As more of the headline details have been announced these have led to an improvement in the plan assumptions and related projections. In particular, with;

- the current H2FY21 having been confirmed as being rolled over for at least Q1 with a strong indication of extending to Q2. What has not been confirmed is the exact detail of this and in particular whether the fixed sum amount for COVID costs will continue at the same amount.

- The additional £500m MH/LD investment announced in the November spending review has been confirmed in totality and that it will be made available from the outset of the year. The detailed ICS allocations are expected imminently and then from this there will then be discussions with commissioners on how this is deployed. Again what is not known yet is the amount allocated to Hertfordshire and how commissioners would look to invest this although there is a firm commitment to £79m of this being ring-fenced for CAMHS.
- Whilst the overall financial outturn for FY21 continues to report a £1.2m deficit the exit position is showing some signs of improvement and there is a level of income received during Q4 that can support the resetting of the operational cost base over the early months.
- In relation to operational and workforce pressures then the detailed report notes that some additional funding is included to provide increased staffing to meet demand growth and it is also expected that there will be a significant annual leave pay accrual brought forward to support staff recuperation. It is also intended to include a £1.2m provision for future COVID costs in the FY21 position. This will provide some headroom against unplanned costs.

Based upon the above key matters then the financial Plan has been set as summarised below. The detailed individual service line plans are still to be fully completed and will be done within the overall values set out below;

	Q1	Q2	Q3	Q4	Total
Total income	**71.7**	**71.3**	**70.1**	**70.5**	**283.6**
Pay	46.6	47.0	47.5	47.9	**189.0**
Sec Comm	9.1	8.8	8.2	8.3	**34.4**
Non Pay	12.9	12.6	12.2	12.2	**49.9**
Financing	3.0	2.9	2.7	2.7	**11.3**
Total Cost	**71.6**	**71.3**	**70.6**	**71.1**	**284.6**
surplus/deficit	**0.1**	**0.0**	**-0.5**	**-0.6**	**-1.0**

This shows an improvement upon the previous projections but it is subject to the confirmation of the specific detail on these funding headlines, the management of the key cost pressures and the progress on the delivering value program.

In terms of the specific financial risks then these are summarised as follows;

1. The final detail of the FY22 funding settlement and contract discussions is to be determined. The current plan includes new income of £9m from MHIS and from the non-recurrent national sum of £500m. This income should be expected but there is a risk on how it is accessed and any specific new commitments attached.
2. The plan assumes on the basis of the rollover of the current arrangements that the COVID related funding will continue but at a reducing amount. For the purpose of the plan it is assumed that this will be at 80% for Q1 & Q2 and 25% for the remainder of the year reflecting the fact that some costs will remain throughout. This would be an income in year of £5.5m which is circa half the previous year amount. This income reduction is expected to be matched by a corresponding reduction in cost.

3. The plan assumes that there will a Delivering Value program of £7m which will deliver in year savings of £5m
4. The plan assumes that there will be a reduction in the costs of external beds both within long term social care placements and through a reduced use of short term private sector provision. The cost for FY21 is forecast at £36.8m with a £2m reduction assumed in FY22

In recognising the higher level of uncertainty around financial settlements for FY22 and the above risks then the Trust continues to consider potential mitigations and actions across four key areas of focus in meeting the current projected financial position summarised above:

1. Securing of additional income from commissioners or through the ICS
2. Further accelerating the reduction in the current cost base beyond that currently forecast.
3. Using non recurrent investment to accelerate key transformation or delivering value programs to achieve an earlier impact
4. Resetting of certain of the proposed LTP and proposed commissioner service investments to enable more funding to be available to address current service pressures.

All forecasts currently assume that there will be no material unfunded cost from the Provider collaborative during FY22.

A separate paper is provided setting out the proposed capital plan of £18m net which would be funded as set out below;

FY22 Plan	£M
investment	23.2
depreciation	(6.5)
disposals	(5.2)
Net cash	**11.5**

The capital plan will for the second year require to be set within the Trusts allocation of the ICS capital limit (ICS CDEL) The proposed plan is therefore subject to further discussion and agreement with the ICS. The plan set is affordable to the Trust and covers the completion of several key investments which commenced in FY21, several significant investments to progress the quality and safety of the estate and the further progression of the digital strategy.

Conclusion

Whilst there is a higher level of uncertainty at the time of setting the annual financial plan than in recent years, the key uncertainties are recognised and relate to the withdrawal of the current national income support, the pace of the service and workforce recovery and the anticipated increase in service demand enabling appropriate mitigations to be considered. Within this challenging environment the plan seeks to strike the correct balance across these key drivers with the reduction in COVID related income support being offset by a reduction in both the specific COVID related costs and also securing system efficiencies through the key work streams within the core transformation program. The Trust has shown that it can deliver effective transformation and has in train a number of work streams to support this next phase. The Trust also has the investment capacity to provide targeted support to key areas of the transformation where this is

needed.

The detailed national planning guidance and timetable, including operating guidance, is still awaited and it is now expected that a full 12-month plan will be required through the ICS for each MH system in advance of the wider system requirements. This review will enable a full discussion with commissioners and the system on the key financial drivers and the opportunities to influence these and will enable the assumptions underpinning this plan to be further validated.

Recommendation

The Board is recommended to approve the: -

1. financial plan for 2021/22 on the basis set out, noting the planned £1m deficit;
2. issuing of detailed budgets to budget holder

Relationship with the Business Plan & Assurance Framework:

Reflects the financial consequences of the Business Plan

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 march 10th & update March 17th
FIC March 16th 2021

Introduction

1. The purpose of this paper is to set out for the Trust Board the basis of the financial Plan for FY22. This plan is based upon;
   1.1. The latest financial assessment for the current year,
   1.2. the most recent update provided by NHSE of the framework and funding for FY22; and
   1.3. An assessment of the likely key financial drivers that will impact in FY22.

2. The exceptional nature of the current environment means that there remains a higher degree of uncertainty over our planning at this stage than would be normal. In particular, the following matters will be critical to next year;
   2.1. The amount & timing of additional MH/LD income provided and any conditions attached
   2.2. The amount of COVID support income that continues into FY22, and any conditions attached
   2.3. Linked to this will be the Trusts success in removing the additional COVID costs in line/ahead of the income withdrawal. In particular;
      2.3.1. the external bed use (mainly CAMHS T4)
      2.3.2. The level of bank shifts and
      2.3.3. additional IPC costs.
   2.4. The level & nature of the expected additional demand
   2.5. The workforce challenges staff recovery and recruitment/ retention.

3. The initial FY22 projections (December Workshop) gave a likely position of a (£5.8m) deficit. The projected range of deficit was between (£1m) and (£13m) dependent upon; the matters listed in para 2 above.

4. As discussed below this position continues to evolve both in relation to the FY21 exit position and some expectations for FY22 planning. In particular;
   4.1. The carry forward of income from the current year will be higher than previously assumed.
   4.2. The financial arrangements from FY21 are being extended through to at least Q1 FY22 with an expectation of Q2 FY22.
   4.3. There is a commitment to provide an additional £500m MH/LD funding non-recurrently in FY22. Whilst this was initially assessed as providing circa £8m income to the Trust it is now expected to be less.

Background

5. For FY21 the expected financial framework was replaced with temporary alternative arrangements. These were in two distinct phases;
   5.1. The basis of the income levels throughout FY21 was the FY20 projected income based upon M8-10. This was then increased through a top up and inflation based upon NHSE's assessment of cost pressures.

5.2. For H1 there was then a reimbursement process to claim the additional costs in responding to COVID.
5.3. For H2 this was withdrawn and each ICS was given a fixed some (based upon M1-3 reimbursements) to allocate across organisations. The ICS allocated these amounts largely based upon the organisational amounts which comprised the total.
5.4. There was also an amount of Top Up provided which was based upon H1 but adjusted. Whilst the amount was provided to the ICS as per 5.3 above within the total there was a specific organisational amount (which for HPFT was a downward reduction of £1.5m.) There was also a growth allocation provided to the ICS which was allocated based upon overall income levels (HPFT received circa 10%)

6. The financial arrangements described above evolved over some months with the specific details not always clear which led to a level of uncertainty. This was particularly the case with the MHIS and SDF funding and also there was ongoing uncertainty over the base contract figure used for HPFT. The final contract value (subject to some minor further detail is shown below with the current anticipated equivalent figure for FY22;

Herts Contract	FY21	FY22	Comments
HV	84,235	86,235	Excel SDF / Winter / IT & Incl MHIS
E&N	83,414	85,414	Excl SDF / Winter / IT & Incl MHIS
C&P	837	837	
HCC	23,883	22,883	Savings 21/22
Total	**192,369**	**195,369**	

Table 1 Hertfordshire contract estimate

7. The Trust continues to forecast a deficit of £1.2m in 2020/21 although it is increasingly likely that a more favourable position will be reported. This is due to potential additional income allocations (£0.7m). In terms of the forecast then the latest position (before considering the matter above) is shown in the summary table below:

	H1	H2	Other	Total
Income	**145.5**	**139.6**	**-2.5**	**282.6**
Costs	**143.5**	**139.5**	**0.8**	**283.8**
Surplus	**2.0**	**0.1**	**-3.3**	**-1.2**

Table 2 retrospective profile of FY21 financial outturn

7.1. There was a surplus in H1 on matching income to costs.
7.2. H2 has seen an increase in costs and an indication of an underlying deficit of circa £100k per month by Month 12.

7.3. There is c. £3.0m transformation income that will be deferred into next year, possibly more.
7.4. There will be some increase in accruals/provisions into next year.

8. The latest NHSEI webinar reported that the national position is indicating that most systems' spending will be within the envelopes available with Trusts being requested to ensure all appropriate accruals and provisions are made.

Plan assumptions

Income

9. As advised above the determination of the income position in year has been much more staggered leading to a delay in new service investment with more funding received later in the year and therefore carried forward to meet the related expenditure in the early part of FY22. This includes:
   9.1. The late release of transformation income (SDF).
   9.2. The switch to a fixed COVID sum provided a benefit in Quarter 3 when costs fell.
   9.3. Winter planning funding not received until March.
   9.4. Recruitment funding again received March.

10. It has been advised that the H2 arrangements FY21 will be extended to Quarter 1 FY22 with a strong indication that this will continue to Month 6. On that basis the following is currently assumed:
   10.1. That there will be a fixed monthly COVID sum for the period to September. It is assumed that this will reduce from the current amount of £881k per month over time to c. £200k per month which will be built into the contract baseline. For the purpose of this projection it is assumed 80% in Quarters 1 and 2 and then 25% of the current amount for the remainder of the year.
   10.2. That the growth sum will continue at the same amount as in FY21 H2, £150k per month.
   10.3. That the Top Up amount will continue as at least the same amount as FY21 H2 (£188k per month) albeit there is a strong case for additional amounts given the H2 financial position. (The amount for the ICS was £71m for H2 with HPFT's allocation being £1.1m.)
   10.4. That there will be no CQUIN amounts for H1 with the full value of CQUIN being within the contract amount as for FY21.

11. That MHIS and SDF funding will continue with the full year amount being available earlier in the year. This amount is as follows:
   11.1. For transformation funding (SDF) there is c. £3.0m brought forward from FY21 (per 9.1 above).
   11.2. There is also c. £3.3m SDF for FY22. It is assumed that this will be held until the amount above is fully spent; however there is the option of

using an element coterminous in order to advance what would otherwise have been FY23 investments.

11.3. The MHIS sum is less precise, it based upon the % growth in CCG funding but is subject to various adjustments; in previous years this has been a minimum of c. £4.0m, though some amounts can go to other providers than HPFT.

12. The November Spending Review announced £500m funding to Providers specifically to support MH/LD services and that this would be made available from Q1. This commitment has been repeated throughout recent months but the fuller detail and the specific amounts available to HPFT are only now beginning to become clearer.

13. During 2021/22 the following contract reductions will take place:
    13.1. West Essex IAPT expected from M5 £1.3m reduction
    13.2. North East Essex IAPT FY £4.2m reduction
    13.3. Reduction in Social Care Hertfordshire of a further 4% c. £1.0m

14. In addition, the following service expansions will take place:
    14.1. Astley Court expansion of community team and increase in beds c. £1.0m.
    14.2. Buckinghamshire additional purchase of beds c. £250k.

15. Comparison between 2020/21 and Quarter 1 expected is shown in the following table this is before any increase for inflation or any efficiency pressure which is considered further below. Whilst this shows a reduction in income from the current year this would be expected to be offset largely by a reduction in operating costs from the change in IAPT services in Essex and from a fall in COVID costs against current levels:

Income	M1-6	M7-12	H1	Q1 Comments
Block	20.4	20.5	19.9	Reduction for Essex IAPTs & Social Care
Top-up	0.3	0.2	0.2	Could be higher
COVID19	1.6	0.9	0.7	Risk this is reset further
Growth	0.0	0.2	0.2	Through ICS
MHIS	0.0	0.7	0.6	Reduced for 12 months offset by 21/22 increase
SDF	0.0	0.3	0.3	Assume release of 20/21
E&T	0.3	0.5	0.5	Reduction for Essex IAPTs / offset higher amount
Other	0.9	0.9	0.9	Non-block income
Additional MH investment	0.0	0.0	0.4	Based upon estimate of 500m total
Total Income	**23.5**	**24.1**	**23.7**	

Table 3 assumed change in monthly income amounts for Q1 FY22

16. There are further additional income amounts that may arise but are not yet included within the above table or further analysis provide below. These amounts include:
    16.1. Additional CAMHS transformation income within Hertfordshire
    16.2. Additional MH investment in Mid Essex

Operating Cost changes

17. Whilst a material amount of the total income remains to be determined the related costs will be similarly subject to final confirmation over the next weeks. In terms of headlines then the following table is provided with further comment in the paragraphs below;

	comment
Pay costs	• Will be inflationary increase for frontline staff of 1% TBC • Additional posts from MHIS investment on IAPT, Perinatal and PATH services • Additional posts from inpatient service expansion Norfolk • Investment will be required to meet demand pressures within some areas of community services. • There will subject to funding confirmation be additional staffing to expand the 24/7 helpline with clinical staff • Any bring forward of the LTP commitments utilising the additional MH funding provided for FY22 will increase staff. • There will be pressure on some areas of support services as there is a move back to business as usual • There will be an increase in HCA staffing as part of the national recruitment plan which will see an offset in reduced bank staff • There will be a reduction in staff in Essex with the transfer of both NE Essex & W Essex. • There will be a reduction in bank costs related to COVID which has been necessary given; levels of sickness & shielding, additional IPC measures, additional 1:1 care and additional needs from complex care arrangements, impact of outbreaks and vaccination.
External bed cost	This is the most significant area of cost pressure given the level of volatility and financial impact. Overall the bed numbers show continuing pressures on adult inpatient units whilst currently there is ongoing capacity within older adult, CHC and Forensic • In particular, we have seen a sustained increase in CAMHS T4 bed requirements particularly relating to eating disorders. The current cost of this provision is significantly above the contract finances and addressing this financial pressure will be key to the financial position.

	comment
	• This year has also seen higher than planned private bed use in older adult services where the level of fluctuation has been much more volatile. • As the national policy of provider collaborative rolls out then there may be changes within commissioning arrangements which could see shifts particularly in forensic inpatient demand should London providers look to move service users back into more local facilities.
Non Pay	Whilst typically relatively stable this year has seen a significant swing in costs particularly from infection control costs mainly on cleaning, additional estate and IT costs and costs in supporting staff throughout the period. Some of this will continue into Q1 before reducing. Other key changes included are; • There is an additional circa £1m cost from the renewal of the facilities contracts although some offset will be targeted through the contract management process. • There will be an increase in travel costs from Q2 and throughout the year but not at previous levels • There will be an increase in IT support costs with the increase in devices and
Financing	FY21 is expected to see a reduction in PDC by circa £700k due to the accelerated cash payments leading to higher cash balances. This is not expected to continue next year and with a high capex spend this year there will be an overall increase in cost. • To mitigate this there is a full review of the estate currently underway to maximise the MEAV use • A full impairment review of all new asset additions will be made.

Table 4 summary detail of key cost assumptions

18. In terms of the current working assumptions then there will be an increase in Pay costs over the year with;
    - 18.1. A net recruitment of circa 100 posts at an average cost of £40k. Whilst there will be a mixture of posts a number of these will be at B3 and B4. Part of this will be the recruitment of posts not recruited to in the current year.
    - 18.2. There is an amount of £2m included over Q2-4 to cover additional demand pressures. This is the circa 50 posts in addition to above.
    - 18.3. It is assumed that circa 50% of the non-recurrent amount of the £500m funding will be used in year on additional linked commitments.
    - 18.4. The CCATT team and the 24/7 helpline cost will be funded from the growth funding whilst recurrent funding is secured.
    - 18.5. There will be a reduction in Pay from M1 with the transfer of NE Essex in April and West Essex in August.

18.6. The additional bank and agency costs from COVID including the CERT team, fit testing and incident command will reduce from Q2.

18.7. There will also be a reduction in pay costs from the DV program. The forecast assume this will be at a run rate of £200k per month from plans such as; increased employment of HCA's, the increased student recruitment increased use of E Roster and changes in corporate services.

19. Over the year there will be a reduction in bed costs against the current year mainly through the reduction in CAMHs T4 back towards FY20 levels and from further savings from the Connected Lives Program.

20. In terms of non-Pay costs then there will be a reduction in costs from reduced IPC deep clean costs plus costs in supporting the transition to home working. There will be additional costs on the interserve contract plus an increase in digital. A key element will be to look at the opportunities for estate rationalisation.

21. Financing costs will increase with the additional depreciation from this year's Capex. This will be partly offset through asset disposals.

22. The above assumptions combined with the detail provided below in terms of cost pressures would indicate the following broad position based upon the likely case assumptions however these will evolve further. Over the next days the position is likely to show an improvement particularly in the second half of the year and the key areas of focus are discussed further below. For the moment these items are not yet incorporated into the summary below;

	Q1	Q2	Q3	Q4	Total
Total income	**71.7**	**71.3**	**70.1**	**70.5**	**283.6**
Pay	46.6	47.0	47.5	47.9	**189.0**
Sec Comm	9.1	8.8	8.2	8.3	**34.4**
Non Pay	12.9	12.6	12.2	12.2	**49.9**
Financing	3.0	2.9	2.7	2.7	**11.3**
Total Cost	**71.6**	**71.3**	**70.6**	**71.1**	**284.6**
surplus/deficit	**0.1**	**0.0**	**-0.5**	**-0.6**	**-1.0**

Table 5 High level Quarterly Financial Summary FY22

Areas of further Review & mitigation

23. In recognising the higher level of uncertainty around financial settlements for 2021/22 and the absence of clarity of how this may play through in planning, we continue to develop plans across four key areas of focus in addressing the current projected financial deficit summarised above. These are;

23.1. **Securing additional income through both the Hertfordshire commissioners and through the ICS allocative process.** In particular;

23.1.1. ensuring that the annual MHIS income is used to address current demand pressures and demographic growth before any additional service development.

23.1.2. That the fullest share of the additional £500m funding is secured and again that it is used to support the transition during FY22 in terms of service demand and workforce pressures.

23.1.3. That where appropriate the SDF FY21 carried forward is used to accelerate key transformation programs supplementing the FY22allocations.

23.1.4. Securing an additional share of the ICS top up funding with only 1.7% of the total being received in FY21H2.

23.2. **Managing down the cost base from current levels.** In particular;

23.2.1. FY21 has seen a legitimate and understandable increase in cost in response to COVID. These costs include those directly attributable such as (IPC deep cleans, additional staffing need to support the ward changes required, increased sickness and staff absence, incident control management and PPE related costs) and other areas which less direct have clearly been impacted (this is particularly an increase in bed costs and in in the crises team and ward observation costs) Reducing these costs appropriately where able and ensuring that operational practice is adapted to work effectively under the new circumstances will be key. This work will be done through both routine practice as staff and teams adapt and will also be driven by the key transformation work streams within the comprehensive transformation program that is underway.

23.2.2. Allied to the above is the transformation investment being provided primarily through the SDF income which is focussed on Community MH and crises services and will reduce the demand for inpatient admissions.

23.2.3. There is a regional response to the significant increase in children's ED presentations which as reported elsewhere has seen the most significant and sustained increase in demand over the year. Providing appropriate and consistent community support will be a key requirement to reduce the current cost base. In addition to the system response there are several service proposals being progressed.

23.2.4. The delivering Value program is being developed and implemented against a target of £7m (FYE) it is recognised that this will take a period to implement but the program is progressing with a program value of £7.5m of which circa £2m is in pace with a further £5m rated as amber which indicates reasonable progress and likelihood of delivery subject to further confirmation.

23.3. Use of non-recurrent support to accelerate transformation and invest to save programs.

23.3.1. This is referred to above in part and is a significant option in supporting the transition from the current position. This is not to temporarily cover a revenue gap but to provide pump prime investment

in areas of transformation where appropriate. In Particular support in extending the CAMHS community ED, more support for bed flow, additional crises response and project support for key DV projects and the comprehensive use of safer staffing and E roster are all under development.

23.4. Review of the proposed service investments within the LTP or proposed by commissioners

23.4.1. The normal annual contract discussion has been delayed this year and will commence during March. There is an early list of proposed investments and these will be subject to detailed discussion regarding timing scale and priority. Where these are reset then this will reduce costs with the income being used to support the existing cost base.

LTP Investments	£k
Perinatal	531
Crisis	627
IPS	268
24/7 Crisis Help Line	1,300
IAPT increasing step 3	
Therapeutic Care	150
CYP Eating disorders	410
CYP Crisis	1,399
LD Community Forensic	200
Total LTP Investments	**4,885**
Service Development	
CYP Front Door	599
PCN Mental Health Practioners	4,000
CYP Autism Diagnosis	100
St Elizabeth's	
	4,699

Cash and Trust Balance Sheet

24. The Trust balance sheet and cash position is set out in Appendix 1 and shows an end of year cash position of £65m.

Summary & Conclusion

25. There are several significant uncertainties in relation to FY22 that make it difficult to make financial projections with certainty at this time. However, it remains

important that we set out our best understanding and then update this as more detail becomes available. To move towards a break even position in year then the most significant impacts will be from;

25.1. The fullest allocation of the £500m spending review injection is provided from Q1 and again with full discretion on its use

25.2. That there is a sensible continuation of the COVID funding to match the reduction in the related cost.

26. Achieving financial balance will also be dependent upon managing the cost base in line with current levels with the additional costs of expanding services and meeting new demand being broadly offset by the removal of the COVID incremental costs and a reduction in external bed use particularly in relation to CAMHs T4 as well as successfully progressing the Delivering Value plans.

27. Over the next weeks as key elements of the framework are finalised the Trust will have a much clearer position to be forecast and the actions that are necessary to achieve a balanced position determined. The detailed planning will ensure that the key metrics are well tested and refined and further that processes are put in place to ensure regular monitoring, feedback and that if required corrective actions can be taken at the earliest point.

Appendix 1 quarterly balance sheet FY22

	Forecast Out-turn 31/03/2021 Month 12 £'000	Plan 30/06/2021 Q1 £'000	Plan 30/09/2021 Q2 £'000	Plan 31/12/2021 Q3 £'000	Plan 31/03/2022 Q4 £'000
Non-current assets					
Intangible assets	815	761	707	653	599
Property, plant and equipment: other	155,350	158,928	162,506	166,084	168,981
Total non-current assets	**156,165**	**159,689**	**163,213**	**166,737**	**169,580**
Current assets					
Inventories	56	56	56	56	56
Trade and other receivables: due from NHS	1,798	1,798	1,798	1,798	1,798
Trade and other receivables: Due from non-NHS	4,003	4,003	4,003	4,003	4,003
Assets held for sale	4,519	4,519	3,245	3,245	0
Cash and cash equivalents: GBS/NLF	75,443	73,027	69,504	66,485	65,017
Cash and cash equivalents: other	207	207	207	207	207
Total current assets	**86,027**	**83,611**	**78,814**	**75,795**	**71,082**
Current liabilities					
Trade and other payables: capital	(1,764)	(1,764)	(1,764)	(1,764)	(1,764)
Trade and other payables: non-capital	(32,518)	(33,466)	(32,518)	(33,466)	(32,518)
Borrowings	(530)	(590)	(530)	(587)	(530)
Provisions	(3,812)	(3,812)	(3,812)	(3,812)	(3,812)
Other liabilities: deferred income	(12,487)	(12,487)	(12,487)	(12,487)	(12,487)
Total current liabilities	**(51,112)**	**(52,120)**	**(51,112)**	**(52,117)**	**(51,112)**
Total assets less current liabilities	**191,080**	**191,180**	**190,915**	**190,415**	**189,550**
Non-current liabilities					
Borrowings	(8,468)	(8,468)	(8,203)	(8,203)	(7,938)
Provisions	(5,845)	(5,845)	(5,845)	(5,845)	(5,845)
Total non-current liabilities	**(14,313)**	**(14,313)**	**(14,048)**	**(14,048)**	**(13,783)**
Total net assets employed	**176,767**	**176,867**	**176,867**	**176,367**	**175,767**
Financed by					
Public dividend capital	94,683	94,683	94,683	94,683	94,683
Revaluation reserve	36,432	36,432	36,432	36,432	36,432
Other reserves	(126)	(126)	(126)	(126)	(126)
Income and expenditure reserve	45,778	45,878	45,878	45,378	44,778
Total taxpayers' and others' equity	**176,767**	**176,867**	**176,867**	**176,367**	**175,767**

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Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 15c
Subject:	FY22 Capital Plan	**For Publication:** yes
Author:	James Thackray Head of Finance	**Approved by:** Paul Ronald Director of Operational Finance
Presented by:	Paul Ronald Director of Operational Finance	

Purpose of the report:

Following discussion and approval at the Finance & Investment Committee on March 16th this paper sets out the recommended FY22 Capital Plan for consideration and approval by the Board. Under the new capital arrangements, the Trusts capital spending limit will be set within the ICS Capital Plan and therefore the plan presented may require to be reduced when the capital limit is confirmed within the ICS. Individual Trust capital limits are scheduled for agreement mid-April.

Action required:

To: -

- Review and approve the outline Capital Program summarised below.
- Noting that the Plan as presented is £18m an increase of £2.6m from the FY22 amount presented to FIC which brings forward the spend on one safety suite by one year of £2.2m and the CCTV investment by £0.4m. The overall sum over the four year period remains the same
- To note that the national system based Capital allocation process means that an organisational limit will be set for each provider trust. Should this process restrict the capital spend allowed in year then the program will be prioritised and an amended plan brought back for approval.

Summary and recommendations to the Executive Team:

Introduction

This paper provides the summarised capital spending requirements for the key capital projects based upon the Trusts forecast of the likely costs derived from; agreed contract details (for those projects in progress) , pre tender estimates or the Trusts experience of similar projects.

The program is set in support of the delivery of our Good to Great Strategy and has been developed in conjunction with key other key areas of Trust development including:

- Estates Strategy
- Organisational Development Strategy
- Digital Strategy
- Quality Strategy

The FY22 program continues the strong progress made within the previous year where a number of key investments were undertaken across a range of works supporting clinical care, quality initiatives and staff welfare.

Whilst the amount of capital allocation for FY22 for the Trust is still to be confirmed the ICS allocation has been notified as £69.5m which compares to £66m received in FY21 and in line with the earlier regional planning assumption of a rollover of the FY21 amount.

Of the £66m Capital CDEL last year HPFT was given an allocation of £15.4m. The draft plan below is set out at £18m but is subject to the ICS process of review and agreement.

In terms of affordability then a plan of £18m for FY 22 would be funded as follows and is within the cash available whilst still supporting the key investment in the East & North Inpatient Unit;

FY22 Plan	£M
investment	23.2
depreciation	(6.5)
disposals	(5.2)
Net cash	**11.5**

The outline plan for FY 22 is set out in Appendix 1 and shows;

- The completion of a number of projects; the safety suites, Forest House and Albany lodge
- Significant refurbishments of Oak ward and Lexden
- Two further safety suite investment and investment in CCTV
- Continuation of digital investment
- A number of other investments to support the estate program

We have set out some high level outline costs for a further 3-year period (FY 23 to FY25) through to the expected completion of the East & North Inpatient Unit. The prudent assumption for planning purposes is a CDEL of £7m to £9m in those later years.

The Trust has applied the Regional prioritisation framework to its programme which is based upon the following criteria. This assessment tool will enable the Trust to evaluate any ICS requests to amend its capital plan in year due and will ensure a transparent consistent approach within the ICS.

Criteria	Objective/Definition	Comments from Region
Patient and public safety – 60%	**Addressing current high risks relating to one or more of the following areas, which cannot be mitigated through alternative routes at lower cost**	**Examples include: -** • **Clinical safety (not clinical quality), i.e. where there is high risk of patient harm** • **Health & safety of patients, staff and/or visitors.** • **Fire safety.** • **Cyber security.** • **Regulatory instruction in relation to safe patient care, e.g. CQC 'must do'.**
30% Maintaining	**Addressing current high**	**Clinical quality which adversely**

an acceptable level of service quality	**risks, for existing services, relating to one or more of the following areas, which cannot be mitigated through alternative routes at lower cost:**	**impact patient experience but do not carry high risk of patient harm.** • **Service continuity.** • **Regulatory instruction in relation to quality of patient care, e.g. CQC 'should do'.**
10% Business case (strategic and financial case)	**A sound case for investment based on strategic fit and financial case**	**Other considerations.**

The content and nature of the programme will evolve over time and therefore this will remain subject to change in terms of the programme and financial impact. The nature of having an ICS system allocation may enable the Trust to increase its allocation in year should other Trusts be unable to utilise the limit granted. HPFT are in a strong place to do this given its cash position.

Funding
The two significant capital investments are the 54 bedded unit in Stevenage (East & North Inpatient Unit) and the Lexden Business Case. The funding of these developments would fall outside of the CDEL and additional funding will need to be sought from central DH programmes. Informal discussions regarding future plans and potential additional funding requirements have been commenced with NHSE on the East & North Investment and will begin imminently regarding the Essex inpatient requirement.

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

Summary of Implications for:

1 Finance
2 IT
3 Staffing
4 NHS Constitution
5 Carbon Footprint
6 Legal

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 10th March 2021
Finance and Investment Committee 16th March 2021

Appendix 1 – Strategic Investment Programme FY21 to FY25 (pages 5 to 7)

Plan 20/21	Project	Forecast FY 21	Plan estimate FY 22	Plan estimate FY 23	Plan estimate FY 24	Plan estimate FY 25	Total 5 Year Plan estimate	
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
	CDEL funded							
	Inpatient Projects							
5,000	Safety Suites	5,087	2,913				8,000	Bus Case approved
	Safety Suites - Beech & Astley Court (£4m)		4,400	2,200			6,600	1 Additional Safety Suite in each year: Lexden, Beech Ward and Astley Court
3,500	Stevenage New Inpatient Unit*	1,030	800				1,830	£0.8m planning permission in FY22
4,000	Oak Ward Refurb (Decant separate provision)	400	4,600				5,000	Complete refurbishment estimate
2,000	Forest House Refurb HDU	573	827				1,400	Bus Case approved
1,500	Albany Lodge Works	257	1,043				1,300	Bus Case approved
0	Lexden A&T Upgrade	100	1,300				1,400	
	Inpatient Upgrade			400	900	3,100	4,400	
16,000		**7,447**	**15,883**	**2,600**	**900**	**3,100**	**29,930**	
	Backlog Maintenance							
842	Boilers etc.	1,273	1,500	1,500	1,500	1,500	7,273	
0	6 Facet Survey Work/ Fire Compliance	780					780	
842		**2,053**	**1,500**	**1,500**	**1,500**	**1,500**	**8,053**	
	IT Projects							
2,400	Digital Strategy	1,594	2,400	2,400	2,400	2,400	11,194	Digital Strategy estimate
100	Ap Development	0					0	
500	IT Allocation	787	300	500	500	500	2,587	Assumes £200k b/fwd. 21/22 to 20/21
3,000		**2,381**	**2,700**	**2,900**	**2,900**	**2,900**	**13,781**	

continued on next page …

Plan 20/21	Project	Forecast FY 21	Plan estimate FY 22	Plan estimate FY 23	Plan estimate FY 24	Plan estimate FY 25	Total 5 Year Plan estimate	
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
	CDEL funded (continued)							
	Reactive Operational Capital							
1,058	Colonnades - 1st Floor (19/20)	645					645	
0	Kingsley Green Overflow Carpark	621					621	
0	CCTV	35	900	100			1,035	
0	Other	1,919		1,500	1,500	1,500	6,419	
	COVID building modifications		500				500	
	Kingfisher Court Windows		600				600	
	CAMHS 15 Forest Lane external works		180				180	
	Slippage on schemes funded by PDC in 20/21							
	Little Plumstead Plant Room		660				660	
	ePMA		192				192	
1,058		**3,220**	**3,032**	**1,600**	**1,500**	**1,500**	**10,852**	
	Disposals							
-300	Alexandra Road Sale	-465					-465	
-2,200	The Stewarts Sale	0	-2,200				-2,200	
-2,000	St Pauls Sale	0	-2,000				-2,000	
0	Little Plumstead Land Sale	-50					-50	
-1,000	Harper Lane Sales	0	-1,000				-1,000	
-5,500		**-515**	**-5,200**	**0**	**0**	**0**	**-5,715**	
15,400	**FORECAST CDEL LIMIT (adj)**	**14,600**	**17,915**	**8,600**	**6,800**	**9,000**	**56,915**	

Additional schemes that fall outside the forecast CDEL envelope

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Plan 20/21	**PDC funded in 2020/21**	Forecast FY 21					Total 5 Year Plan estimate	
1,000	Little Plumstead Plant Room	340					340	
892	ePMA	700					700	
286	Remote Working Devices	286					286	
2,178	**PDC**	**1,326**	**-**	**-**	**-**	**-**	**1,326**	

Plan 20/21	**Additional schemes for which a combination of increased CDEL envelope and PDC would be required**		Plan estimate FY 22	Plan estimate FY 23	Plan estimate FY 24	Plan estimate FY 25	Total 5 Year Plan estimate	
0	Lexden Business Case/ Essex Bed Review			7,000			7,000	
0	Stevenage New Inpatient Unit - land purchase			3,500			3,500	£3.5m land purchase
0	Stevenage New Inpatient Unit - construction			7,200	40,800	12,400	60,400	Assumes construction costs would require funding by additional CDEL allocation and PDC
0	Albany Lodge disposal					-4,300	-4,300	Disposal proceeds badged against new E&N/Stevenage Unit in OBC
0	**Schemes falling outside of the CDEL**	**-**		**17,700**	**40,800**	**8,100**	**66,600**	

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Meeting Date:	25 March 2021	**Agenda Item:** 16
Subject:	Trust Risk Register February / March 2021	**For Publication:** Yes
Author:	Nick Egginton, Compliance and Risk Manager	**Approved by:** Dr Jane Padmore, Executive Director Quality and Safety (Chief Nurse)
Presented by:	Dr Jane Padmore, Executive Director Quality and Safety (Chief Nurse)	

Purpose of the report:

For the Board of Directors to consider and review the risks presented, the mitigating actions and resultant risk scores on the Trust Risk Register (TRR).

Action required:

To receive the Trust Risk Register for assurance which has previously been received and reviewed at the Integrated Governance Committee.

Summary and recommendations:

This paper is the Trust Risk Register and contains the current position, scores and mitigation. The paper indicates that a new risk is currently being added in relation to CAMHS demand outweighing the capacity of services, both within general CAMHS and CAMHS Eating Disorder Services.

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

Relation to the BAF: (the following Strategic Objectives link to individual risks on the Trust Risk Register)

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

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

There are no budgetary or financial implications in the Trust Risk Register report, however some actions taken linked to the risks may have budgetary or financial implications.

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

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

Health and Social Care Act 2008 (Regulated Activities) Regulations

Regulation 12: Safe care and treatment

- Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible. They should review methods and measures and amended them to address changing practice.

Regulation 17: Good Governance

- Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.
- Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.
- Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.
- Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate.
- Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.

Care Quality Commission Key Line of Enquiry; Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions

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

Exec 24.02.2021
Integrated Governance Committee- 8th March 2021

Trust Risk Register Executive Summary February / March 2021

1. Introduction

1.1. The purpose of this report is to present the Trust Risk Register (TRR) for discussion. Consideration should be given to the current situation and the mitigations that have been put in place. The TRR identifies the high level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them.

1.2. The Full Trust Risk register is detailed attached and preceded by a summary overview. Each Director has reviewed the risks that they are Senior Responsible Officer for. The Executive Team met, reviewed the TRR as a whole and approved the current scores. Scores change over time in response to changes in the likelihood and severity of impact should it occur (appendix 2)

2. Summary

2.1. The Trust currently has 11 risks on the Trust risk register that can be grouped into the following themes:

- Quality and Safety (3)
- Finance (2)
- Workforce (2)
- External landscape (1)
- Operational (1)
- EU Exit (1)
- Information Management and Technology (1)

Quality and Safety

COVID and winter pressures

2.2. The Trust continues to experience some pressures due to the pandemic but the pressures due to a potential outbreak of flu did not materialise. In addition, the winter season is coming to an end. The Executive Team approved closing the risk 1147. The risk in relation the impact of the COVID pandemic and being in National Level 4 Incident Response remains.

Unlawful detention in the Places of Safety

2.3. There continue to be challenges in relation to the unlawful detention of service users in the Place of Safety. A Letter before action has been received and reported previously to Board. This was in relation to the detention of a service user in the S136 suite on Oak ward on 22nd October 2019 for longer than 24hrs. The Trust has admitted that he was detained for over 24 hours but that the delay was due to the unavailability of a bed. The claim has brought under for unlawful detention/imprisonment and under the HRA 1995 (breach of Article 5 ECHR). The Trust has denied false imprisonment and is a awaiting a further response from the claimants solicitor.

2.4. In Quarter 3, 27% in October 2020, 32% in November 2020 and 22% in December 2020 exceeded the 24 hours. The first month in 2021 saw a similar proportion (25%). Analysis of these has shown that S136 admissions cluster together and therefore demand is difficult to anticipate and manage.

2.5. Confounding factors include the longer lengths of stay in acute pathway impacting which impact on bed availability, delaying S136 admissions and a period of 6 weeks where the

CAMHS place of safety was decommissioned in order to safely care for a young person waiting for a bed in a low secure unit.

2.6. In addition to those who were not fit to be assessed (intoxicated), individuals remain in the place of safety longer than the 24hr period primarily for two main reasons. These are delays in the actual assessment taking place because the staff (AMHP, Crisis Team or Doctor) are not available or the service user has been assessed as requiring an inpatient bed and there is no bed available.

2.7. A protocol for escalation of service users detained under Section 136 of the Mental Health Act 1983 has been developed with clear timescales. In addition the Hertfordshire Mental Health Crisis Care Concordat being reenergised and an interagency meeting continue to work to reduce S136 detentions.

Finance

Long term

2.8. NHSE has proposed to implement a regional Provider Collaborative from October 2022 covering CAMHs Forensic and ED services currently provided through NHSE. Work continues on each work stream to implement the clinical redesign, agree the resource allocations and implement the governance and risk share structures.

2.9. The Trust has been given organisational control totals up to 2024, however, following the change to a system control total in 20/21, there are signals that this and other changes to the financial arrangements will be made for future periods which will likely change the financial metrics for individual organisations. At the moment this has been substituted with temporary arrangements which see a payment based upon 19/20 contract values which is then topped up based upon current spend to cover existing costs. Details of the proposed further changes in the financial structure are not expected until May/June 2021. The Trust will continue to work actively as part of the ICS to ensure these arrangements provide a fair settlement for MH & LD services.

2.10. The Trust has set an initial Delivering Value target of £7m and is continuing to develop plans to meet this. The Trust is also developing its next 3 year capital plan with a core element being the completion of the OBC and planning application for the investment in a new inpatient unit to provide for the eastern County

Short term

2.11. For H2 of FY21, the Trust set a forecast for the year of £1.2m deficit that was accepted as part of the ICS Control Total position within the regional total of a £16m deficit. Subsequently further funding is being provided through NHSE to meet the shortfall of non NHS income against plan. This will provide the Trust with £0.7m additional income and an adjusted Control Total of £0.5m deficit. There remains the possibility of further income receipts before the end of the financial year however at this point the Trust continues to forecast a deficit both in year and on a recurrent basis when the non-recurrent income and exceptional expenditure is removed.

2.12. To support the achievement of the financial control total this year requires a continuing focus on:

- Continuing to ensure the key controls on pay including efficient rostering are applied consistently
- Managing out of area beds back towards budgeted levels
- Managing down Covid-19 related costs where no longer necessary
- Renewed focus on the Delivering Value Programme including for Support Services, in particular working up schemes for 2021/22
- Review of discretionary expenditure.

Workforce

Insufficient Workforce

2.13. Recruitment and retention continue to be a challenge and are reported in the workforce paper. Of note are the mass recruitment campaigns that are underway. Also work is concentrating on recruitment to the 116 healthcare support worker vacancies with the aim of being at zero by the end of March 2021. The Trust is also exploring an international recruitment programme for registered nurses with support from NHSE/I.

Staff wellbeing

2.14. The Trust has had a full comprehensive well-being plan but despite the mitigation there are many elements of the pandemic that impact on wellbeing and morale for which there is little control. This risk score has therefore increased.

External landscape

2.15. The mental health investment standards and Long Term Plan commitment remains and planning guidance is expected in early / mid-March.

2.16. The development/collation of an ICS MH & LD strategic response to Covid Pandemic commissioned report is due back early May.

2.17. The Herts MH & LD ICP Partnership Board is firmly established, developing well with a strong partnership in place, priorities identified and being implemented with focus on Community and Primary Care Network.

2.18. EOE Provider Collaborative continues to develop with go live date July 2021 reflecting the impact of the pandemic. Business case being finalised with underpinning activity and financial modelling. Negotiations with NHSE/I re financial settlement ongoing.

2.19. The Trust responded to the consultation on the resulting white paper Integration and innovation: working together to improve health and social care for all', published February 2021 which describes the way the ICS will develop, the impact for HPFT is being considered.

Operational

2.20. The operational risk relates to the future provision of SRS. There is a programme of work being undertaken around the future provision of SRS, led by the Trust with the Steering Group being led by commissioners. The first stage of co-production was completed in December; a further round is due to take place ahead of a formal consultation. It is not expected there will be any significant change in service provision for a further 12-24 months.

2.21. Current vacancies for SRS are 32% vacancies for unregistered staff and 40% for registered. On-going recruitment efforts have not been successful and the service is seeing a significant increase in use of bank staff.

2.22. Some immediate, low risk actions are being taken to reduce costs, which will reduce potential in-year shortfall to £300k in 2020/21 and £509k in 2021/22 involving revised staffing, subject to safer staffing levels being confirmed. However, more significant action will be required to stay within the financial envelop. These options are being considered however, SRS is currently expected to deliver a £1m shortfall in 2020/21 due mainly to loss of income due to COVID related rules and changes around overhead calculations. The Director of Finance is currently supporting resolution in these areas.

2.23. The Service has managed well over the COVID period but this has led to some delays in the development of the frailty pathway work. However some progress has been made with multi factorial falls assessments and prescription of VitD. Sadly, three service users have passed away unexpectedly in SRS in recent months (June – August 2020)

EU Exit

2.24. The risk associated with the EU exit (1319) has diminished and therefore the score will be lowered but the risk will remain on the register at present. This lowering of risk is to there not having been a 'no deal' outcome of the EU negotiations.' The European Union (EU) and

the United Kingdom (UK) have agreed a Trade and Cooperation Agreement which took effect from 1 January 2021.

2.25. The Trade agreement reached with EU has significantly reduced the impact to the Trust, particularly around supply chain, finance and data flow risks. However as the impact of the changes for EU national workforce will not come into effect until 1st July 2021, workforce related risks to the Trust and other independent providers in the care delivery remain unchanged. The overall impact of the risk has therefore been reduced to reflect the mitigations provided by the trade agreement.

2.26. The Trust will continue to monitor the impact of the new Agreement and end of the transition period, escalating any risks or issues.

Information Management and Technology

2.27. A deep dive into cybersecurity was presented and discussed at the Audit Committee's December 2020 meeting. Two externally facilitated workshops have been completed in January 2021, which resulted in a more granular vulnerability and risk assessment and an associated action plan. These will be managed at departmental level, but will be used to inform the Trust level overall risk.

2.28. Further mitigation and assurance actions planned in Q4 include:

- New Cyber Risk Management Framework
- Gartner IT Score for Security and Risk Management
- Start implementing Single Sign On
- Penetration Testing
- Cyber Essentials Plus Assessment
- Start migration to N365
- Network Operations Centre
- Targeted phishing campaign with training (unannounced)

3. New Risk

3.1. Following discussion by the Executive Team, it has been agreed that a new risk will be added to the Trust risk register. This is in relation to CAMHS's ability to meet demands. This has been evident due to the number of service users in out of area beds and an increase in demand in the CAMHS Eating Disorder Service. The capacity of the service to meet the demand is not aligned. This risk along with mitigation and actions being taken will be developed and the Senior Responsible Officer is The Executive Director for Service Delivery and Experience.

4. Conclusion

5.1 This summary has given an overview of the Trust Risk Register, which is detailed below this overview. The current position, mitigations and work to add a new risk has been considered.

Summary Trust Risk Register by Exec Lead and linked to Trust Strategic Objectives

	Opened	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Key Mitigations	Executive Lead
1	17.02.20	1253	**Quality and Safety:** The Trust may not be able to sustain core operational services and maintain service user and staff safety during the continued COVID19 outbreak	25 (5x5)	20 (Likely 4 x Catastrophic 5)	5 (1x5)	We will provide safe services, so that people feel safe and are protected from avoidable harm	Winter plan in place. IPC procedures in place. Staff COVID risk assessments undertaken. Appropriate PPE and supply in place. Safe staffing levels reviewed and monitored daily. Current arrangements re COVID costs extended to June 2021 Lateral flow home testing has been launched for all service user-facing staff and non-service user facing as required. Staff vaccination almost completed – 1st dose	Dr Jane Padmore (Executive Director of Quality and Safety (Chief Nurse))
6	08.10.20	1321	**Workforce:** The Trust is unable to maintain staff wellbeing and staff morale during the pressures of COVID19, with increased demand now and during the recovery phase.	12 (4x3)	16 (Likely 4 x Major 4)	6 (2x3)	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	Wellbeing programme /activities in place Supervision and PDP in place Staff helpline in place Supportive Annual leave process Staff risk assessment/ Occupational health support COVID secure environments including break rooms Flu Vaccination & COVID T&T Implementation of changing facilities	Ann Corbyn (Executive Director of People & Organisational Development)
2	27.12.17	882	**Quality and safety:** S136: Unlawful detention of service users under S136 breaching beyond 24hrs which has legal implications and an impact on service user care, treatment and experience	16 (4x4)	15 (Almost certain 5x Moderate 3)	3 (1x3)	We will provide safe services, so that people feel safe and are protected from avoidable harm	Detention monitoring for each service users Dedicated 136 team in place Dedicated suite Alternative to admission available Street triage active Crisis Team availability at Kingfisher Court Protocol for escalation of service users detained under Section 136 Interagency S136 meetings	Sandra Brookes (Executive Director Service Delivery & Service User Experience)
3	09.08.19	1147	**Quality and safety:** The Trust may not be able to sustain service user safety due to risks of COVID, flu outbreak and other winter pressures	12 (3x4)	15 (Possible 3 x Catastrophic 5)	4 (1x4)	We will provide safe services, so that people feel safe and are protected from avoidable harm	Trajectories in place for mandatory training compliance IPC Guidance , PPE available Stratified MH & COVID risk assessments for service users	Dr Asif Zia, (Executive Director of Quality and Medical

								Flu vaccination Physical health checks Advanced care plans	Leadership)
4	16.10.18	1001	**Finance:** The Trust may not have sufficient resources to ensure long term financial sustainability	12 (3x4)	12 (Likely 4 x 3 Moderate)	6 (2x3)	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	Secure a fair share of the ICS revenue allocations including Income allocated to MH Investment standard and LTP. Effective grip on resource use with appropriate cost controls Robust Delivering Value programme Effective Service Transformation programme Effective use of capital spending Supporting innovation	Paul Ronald (Director Operational Finance)
5	08.10.20	1320	**Workforce:** Insufficient workforce to meet predicted increased demand and deliver commitments in Long Term Plan	12 (4x3)	12 (Likely 4 x Moderate 3)	6 (2x3)	We will attract, retain and develop people with the right skills and values to deliver consistently great care, support and treatment	Recruitment process underway, Redeployment and Training programme in place Robust Bank process Vacancy management system Student placements and recruitment process	Ann Corbyn (Executive Director of People & Organisational Development)
6	02.02.19	749	**External landscape:** The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health and learning disability services provided by HPFT	20 (4x5)	12 (Possible 3 x Major 4)	8 (2x4)	We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	Active Engagement across the system Inc. ICS & Geographical ICP and partner organisations Robust Stakeholder & Communications plan & Narrative Development of MH ICP Positive Relationship with Regional office and other regulators Focus on MH Investment Standard and LTP plan requirements	Karen Taylor (Executive Director of Strategy & Integration)
7	14.10.20	1323	**Operational:** Risk that the sustainability of SRS becomes unviable following the reduction and changing needs of service users leading to an impact on quality and finance.	16 (4x4)	12 (Possible 3 x Major 4)	4 (1x4)	We will improve the health of our service users through the delivery of effective, evidence based practice	Programme of work on future shape of service provision Establishment of options for service reconfiguration Commissioner financial support to end March 2021 Support from older peoples services to implement frailty pathway approach	Sandra Brookes (Executive Director Service Delivery & Service User Experience)
8	10.07.20	1301	**Finance:** The Trust is unable to ensure short term financial performance in current financial year	9 (3x3)	10 (Almost Certain 5 x Minor 2)	2 (1x2)	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	Effective grip on resource use with appropriate cost controls Robust Delivering Value programme Management of Out of Area placements Commissioner relationships and dialogue	Paul Ronald (Director Operational Finance)
9	07.10.20	1319	**EU Exit:** Implications for the Trust of	12	8	4	All strategic objectives	Internal EU Exit cell within incident	Keith Loveman

			unforeseen consequences arising from the end of the EU exit transition period on the 31 December 2020 at which point the UK and EU's relationship will be governed by what is agreed in the future relationship agreement	(3x4)	(Unlikely 2 x Major 4)	(1x4)		command structure Monitoring and implementing guidance from NHSEI Encourage non-British EU staff to apply for settled status Revisit the DHSC developed mandatory Self-Assessment Reviewed contracts that may be impacted by a 'no deal' EU exit. Reviewed information flow to re-assess potential risk Action plan for identification and implementation of contingencies arising New trade agreement with EU that reduces the impact on supply chain, finance and data flow related risks	(Deputy CEO/Executive Director Finance)
10	30.01.17	747	**Information Management and Technology** : Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability	12 (3x4)	8 (Unlikely 2 x Major 4)	4 (1x4)	We will improve, innovate and transform our services to provide the most effective, productive and high quality care	IT security policy in place (Inc. devices , Internet , emails) Training /development & communications for staff Programme of penetration testing Robust infrastructure and mirrored data centres Support arrangements for software and security patches applied Data Protection Impact Assessments current New Cyber Risk Management framework	Keith Loveman (Deputy CEO/Executive Director Finance)

Hertfordshire Partnership University NHS Foundation Trust

Trust Risk Register
February / March 2021

To be reviewed by:

Integrated Governance Committee

Trust Board

Audit Committee

Appendix 2: Risk Bubble Matrix

ID	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Dr Jane Padmore **Last Review Date** 01.03.2021 (via Tactical Command) **Current Position:**
1253	The Trust may not be able to sustain core operational services and maintain service user and staff safety during the continued COVID19 outbreak	There is a significant risk that the Trust is unable to sustain operational services and maintain service user and staff safety during the COVID19 outbreak, combined with winter pressures, following the outbreak being declared a Public Health Emergency of International Concern on the 30th January 2020 by the World Health Organisation (WHO). The risk specifically covers: - Service user and staff death - Unable to sustain core services - Unable to sustain safe staffing and the wellbeing of staff - Unable to meet the legal and	25 (5x5)	Staff have been advised to follow the Public Health England guidance regarding the risks associated with the virus. Public Health England posters have been sent out to display in the entrance to HPFT locations. PPE supply and distribution process in place. Incident Command implemented in line with Business Continuity Plan to manage and oversee the Trusts preparedness and incident management. Emergency/Contingency plan in place. Detailed winter plan in place. Environments Covid Secure and IPC procedures in place Staff risk assessments, appropriate PPE , enhanced technology Safe staffing levels	20 (4 x 5)	5 (1x5)	Increase in UK confirmed cases of COVID19 and deaths attributed to COVID19 Increase in confirmed cases of COVID19 within Hertfordshire, Buckinghamshire, Essex and Norfolk. Increase in staff self-isolating at home if they have a high temperature, a new continuous cough or less of sense of taste/smell. Increase in demand arising from impact of winter season.	<u>Unable to maintain and work within the financial envelope</u> • Contingency of £700k within provisions. • Cash is being paid regularly for block contracts (90% plus of Trust income) based on Month 9 19/20 Agreement of Balances exercise. This should ensure the Trust has most of its expected income. • Although c. 90% of expected income will be received, this does represent a shortfall, and where new or expanded services were expecting funding from April, this has not all been forthcoming. Focus is needed to maintain financial control, particularly around recruitment, to ensure only funded posts are recruited to and any issues are flagged promptly. • There is a twice weekly KPI report on various finance indicators including COVID spend. • All costs for COVID19 are being collected, with a dedicated senior person responsible for this, guidance to be issued to budget holders, and dedicated cost centre and account code to make tracking easier. Assurance has been given that all costs will be reimbursed. • The current assessment based upon the changes to the financial arrangements and assuming that the Trust secures through the ICS the full COVID reimbursement amount is that income will be slightly higher in the second half of the year compared to the first half. This additional revenue can support the Trust for the remainder of the year in addressing the current cost pressures but clearly there is an ongoing risk of further cost escalation during this period and given the cap on COVID cost reimbursement this remains a significant risk. • The Trust has now been informed that the contractual process is again suspended from April for at least Quarter 1 2021/22. At moment this has been substituted with temporary arrangements which see a payment based upon 19/20 contract values which is then topped up based upon current spend to cover existing costs. Details of the proposed further changes in the financial structure are not expected until May/June 2021. • Current arrangements re COVID costs extended to June 2021. • This links into the Trust finance risks on the Trust Risk Register.

		regulatory requirements - Unable to maintain and work within the financial envelope - Unable to provide the equipment required		reviewed & monitored daily				<u>Reduced provision of face to face mandatory training and the impact on staff compliance and consequently staff and service user safety</u> • Trajectories of each face to face training course have been scoped which are based upon the current non-compliance of our substantive staff and the planned training courses which are taking place now and throughout the new 2021/2022 financial year. The trajectories also take into account the need to train our bank staff and offer spaces to these staff as well as new starters joining the Trust and a level of DNA's which we experience frequently. Basic Life Support (BLS) and Intermediate Life Support (ILS) • Commissioning of BLS and ILS training has taken place for the new financial training cycle year and we have taken into consideration the amount of staff who are non-compliant to ensure we run as much training as possible in order to support our recovery plan. We have prioritised our internal SME's as well as our Train the Trainers to ensure they cover the majority of dates and any other dates where we have no availability we have offered these to our external training provider (Middlesex University). The commissioning of training is across all SBU's and counties. Moving and Handling (Hoist) • A Moving & Handling Recovery and Implementation paper went to Tactical Command in February 2021 and was presented by the Head of Learning & Development. Strategic command has asked for a hybrid approach to help contain the costs and be more sustainable. The Head of Learning & Development is working with the SME for Moving & Handling to look into the option of recruiting fixed term trainers (12-18 months) or a train the trainer model but in the meantime deliver via external trainers for first couple of months. The Head of Learning & Development has met with the Moving & Handling SME's to take this forward and we are looking to set up a Train the trainer course imminently and have a few names already put forward with another 4-5 spaces to be put to the SBU's for support. RESPECT Recovery Phase • Module 4 / 5 full RESPECT Training courses taking place. • Job Description has been approved (based on 1 small change) which has been sent to the Practice Development and Patient Safety Lead for approval. • A meeting was held with the train the trainers and they agreed

								they would be released for 15-20 days a year to provide Respect Training. In order for all the train the trainers to be competent to carry out Module 3b and Module 4 courses they have been offered dates over the coming weeks and months to shadow the 1 full time trainer to gain the competence and to be signed off to deliver independently which will increase training capacity. All of the train the trainers have come back with dates they will shadow to improve their knowledge and experience in order to provide the training autonomously. <u>Service user and staff COVID19 related deaths as a result of Trust actions and/or failure to act</u> • A Clinical Professional Advisory Committee (CPAC) has been established to review advice and update clinical guidelines during the pandemic to ensure service user and staff safety. • The Trust has commenced re-fit testing staff on the basis that the current FFP3 masks expire March 2021 or they will have gone out of stock. Absolute RPE Solutions Ltd have been awarded the tender externally and FFP3 fit testing by internal and external fit testers has commenced as of Monday 4th January 2021 with a schedule in place. • Handover script on LFT's and PPE to be used on all inpatient wards as a reminder of the protocols in place. • LFT Home testing kit Trust wide email reminders for staff to take the tests and submit results. • Only 52% off staff are compliant with recording a test result twice in the last 7 days using Lateral Flow Tests (LFT's) with some inpatient wards with low compliance. Exception reports are being sent to all managers, prioritising inpatient areas with trajectories for uptake. Conversations are also being raised with staff before shifts to ensure lateral flow tests have been complete prior to coming to work a shift on the wards. A letter has been to be sent to all staff on the importance and responsibility for undertaking and recording the LFT tests and results. • As of 23.02.2021 there were 8 outbreaks. • Full guidance on staying at home and social distancing has been provided by the Trust following national guidance. Including those staff with high risk underlying health conditions. This message has been reinforced following the 3rd national lockdown. • The New National Lockdown Stay At Home guidance does not state a blanket ban on visiting. CPAC have advised Tactical that a blanket ban is not feasible, Tactical to establish how we can

								make visiting feasible in terms of equipment i.e., screens, pods, windows and clear guidance to staff around risk assessing. • The CPAC committee support the temporary pause of community face to face groups in favour of remote option. However, if there is an acute risk of deterioration of their mental health which may result in an inpatient admission, group face to face therapy may be considered. • CPAC agree that the option of face to face contact should always be available. The RAG rating system should still be used when considering face to face appointments. CPAC have agreed we should continue to use the face to face guidance we currently have, some aspects of the guidance can be looked at and reviewed going forward. • The Trust has implemented testing of all service users on admission to inpatient services and 72 hours prior to discharge. On admission servicers are asked to self-isolate in en-suite bedrooms prior to knowing the test results. Most service users adhere to this request with a small minority refusing and presenting with behaviours that challenge. • Each SBU has developed cohorting and isolation plans around what to do when they admit patients with known or unknown COVID status taking into account capacity and compliance to adhere to self-isolation. • COVID19 situation reports - This enables Tactical and subsequently Operational Commands to monitor the high risk locations specifically in relation to COVID19 confirmed cases to put in place any mitigating action to prevent future COVID19 transmission. • Service user deaths continue to increase, as of 23.02.2021 the Trust has reported 181, an increase of 13 since v46 of the COVID risk register (10.02.2021). Service user deaths are those either confirmed or suspected COVID-19. Of these 33 deaths are from inpatient services, there has been no increase in inpatient deaths since 24th January 2021 • At the beginning of the COVID-19 pandemic all the teams were asked to RAG rate their service users to enable the allocation of care and treatment based on vulnerabilities, risk and need. This was recorded in the service user risk assessments and individual team spreadsheets. The Trust has now created a COVID Rag Rating Case Note on PARIS which enables staff to record the RAG Rating in a specific case note. The service users RAG rating will then show on their front page on PARIS. This will also enable the RAG rating for teams to be viewed on SPIKE2 to enable monitoring and to prioritise resources. RAG ratings continue to

								be reviewed. • The Trust needs to ensure it reduces the potential risk of transmission between members of staff. In consideration of the new government guidelines the Trust has revised restrictions and following a recent issue of revised IPC guidance, the Trust has made the decision that with effect from Thursday 23 September 2020 all staff must wear a facemask (fluid repellent, not just a face covering) at all times whilst on Trust premises. This extended use of facemasks is for all staff (both clinical and non-clinical) and includes staff only areas. Clear guidance has also been issued on staff eating and drinking. • COVID Early Response Team (CERT) is now operational from Monday to Friday 9 – 5. CERT are available to provide virtual physical health advice and support to staff caring for service users with COVID-19. Care of service user with COVID-19 teaching can be arranged over MS Teams with supporting resources available on The Hive. • GP's are starting to commence vaccination of service users in older people inpatient units. • COVID vaccinations for service users has commenced. • Guidance for staff on the South Africa variant of COVID19 has been communicated for those staff in the EN10 postcode area in Broxbourne. <u>Increased harm or death of service users due to mental health related illness</u> • Review of self-harm incidents categorised as moderate or severe harm on Datix by quarter completed, data suggests no discernible increase. <u>The Trust is unable to manage subsequent COVID19 Waves</u> • The Trust now has well established processes. • The Trust has refreshed the COVID Incident Command Framework and principles and has continued to flex arrangements including going to 7 day working 08:00-20:00 from 5th November 2020. • Tactical Command support function has been supplemented with additional staff/bank staff to cover 7 day working. • Tactical Command structure has been supplemented with additional commanders. • Tactical command is covered by the same commander Monday to Thursday and Friday to Sunday to ensure consistency of information and action follow up this is working well. • Communications with key stakeholders service users and carers

								is to be intensified during the surge phase.
								• CPAC continue to meet weekly with additional meetings as necessary.
								• New internal sitrep now live, this incorporates:
								  ○ Suspected cases staff and service users.
								  ○ Confirmed cases staff and service users.
								  ○ COVID workforce data; staff working from home due to isolation / not working.
								  ○ Staff absence data; annual leave or sickness non COVID.
								• Continued twice weekly asymptomatic LFT testing for frontline /patient facing staff.
								• Covid19 Early Response team model including physical health outreach support has gone live in December 2020.
								• From week commencing 14th December 2020 an enhanced IPC Taskforce is being mobilised to support management and oversight and learning from Outbreaks. Operational Outbreak, IIMARCH and Outbreak and Cluster Control meetings are being held.
								• All staff vaccination almost complete.
								
								<u>Unable to maintain core services</u>
								
								Acute Inpatient Services
								• Due to the number of outbreaks on acute inpatient wards cohorting is taking place but proving challenging. Admissions have been reduced and are only taking place on a risk based approach and following senior approval and sign off. Any required admissions to a COVID19 outbreak ward will be in line with Public Health England Guidelines and Infection Prevention and Control Guidelines and reported at the Outbreak meetings.
								• An example of the cohorting process is that the x2 service users positive on Robin have been transferred to existing cohorting on Albany Lodge to enable new admissions to Robin Ward.
								
								Adult Mental Health Community Services (West SBU)
								• Potential for a small number of Initial Assessments (IAs) breaching in West Adult Community, oversight of these IA's in place and bookings are being prioritised.
								• Winter Pressure funding being spent on FACT function to support community teams.
								
								Older People Inpatient Services
								• Outbreak units have closed to admissions, although

								consideration would be given to admitting COVID positive patients to these wards. Cohorting plans are in place where necessary. Staffing support has been requested and received from Older People Community Teams. • Seward Lodge is currently empty with remaining service users transferred to other units) and staffing redeployed, Seward Lodge remains available if required. • Outbreak on Wren Ward impacting ability to admit, mitigation in place avoid admissions or to use private beds if required. • Any decisions to admit to outbreak wards follow the risk assessment process via Strategic Command. Older People Community • EMDASS in Business Continuity Plan to be able to provide support for the community crisis function and older people inpatients (7 qualified staff supporting inpatients), the service will continue in a reduced capacity. • Currently EMDASS not breaching targets, but potential for knock on effect. • Final staff member from EMDASS redeployed to inpatients is expected to return next week. Adult Mental Health Community Services (East and North SBU) • Some slippage with IA's (now recovered), with North Herts and Stevenage Adult Community Teams supporting each other. Similar reciprocal arrangement between Oxford House and Cygnet House. • Greater risk is the impact of the reduction of face to face appointments as potential service users risks might be difficult to identify through remote consultations. • Support being provided to SPA with adult (and CAMHS) initial triaging. • Additional work commitments asked of the community teams – reviewing new group of shielding service users and reviewing their RAG ratings. • Continue to provide a higher level of service to service users who under pre COVID conditions wouldn't normally receive this level of service. • Community teams likely to become involved in mop up exercise / support for vaccinating service users with Severe Mental Illness (SMI). Forest House Adolescent Unit • Risk remains the same - Demand remains high and bed

								reduction due to challenging service user. CAMHS Eating Disorder Service • Risk remains the same - The CAMHS Eating Disorder Service has commenced a waiting list system for new referrals to manage the excessive referral rate. This involves regular team members working additional shifts to assess new referrals and commence treatment. An agency nurse has been running a weekly assessment review clinic where young people and their families are medically and psychologically reviewed on a weekly basis. Feedback on these service users is given in the team meeting each week. As soon as there is capacity in the team for someone to move into full treatment then priority is given to the most urgent referrals. CCG have been informed of this service change. <u>Deterioration in core performance</u> Weekly performance KPI report control measure (w/c 15.02.2021) • CAMHS P1 7 day waited (Face to Face, Telephone and Virtual Assessments) – 50%, Red (Target 75%). This represents 1 case. • LD&F 28 days waited (Face to Face, Telephone and Virtual Assessments) – 90%, Red (Target 98%). This represented 1 case. • Risk Assessment completion rate at 92%, Amber (Target 95%) • West SBU Physical Health Checks SMI – 62%, Amber (Target 65%) • First Episode Psychosis Physical Health Checks – 58%, Red (Target 90%) • The proportion of those on Care Programme Approach for at least 12 months who have had a CPA review within the last 12 months – 86%, Red (Target 95%) • SPA 5 day waited performance is below expected target at 64%, Red (Target 95%) • SPA 14 day waited performance is below expected target at 86%, Red (Target 95%) • SPA 5 day waited performance (CAMHS only) is below expected target at 33%, Red (Target 95%) • People entering IAPT / Wellbeing services remains below target in Mid Essex, NE Essex and Herts Valleys. <u>Unable to sustain safe staffing during COVID19</u> • Close monitoring of planned staffing levels across the trust is enabling prioritisation and the redeployment of staff from other inpatient units to support. Generally services with an outbreak are having staffing challenges with support requested from

								other units or services. • Safer Care calls taking place 3 times a day, before each shift. • Staffing levels are discussed at each morning SBU Command meeting. • Safer Care reports to Tactical. Adult Acute Inpatients Staffing • Wider MDT team are supporting Adult Acute inpatient units where necessary. • Staff are being asked to undertake shifts on bank during their annual leave. • Approval to use agency staff has been agreed as an interim. • West SBU Command have confirmed that the situation around staffing is much improved. Adult Community Mental Health Teams • The staff situation is challenging with the Borehamwood Adult Community Team with the loss of a band 5, 6 and a part time agency band 5, the team is also down a band 6 social worker. The team leader is shielding. There is some very limited support from Watford and a new clinical nurse specialist has started, some internal cover is being planned for the band 5 post. • Dacorum staffing situation remains fragile, the situation is monitored daily with enough staff to cover day to day operations. Older People Inpatient Units • Staffing challenges remain but less reliance on community staff support. Staff have been redeployed from Seward Lodge to other units. Learning Disability Inpatients • Dove Ward continues to be impacted by staffing shortages, however the situation continues to improve with the majority of community staff who were supporting staffing on the ward being released back to their community teams, the teams is still reliant on bank and agency staff. The level of staff absence due to COVID19 as of 23.02.2021 is as follows: • 26 staff working from home due to self-isolation (continued reduction) • Staff not working due to COVID19 (small reduction) • Shielding has been reinstated for clinically extremely vulnerable (CEV) people. Managers have been asked to urgently review

								staff risk assessments, prioritising those in the purple and red categories to ensure that staff are kept safe. 85 staff are currently shielding (65 working from home, 20 not working). Slight increase in shielding staff. <u>Unable to maintain the wellbeing of staff during COVID19</u> • Executive Briefing Sessions continue to provide direct updates to staff. • Staff Resilience Hub 'Here for You' has been launched and will take over from the Staff Support Line expected 1st March 2021. • Supporting you bulletins setting out EAP, OH plus Trust and national wellbeing resources continue. • Introduced lateral flow home testing kits for all service user facing and non-service user facing staff in line with national guidance. • 84% (3,538) of staff have been vaccinated with their first dose. The Trust is reporting this information on SPIKE and via the National Immunisation Vaccination System (NIVS). • Launched Virtual Staff Wellbeing Spaces on a fortnightly basis for all staff to drop in to. • Shielding has been reinstated for clinically extremely vulnerable (CEV) people. Managers have been asked to urgently review staff risk assessments, prioritising those in the purple and red categories to ensure that staff are kept safe. All managers and staff are automatically notified via SPIKE when a staff COVID risk assessment is due for review. • Staff COVID risk assessment - Overall only 74% of these risk assessments are in date. • 83% (3,545) of staff have been vaccinated with their first dose. • Colonnades Vaccination Clinic – now completed • The Trust has asked all SBU's to ensure that their senior managers have a plan for their staff taking annual leave to ensure staff rest and recuperate as much as possible. At this point in the year it would be expected that the majority of staff to have taken 75% of their annual leave, with the remaining 25% to be used by the end of March. This annual leave trajectory is being monitored and disseminated through tactical command. <u>Unable to sustain the necessary support across the range of Trust infrastructure</u> • All three VPN lines has been upgraded to 5GB • Tablets ordered (awaiting delivery) to assist Acute inpatient units will recording LFT results. • Positive Pressure Rooms work completed on Beech, Oak and

								Forest House. • Installation of screens around identified reception desks has been completed. • Six teams were in place covering COVID19 cleaning requests. These had been stood down. This is again operational due to high levels of Covid cleaning demand. • Maintenance levels have returned to normal, working through small backlog with sub-contractors however non-essential maintenance works suspended in Covid Outbreak Areas • Daily Interserve sitreps provided and discussed at Tactical • 9 temporary staff changing facilities have been delivered and are now operational. Unable to meet the legal and regulatory requirements • The last MHA CQC remote inspection was Robin Ward CQC MHA remote inspection completed w/c 25.01.2021. • Updated guidance in relation to Patient Leave including S17 Leave (MHA) during COVID-19 outbreak continues to be updated as government advice in respect of lockdown conditions change. • From 1 December 2020 the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 governing the completion and furnishing of statutory forms under part 2 of the MHA (including forms needed for detention in hospital, treatment, guardianship and CTOs) was amended allowing for these forms to be completed and served electronically. The new process is being implemented but is proving challenging rolling this out during the current COVID19 pressures. At present the MHA team are operating both the old and new processes. • There has now been a judgement issued in the case between Devon Partnership NHS Trust and the Secretary of State for Health and Social Care on the use of remote or video assessments as an alternative to face to face assessments under the Mental Health Act. The Court has ruled that "personally seen" must mean in person, as a result no further remote or video assessments for detention under the Mental Health Act are to be undertaken. Directorate Manager (Mental Health Legislation) has confirmed HPFT had not undertaken virtual Mental Health Act Assessments. As a precaution the MHL Dept are reviewing all mental health act section transfers from other Trusts to HPFT to ensure we are not holding anyone illegally, all CTOs and renewals are being reviewed to ascertain if any of these were done remotely . No virtual renewals/extensions or revocations should take place with immediate effect.

								Inability to provide essential clinical equipment • The Trust has commenced re-fit testing staff on the basis that the current FFP3 masks expire March 2021 or they will have gone out of stock. Absolute RPE Solutions Ltd have been awarded the tender externally and FFP3 fit testing by internal and external fit testers has commenced as of Monday 4th January 2021 with a schedule in place. • Generally there is a good steady supply of items but where necessary we are able to ask for Mutual aid or utilise the NSDR to achieve the required levels. The aim is for all trusts to always have 14 days of stock that will be continually replenished as stock is consumed. • We have a stock check for all teams. The minimum level of PPE stock has been adjusted to cover 10 working days. • PPE Push Stock will now continue in some form until at least June 2021. • Handover script on LFT's and PPE to be used on all inpatient wards as a reminder of the protocols in place. • LFT stock delivery received (4,000 LFT's) and distributed to staff.

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Ann Corbyn **Last Review Date** 02.02.2021 **Current Position:**
1321	The Trust is unable to maintain staff wellbeing and staff morale during the pressures of COVID19, with increased demand now and during the recovery phase.	There is a risk that a higher number of existing staff choose to exit the organisation due to high workloads, working requirements and experience and a perceived lack of career pathways leading to increased and unplanned vacancies and a drain of knowledge and experience from the organisation. The Trust is unable to support and protect the well-being of its staff - Impact of COVID on staff - Anxiety about COVID on staff	12 (4x3)	Trust Values Appraisal / PDP Staff Inspire Awards Annual HPFT 'Stars' Staff Awards Big Listen events Tom's Q&A sessions Supporting You Bulletin Staff Network Groups HAW Strategy Inclusion Strategy	16 (4x4)	6 (2x3)	High turnover rates Negative NHS Staff Survey Results Negative Staff PULSE Survey results WDES / WRES indicate difference in experience according to protected characteristic	Resource is in place to support and develop all staff with the ability to hold confident and facilitated conversations. This is an important part of the development of the just and learning culture and will provide managers with the tools to address issues at a local level, an area of concern that was identified during the review of the disciplinary process, this will now be reviewed against the requirements of the organisation's recovery progresses. Staff Support • COVID19 Workforce Wellbeing Strategy details the support we are offering to both teams and individuals. • Our COVID19 Staff Support offer remains in place to staff within HPFT and colleagues across the Herts system from 0900 to 1700 telephone service supported by HPFT clinical staff. The ability of staff to cover the service has reduced owing to staff prioritising BAU work. • Executive Briefing Sessions continue to provide direct updates to staff. • We are launching a staff hardship fund to provide emergency financial relief to any staff in need. • Staff Resilience Hub 'Here for You' has been launched and will take over from the Staff Support Line. • Winter Wellbeing Programme February 2021 launched • Increasing staff designated eating and drinking areas – this work is being combined with the wobble/staff wellbeing rooms and being led by Services Manager – Soft FM and Health and Wellbeing Manager. • Supporting you bulletins setting out EAP, OH plus Trust and national wellbeing resources continue. Clinically Extremely Vulnerable People, Shielding and Self-Isolation • In the first wave of the pandemic, 112 staff had shielding letters, once shielding ceased guidance on staff ceasing shielding was produced and coffee mornings with shielded staff took place in each SBU to ensure staff were supported, concerns addressed and anxiety levels are reduced. A video to support shielded staff was also shared. Working arrangements were being based on their individual risk assessment. • Shielding has been reinstated for clinically extremely vulnerable

								(CEV) people. BAME • The BAME staff network is flourishing with virtual meetings taking place frequently, to enable staff to share experiences and concerns and ensure support is put in place. • The BAME staff support line is available 24 hours a day, 7 days a week and the rota is managed by the BAME staff network and all the operators on the rota are part of the BAME staff network. Individual Risk Assessment • The Trust developed an individual risk assessment to help understand staffs individual needs so that the Trust could support staff and keep staff safe at work. The Trust prioritised those with risk factors (including BAME staff) for completion. 100% completion achieved and managers and staff are now reviewing the risk assessments regularly directly on SPIKE2 therefore removing the reliance on paper processes and creating a shortened process with less steps. Any risk assessments which have resulted in an outcome of purple, amber and red need to be reviewed on a monthly basis and any risk assessments in blue and green need to be reviewed every 3 months. • Managers have been asked to urgently review staff risk assessments, prioritising those in the purple and red categories to ensure that staff are kept safe. All managers and staff are automatically notified via SPIKE when a staff COVID risk assessment is due for review. Swab Testing / Vaccination • Introduced lateral flow home testing kits for all service user facing and non-service user facing staff in line with national guidance. • Colonnades Vaccination Clinic – the final clinic for first doses was held in February. • 84% (3,538) of staff have been vaccinated with their first dose. The Trust is reporting this information on SPIKE and via the National Immunisation Vaccination System (NIVS). Annual Leave • The Trust has asked all SBUs to ensure that their senior managers have a plan for their staff taking annual leave to ensure staff rest and recuperate as much as possible.

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Sandra Brookes **Last Review Date** 04.02.2021 **Current Position:**
882	S136: Unlawful detention of service users under S136 breaching beyond 24hrs which has legal implications and an impact on service user care, treatment and experience	From December 2017, changes to Section 136 of the Mental Health Act came into force as a result of the Police and Crime Act, for Section 136 detentions to last no longer than 24 hours (unless there are circumstances that warrant an extension of up to 12 hours). The risk, therefore, is in relation to availability of a bed to admit someone into, should this be the outcome of the S136 assessment; or the lack of availability of clinicians to carry out triage and assessment in a timely way i.e. discharge from S136 within 24 hours which results in the unlawful deprivation of liberty for which the legal proceedings could	16 (4x4)	Availability of Street Triage for Police to consult regarding anyone over 16. Dedicated Section 136 team to monitor progress against 24 hour timeframe and co-ordinate assessing clinicians. Between 9 – 5, Monday to Friday, AMHP Service prioritise Section 136 assessments in order to meet timescales. Presence of CATT staff in Kingfisher Court overnight, increasing availability for assessment. Interagency meetings and governance arrangements in place to monitor implementation of the Police and Crime Act changes to Section 136, reporting to Hertfordshire's	15 (5x3)	3 (1x3)	Lack of Street Triage involvement in Police decision to detain. Use of Section 136 by Police to manage risk as a result of intoxication, rather than use of public order offence or return to home. Lack of availability of AMHP's out of hours to undertake assessment. Lack of availability of S12 approved Dr's to support AMHP if detention necessary. Numbers of people discharged from Section 136 with no evidence of mental disorder or no further action required either continues at current rate or increases. Lack of bed capacity in HPFT.	S136 admissions continue to cluster together, demand is difficult to anticipate and manage. Longer lengths of stay in acute pathway impacting on bed availability delaying S136 admissions. S136 impacted in the short term of around 6 weeks whilst dedicated CAMHS S136 was being used as a permanent room for a service user. Hertfordshire Mental Health Crisis Care Concordat being reenergised. Interagency meeting continue to work to reduce S136 detentions. Failure of police to liaise with Mental Health professionals prior to S136 admission still having an impact. Street Triage remains funded and access to first response has been offered if needed. Excluding those who are not fit to be assessed (intoxicated), individuals remain in the place of safety(POS) longer than the 24hr period for two main reasons: • Delays in the actual assessment taking place because the necessary staffs (AMHP, Crisis Team or Doctor) are not available. • The service user has been assessed as requiring an inpatient bed and the current bed capacity does not allow this to take place. Each Section 136 breach is entered as a Datix, reviewed as an incident of potential harm, and learning shared to reduce the likelihood of this happening. Further work is ongoing to ensure that this process is being robustly undertaken. A daily acute demand and capacity call is routinely undertaken, where all Section 136 cases are noted The following actions are anticipated to make further progress in reducing, with the aim of eliminating, the number of unlawful detentions in the Section 136 suite: • Consistency in the recording of unlawful detentions using Datix, and weekly review of these between Matron, Team Leader and Service Line

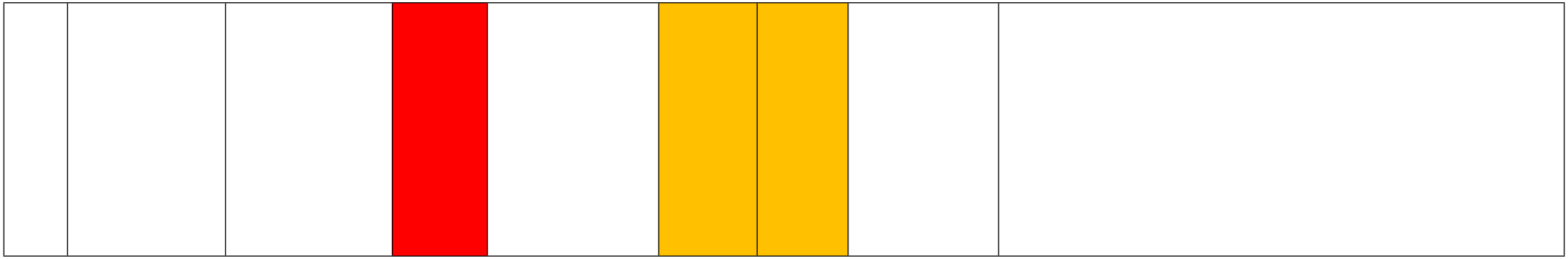
		be brought against the Trust by an individual. The secondary consequence of service users being in S136 for longer that 24hrs is that it impacts the service users care, treatment and experience.		Crisis Care Concordat Group				Lead to agree learning and take forward with the team • Weekly review of data from Section 136 Suite to continue as part of acute oversight meeting and learning of factors that contribute to extended detention, such as unstable housing or frequent crisis presentation • Consistency in the use of the escalation procedure for Section 136 detentions, where there is concern about the likelihood of breaching 24 hours, including out of hours. Draft Escalation Protocol now in place. • Senior Service Line Lead to establish relationship and escalation processes with equivalents in key London Trusts, with the aim of avoiding delays due to disputes • Agree communication, monitoring and escalation processes with key partners for those detained outside of a HPFT Section 136 Suite, in order to ensure that individuals do not breach timescales elsewhere in the system. Protocol for escalation of service users detained under Section 136 of the Mental Health Act 1983 drafted. When individual service users remain in the POS at 6 hours following point of entry the escalation process will commence. Letter before action received 26th June 2020 following the detention of a service user in the S136 suite on Oak ward on 22nd October 2019 for longer than 24hrs. The Trust has admitted that he was detained for over 24 hours but that the delay was because of trying to find an available bed for the service user. The claim is brought under for unlawful detention/imprisonment and under the HRA 1995 (breach of Article 5 ECHR). The Trust has denied false imprisonment and is awaiting a further response from the claimants solicitor.

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Paul Ronald **Last Review Date** 21.02.2021 **Current Position:**
1001	The Trust may not have sufficient resources to ensure long term financial sustainability	Failure to maintain long term financial sustainability specifically: 1) Potential risk to future income levels with change to system allocations directed through the ICS 2. That the allocation of resources to the MH/LD ICP organisations is not sufficient 3)Failure to address underlying demand and/or cost pressures and/or to deliver required efficiency savings 4) Significant unidentified QIPP requirements across the ICS that are allocated across provider oganisations without due evaluation of the individual	12 (3x4)	For 21/22 Q1 temporary national rules in place for health and social care contracts for Q1 rolling over from PY. Relationship management with commissioners and partners to support fair resource allocation based upon detailed analysis of likely demand/capacity and outcomes Regular financial Reports and forecasts are made to the Trust Board, Finance & Investment Committee, Executive Team and Trust Management Group The transformation boards oversight of the transformation program. The implementation of the Trust	12 (4x3)	6 (2x3)	Level of income tariff uplifts and national efficiency requirement proposed in planning guidance. Negotiations with commissioners ICS regarding 21/22 amounts and level of related resource commitments Level of CRES assessment and early view on plans to deliver Level of external bed use and forecast over next period	Hertfordshire - A five year contract with an option to extend for a further two years is in place. Included in the contract are agreements in relation to access target thresholds for CAMHS and Adult services. Additionally, funding meets the Mental Health Investment Standard and allows us to meet the commitments made within the Five Year Forward View for Mental Health. Uncertainty is whether as a result of current response to pandemic there will be changes to existing commitments. NHSE- proposed to implement a regional Provider Collaborative from October 2022 covering CAMHs Forensic and ED services currently provided through NHSE. Work continuing on each work stream to implement the clinical redesign, agree the resource allocations and implement the governance and risk share structures. The Trust has been given an organisational control totals up to 2024, however following the change to a system control total in 20/21 there are signals that this and other further changes to the financial arrangements will be made for future periods which will likely change the financial metrics for individual organisations. At moment this has been substituted with temporary arrangements which see a payment based upon 19/20 contract values which is then topped up based upon current spend to cover existing costs. Details of the proposed further changes in the financial structure are not expected until May/June 2021. The Trust will continue to work actively as part of the ICS to ensure these arrangements provide a fair settlement for MH & LD services. The Trust has set an initial Delivering Value target of £7m and is continuing to develop plans to meet this. The Trust is developing its next 3 year capital plan with a core element being the completion of the OBC and planning application for the investment in a new inpatient unit to provide for the eastern County

		organisations underlying position. 5) availability of capital funding to provide fit for purpose infrastructure to support services and staff		workforce plan to ensure a capable motivated workforce with the required skills and capacity. Regular Placement Panel with cross-SBU coordination of placements pathway Ongoing Delivery Value Program including range of actions to support effective resource use; Model hospital champions promoting the use of benchmarking. Use of CQI to support process review and implementing best practice Corporate service redesign. Three year rolling capital program developed with partners				

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Ann Corbyn **Last Review Date** 02.02.2021 **Current Position:**
1320	Insufficient workforce to meet predicted increased demand and deliver commitments in Long Term Plan	There is a risk that the organisation is not able to recruit and retain the best staff and that timely recruitment to vacancies does not occur leading to increased operational pressures and a reduction in quality of care	12 (4x3)	Long standing number of vacancies and hotspots Increased bank /agency costs Lack of clarity to plan recruitment campaigns Increasing turnover and a falling stability index Increasing Short Term sickness absence Staffing management controls including safer care, e-roster and establishment control Recruitment reporting through the recruitment and retention group is escalated to Exec and Board level. Emerging system, regional and national workforce planning requirements	12 (4x3)	6 (2x3)	Long standing number of vacancies and hotspots Increased bank /agency costs Lack of clarity to plan recruitment campaigns Increasing turnover and a falling stability index Increasing Short Term sickness absence Lack of skills and capability to manage services differently Failure to attract people with the right experience	The WODG has been 'relaunched' as PODG with updated ToRs and revised membership to provide more focus and senior management input to support staffing requirements. A Recruitment, Retention and Reward plan has been developed which addresses the on-going challenges around recruitment and retention and lays out the commitment to our staff, their development and their working lives in HPFT. The recruitment process has continued throughout the pandemic with the impact that the Trust vacancy rate was 12.27% at the end of Q3 against a target of 10.5%. Since Q2, there has been an increase in establishment of 124 wte, which has been matched by a corresponding increase in staff in post. We have also almost doubled the number of active recruitment episodes to ensure the pipeline continues to bring in the level of starters we need, with around 250 candidates at the post offer stage. This model of utilising social media for a focused locality and/or staff group continued to be successful in recruiting to a number of hard to fill posts, against a back drop of no face to face interviews and increased use of video link interviews. The time to hire remains higher than our target of 35 days, however, addition resource is now in place to support managers at key bottle neck points. During Q3 we had 150 new starters and only 96 leavers. This is a net gain of 54 staff. Our stability rate remains around 89% and unplanned turnover at 8.41%. Mass recruitment campaigns are underway. A project plan to address our 116 HCSW vacancies has been enacted, with a trajectory to have achieved zero vacancies by end March 2021. We are also establishing an international recruitment programme for registered nurses. A forward plan is being developed to enhance:- • Workforce planning with forecasting demand Reflecting MH LTP requirements • Talent Management and Succession Planning • Training Needs Analysis

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Karen Taylor **Last Review Date** 01.03.2021 **Current Position:**
749	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health and Learning Disability.	The rapidly changing health and social care landscape nationally and locally creates a potential risk to the sustainability of high quality service provision for people with a mental illness or learning disability due to: • Dilution of a strong mental health and learning disability voice and presence within new models of care and systems or structures that are focused on reducing activity within general acute hospital settings • Increased sharing of risks and financial pressures across the system resulting in shifting of resources away from mental health and learning disability services	20 (4x5)	Active engagement with the system about MH & LD by HPFT leaders; together with leading the development of a Herts MH & LD ICP Regular review of position by the Executive and Board Active monitoring and support by Council of Governors Strong leadership roles for key staff within local ICS On-going regular dialogue with commissioners ICS Mental Health & LD workstream chaired by HPFT National LTP commitments for MH documented within ICS LTP	12 (3x4)	8 (2x4)	Commissioning intentions demonstrate reduced funding/intention Parity of esteem agenda not honoured within contract negotiations or lack of commitment Lack of discussion about Mental Health & LD priorities across ICS, within developing geographical ICPs and in Local Delivery Boards No demography increase and / or usual commitments aren't delivered by CCG's. Insufficient attention to the recovery of mental health services from the Covid incident	MH Long Term Plan provides a roadmap for further investment and priorities and is reflected within the ICS LTP submission. MH investment standards and LT plan commitment remains. Anticipate planning guidance early / mid-March. NHSE transformation • Funding secured for community (Adult & Older People) and Crisis, service design commenced; confirmed for 2020/21. • Funding secured for 2021/22. Funding secured for Suicide Prevention. HPFT CEO/directors involved in key ICS decision making forums and groups. E&N ICP and West Herts ICP developing at pace; with HPFT well represented and supporting/shaping development, including MH & LD priorities within the ICPs. ICS wide MH & LD group in place, overseeing MH investment and developments across the ICS – chaired by Dir. Strategy. The development/collation of an ICS MH & LD strategic response to Covid Pandemic – commissioned report due back early May. Herts MH & LD ICP Partnership Board is firmly established, developing well with a strong partnership in place, priorities identified and being implemented with focus on Community and Primary Care Network. EOE Provider Collaborative continues to develop with go live date July 2021reflecting the impact of the pandemic. Business case being finalised with underpinning activity and financial modelling. Negotiations with NHSE/I re financial settlement ongoing. Norfolk Commissioners have supported the development of a Multi-Speciality Community Provider (MCP) model for LD services across Norfolk and a Partnership across NSFT, NCHC & HPFT is under development. The Trust responded to the consultation on the resulting white paper Integration and innovation: working together to improve health and social care for all', published February 2021 which describes the way the ICS will develop, the impact for HPFT is being considered.



	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Sandra Brookes **Last Review Date** 14.10.2020 **Current Position:**
1323	Risk that the sustainability of SRS becomes unviable following the reduction and changing needs of service users leading to an impact on quality and finance.	Specialist Residential Services is home to 25 individuals with severe learning disabilities and autism; most of whom have spent their entire lives in hospital in Hertfordshire. Due to previous legal proceedings, the service is in a unique position nationally, which has meant discharges from the service have effectively been unable to happen since 2010. The service does not take new admissions, therefore, there is a significant income risk as service users are either discharged or pass away. There is a risks of a short-medium term financial gap in 2020/21 and 2021/22. Without mitigation the shortfall will be £430k in 2020/21, growing to £732k in	16 (4x4)	Financial and operational plans developed. Conversations commenced with commissioners. Co-production commenced with stakeholders. Bank Shifts covered by unit staff, ex unit staff and external bank staff. Expansion of band 4 associate practitioner role planned. Secondments from Dove ward to support practice.	12 (3x4)	4 (1x4)	Increasing vacancies linked to retirement. Increase in incident reports of adverse physical health outcomes.	<u>Future provision of SRS</u> There is a wider programme of work being undertaken around the future provision of SRS. This has been led by HPFT up until recently with the Steering Group now being led by commissioners. The co-production work regarding the long term provision of SRS is due to start in the third week of September. It is proposed that if consultation regarding consolidation is required, that the two processes take place at the same time as they will involve the same stakeholders. It is not expected there will be any significant change in service provision for a further 12-24 months. Co-production was launched in September with all stakeholders. Underway and due to be completed in November. Following this key options will be identified to be formally consulted on in January. <u>Staffing</u> Current vacancies for SRS are 32% vacancies unqualified and 40% qualified. On-going recruitment efforts have not been successful and the service is seeing a significant increase in use of bank staff. <u>Financial</u> Some immediate, low risk actions can be taken to reduce costs which will reduce potential in-year shortfall to £300k in 2020/21 and £509k in 2021/22 involving revised staffing subject to safer staffing. However, more significant action will be required to maintain 1. Consolidate bungalows down to five a. Close 1FL, create mixed sex ward b. Create an extra bedroom on 4FL. Close 3FL. c. Move a male into 1FL Annex. Close 3FL d. Creation of mixed sex frailty unit. Close 1FL 2. Request further investment from commissioners to cover shortfall 3. Combination of 1 and 2. The preferred option, which would be least disruptive to service users, is option 2. Commissioners would need to pay an additional £12k for each remaining service user in 2020/21 and £20.4k in 2021/22 to meet the shortfall. However, it is likely to be challenging to get all 8 commissioners to agree to increased funding in the medium term and therefore this option is potentially the most financially risky. This option would allow us

		2021/22. There is a risk that difficulties with ongoing recruitment to vacant posts will leave the service heavily reliant on bank staff. There is a risk that the changing physical health / declining physical health of the service users increases the need for additional staff training and additional changes to the environment, nationally this cohort is within the age range of people with learning disabilities who are at a higher risk of premature death from both expected and unexpected causes.						to maintain the status quo (including single sex units) and avoid the need for multiple moves which could arise following the co-production process. The second preference is 1d – creation of mixed sex frailty unit. Close 1FL. This would have a positive impact on quality whilst also delivering the necessary savings - £547k-£774k FYE. Whilst HPFT would be required to consult with stakeholders on implementing this change, it's a process and change that would be within our control to implement and is therefore less financially risky. This option would involve creating a mixed sex unit but the challenges of this are outweighed by the benefits of cohorting the most frail service users together. Discussed 2 options with commissioners (create a frailty unit by consolidating the bungalows / commissioners fund short term) Commissioners have agreed to fund the shortfall in 2020/21 and then will review in partnership with HPFT beyond that. The first stage of co-production was completed in December; a further round is due to take place ahead of formal consultation. Option 2 was agreed with commissioners with the current agreement running up to end of March. The current proposal is to extend this agreement till the end of Q1. However, SRS is currently expected to deliver a £1m shortfall in 2020/21 due mainly to loss of income due to covid related rules and changes around overhead calculations. The Director of Finance is currently supporting resolution in these areas. <u>Physical Health</u> The Service has managed well over the covid period but this has led to some delays in the development of the frailty pathway work. However some progress has been made with multi factorial falls assessments and prescription of VitD. Sadly, three service users have passed away unexpectedly in SRS in recent months (June – August 2020)

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Paul Ronald **Last Review Date** 21.02.2021 **Current Position:**

1301	The Trust is unable to ensure short term financial performance in current financial year	This year has seen fundamental changes to the normal contracting and financial reporting processes to support and facilitate the clinical response to COVID-19. The contract process for 2020/21 was suspended. In M1-6 NHS Organisations were directed to report a break-even position with income being made available to fully match expenditure. For M7-12 changes were made to the above with; The COVID cost reimbursement process replaced with a fixed sum based upon M1-3. There were reductions made to the initial block contract. The MHIS income was made available	9 (3x3)	Continuing discussions with commissioners and the ICS to ensure a fair allocation of the FY20 income allocation. NHSE/I have used a proxy budget based on 2019/20 for reporting purposes Progressing the CRES / Delivering Value Programme	10 (5x2)	2 (1x2)	There is weekly monitoring of key indicators which is discussed at the weekly meeting of senior operational leadership. Monthly flash report provided to ET first meeting of the month. End of year forecast provided in the monthly finance report from Q1	For H2 of FY21 the Trust set a forecast for the year of £1.2m deficit that was accepted as part of the ICS Control Total position within the regional total of a £16m deficit. Subsequently further funding is being provided through NHSE to meet the shortfall of non NHS income against plan. This will provide the Trust with £0.7m additional income and an adjusted Control Total of £0.5m deficit. There remains the possibility of further income receipts before the end of the financial year. To support the achievement of the financial control total this year requires a continuing focus on; • Continuing to ensure the key controls on pay including efficient rostering are applied consistently • Managing out of area beds back towards budgeted levels • Managing down Covid-19 related costs where no longer necessary • Renewed focus on the Delivering Value Programme including for Support Services, in particular working up schemes for 2021/22 • Review of discretionary expenditure

	Title	**Description**	**Rating (initial)**	**Controls in place**	**Rating (current)**	**Rating (Target)**	**Early warning indicators**	**Executive Lead:** Keith Loveman **Last Review Date** 01.02.2021 **Current Position:**

1319	Implications for the Trust of unforeseen consequences arising from the end of the EU exit transition period on the 31 December 2020 at which point the UK and EU's relationship will be governed by what is agreed in the future relationship agreement.	If agreement on the terms of the future relationship with the EU are not resolved then it is likely that the Trust will need to undertake preparations for potential no-deal style disruption. There is a risk that some or all of the agreements required will not be reached. Supply of medicines and medical technologies – New border arrangements and requirements on goods, as well as regulatory barriers, could cause delays in release of supplies / increased costs onto the UK market. The health and care workforce – In addition to the changes that a new future relationship will bring, from January 2021 the UK will have a new immigration system, which will affect international recruitment for the health and care	12 (3x4)	Guidance on plans / preparedness from the NHS confederation / Department of Health and Social Care. The Trust's CIO, Hakan Akozek, will act as the EU Exit SRO and the preparation activities will be managed through the existing incident management structures for COVID-19, in line with the national direction. Automated system to monitor minimum medication stock levels and order as appropriate.	8 (2x4)	4 (1x4)	Increase difficulty or delay in sourcing sufficient quantities of medication or equipment. Increased staff turnover of EU registered staff	The Trade agreement reached with EU has significantly reduced the impact to the Trust, particularly around supply chain, finance and data flow risks. However as the impact of the changes for EU national workforce will not come into effect until 1st July 2021, workforce related risks to the Trust and other independent provides involved in care delivery remain unchanged. <u>Actions completed</u> • Monitor, advise and implement guidance from NHSEI as appropriate • Review and advise on briefings from NHS Providers and NHS Confederation • Encourage non-British EU staff to apply for settled status • Revisit the DHSC developed mandatory Self-Assessment Methodology for NHS Trusts to use to review contracts that may be impacted by a 'no deal' EU exit. • Review our information flow to re-assess potential risk • Identify and finalise key risks • Develop action plan for identification and implementation of contingencies arising <u>Medicines Management</u> MHRA guidance published 1 September 2020 for pharmaceutical industry and organisations on how to operate from 1 January 2021, including on licensing of medicines and devices, clinical trials, importing and exporting medicinal products, pharmacovigilance procedures and new IT systems. On the 3rd August 2020 the Department of Health and Social Care wrote to medicine suppliers and the wider supply chain advising medicine suppliers to stockpile six weeks' worth of drugs to guard against disruption at the end of the Brexit transition period and to make boosting reserves a priority. The medicines management team have an automated system to monitor minimum stock levels and order as appropriate, DHSC monitor any changes in ordering patterns. <u>EU Staff</u> Encouragement of the Trusts non-British EU staff to apply for settled status. All EU employees (c.211 staff) were written to in January 2020 and again in October 2020 to remind them of the process, the support available and to ask them to keep us apprised of their situation and any ways in which we might be able to help and support them.

		services. There is a risk if Care Homes are more heavily reliant on EU staff with a smaller staff pool then this might impact their capacity and ability to take admissions from HPFT.						

	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	**Executive Lead:** Keith Loveman **Last Review Date** 01.02.2021 **Current Position:**
747	Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability	Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability, together with a negative impact on organisational reputation and potential financial legislative penalties. Our IT infrastructure contains some vulnerability and there are some insecure working practices which are contributing to our exposure to Cyber risk.	12 (3x4)	Cyber security audits undertaken within HBL ICT. IT Security Policy in place. Email and Internet Policy in place. Mobile Device Policy in place. Intrusion Prevention Sensors on all 'internet' connections Regular/periodic messaging to staff regarding potential issues, vigilance, expected behaviours and appropriate responses. Information Governance mandatory training. Move to NHSmail	8 (2x4)	4 (1x4)	Increase in cyber security related or suspected related issues/calls logged on Service Now Advice from HBL ICT, NHS Digital or other key organisations Cyber-attacks on other HBL ICT organisations, other NHS organisations and/or wider organisations	The Trust remains up to date in applying critical cyber security patches The Trust has, with HBLICT, invested in two Data Centre's in the past two years, including firewall Upgrades. The Trust will continue to review the benefits from the NHS Secure Boundaries initiative as it develops further. The NHS has agreed extended support arrangements for Windows 7 until January 2021. The upgrading of IT equipment to Windows 10 was paused owing to COVID related activities, but this has now recommenced, awaiting final completion. HPFT secured 420k support from NHS Digital for further cyber security, work including new network routers and network switches to upgrade any of the existing kit which are end of life or potentially vulnerable to minimise chance of cyber issues. COVID19 has resulted in the rapid implementation of a number of projects and software solutions to support remote working. To support this, a shortened data protection impact assessment has been developed. The intention is to capture any immediate risks and propose practical mitigations. Advanced Threat Protection (ATP) gives better cyber security protection. It is also linked to the Data Security Centre (DSC), which improves cyber security protection for local health and care communities, and the NHS as a whole. ATP monitors and identifies any indicators of cyber security comprise or attack, it can then take immediate action to address the problem before it spreads. It also alerts local system managers and the DSC. Risk of cyber-attack is ever present. A deep dive on Cybersecurity was presented and discussed at the Audit Committee's December meeting. Two externally facilitated workshops have been completed in January which resulted in a more granular vulnerability and risk assessment and an associated action plan. These will be managed at departmental level, but will be used to inform the Trust level overall risk. Further mitigation and assurance actions planned in Q 4 include: • New Cyber Risk Management Framework (January 2021) • Gartner IT Score for Security and Risk Management (January 2021) • Start implementing Single Sign On (February 2021)

								• Penetration Testing (February 2021) • Cyber Essentials Plus Assessment (February 2021) • Start migration to N365 (March 2021) • Network Operations Centre (March 2021) • Targeted phishing campaign with training (unannounced)

Appendix 1 Risk Scoring Matrix (Risk = Likelihood x Consequence)

Step 1 Choose the most appropriate row for the risk issue and estimate the potential consequence

Consequence score (severity levels) and examples of descriptors					
	1	***2***	***3***	***4***	***5***
Domains	***Negligible***	***Minor***	***Moderate***	***Major***	***Catastrophic***
Impact on the safety of patients, staff or public (physical/psychological harm)	*Minimal injury requiring no/minimal intervention or treatment.* *No time off work*	*Minor injury or illness, requiring minor intervention* *Requiring time off work for >3 days* *Increase in length of hospital stay by 1-3 days*	*Moderate injury requiring professional intervention* *Requiring time off work for 4-14 days* *Increase in length of hospital stay by 4-15 days* *RIDDOR/agency reportable incident* *An event which impacts on a small number of patients*	*Major injury leading to long-term incapacity/disability* *Requiring time off work for >14 days* *Increase in length of hospital stay by >15 days* *Mismanagement of patient care with long-term effects*	*Incident leading to death* *Multiple permanent injuries or irreversible health effects* *An event which impacts on a large number of patients*
Quality/complaints/audit	*Peripheral element of treatment or service suboptimal* *Informal complaint/inquiry*	*Overall treatment or service suboptimal* *Formal complaint (stage 1)* *Local resolution* *Single failure to meet internal standards* *Minor implications for patient safety if unresolved* *Reduced performance rating if unresolved*	*Treatment or service has significantly reduced effectiveness* *Formal complaint (stage 2) complaint* *Local resolution (with potential to go to independent review)* *Repeated failure to meet internal standards* *Major patient safety implications if findings are not acted on*	*Non-compliance with national standards with significant risk to patients if unresolved* *Multiple complaints/ independent review* *Low performance rating* *Critical report*	*Totally unacceptable level or quality of treatment/service* *Gross failure of patient safety if findings not acted on* *Inquest/ombudsman inquiry* *Gross failure to meet national standards*
Human resources/ organisational development/staffing/ competence	*Short-term low staffing level that temporarily reduces service quality (< 1 day)*	*Low staffing level that reduces the service quality*	*Late delivery of key objective/ service due to lack of staff* *Unsafe staffing level or competence (>1 day)* *Low staff morale* *Poor staff attendance for mandatory/key training*	*Uncertain delivery of key objective/service due to lack of staff* *Unsafe staffing level or competence (>5 days)* *Loss of key staff* *Very low staff morale* *No staff attending mandatory/ key training*	*Non-delivery of key objective/service due to lack of staff* *Ongoing unsafe staffing levels or competence* *Loss of several key staff* *No staff attending mandatory training /key training on an ongoing basis*

Statutory duty/ inspections	*No or minimal impact or breech of guidance/ statutory duty*	*Breech of statutory legislation* *Reduced performance rating if unresolved*	*Single breech in statutory duty* *Challenging external recommendations/ improvement notice*	*Enforcement action* *Multiple breeches in statutory duty* *Improvement notices* *Low performance rating* *Critical report*	*Multiple breeches in statutory duty* *Prosecution* *Complete systems change required* *Zero performance rating* *Severely critical report*
Adverse publicity/ reputation	*Rumours* *Potential for public concern*	*Local media coverage – short-term reduction in public confidence* *Elements of public expectation not being met*	*Local media coverage – long-term reduction in public confidence*	*National media coverage with <3 days service well below reasonable public expectation*	*National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)* *Total loss of public confidence*
Business objectives/ projects	*Insignificant cost increase/ schedule slippage*	*<5 per cent over project budget* *Schedule slippage*	*5–10 per cent over project budget* *Schedule slippage*	*Non-compliance with national 10–25 per cent over project budget* *Schedule slippage* *Key objectives not met*	*Incident leading >25 per cent over project budget* *Schedule slippage* *Key objectives not met*
Finance including claims	*Small loss Risk of claim remote*	*Loss of 0.1–0.25 per cent of budget* *Claim less than £10,000*	*Loss of 0.25–0.5 per cent of budget* *Claim(s) between £10,000 and £100,000*	*Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget* *Claim(s) between £100,000 and £1 million* *Purchasers failing to pay on time*	*Non-delivery of key objective/ Loss of >1 per cent of budget* *Failure to meet specification/ slippage* *Loss of contract / payment by results* *Claim(s) >£1 million*
Service/business interruption Environmental impact	*Loss/interruption of >1 hour* *Minimal or no impact on the environment*	*Loss/interruption of >8 hours* *Minor impact on environment*	*Loss/interruption of >1 day* *Moderate impact on environment*	*Loss/interruption of >1 week* *Major impact on environment*	*Permanent loss of service or facility* *Catastrophic impact on environment*

Step 2 Estimate the likelihood

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency *Time framed descriptors*	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probably *Will it happened or not?*	<0.1 %	0.1 – 1%	1 – 10 %	10- 50%	>50%

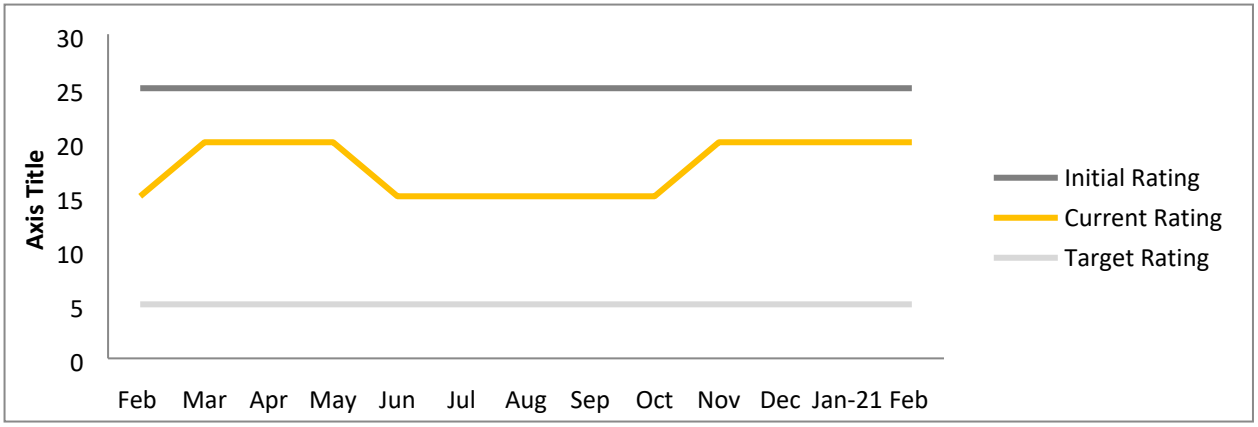
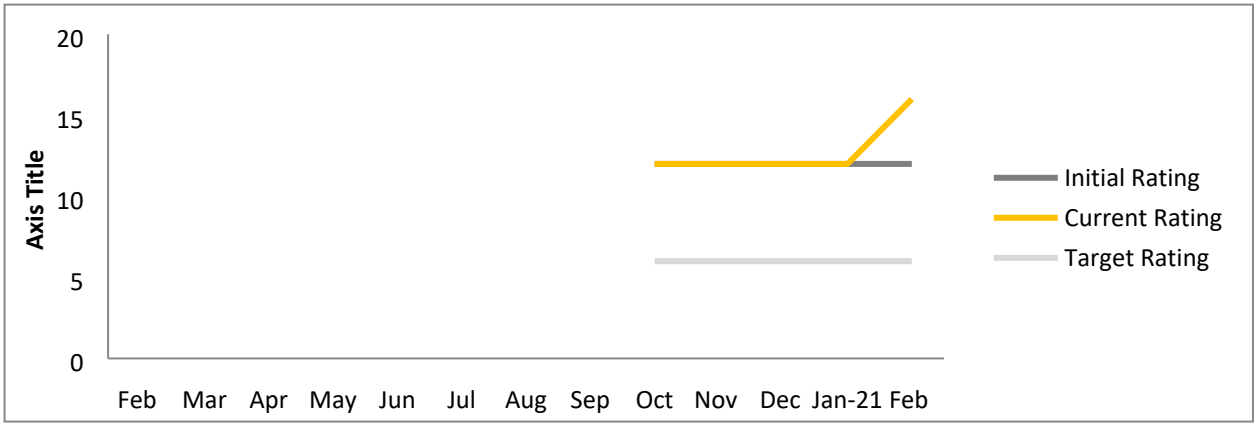
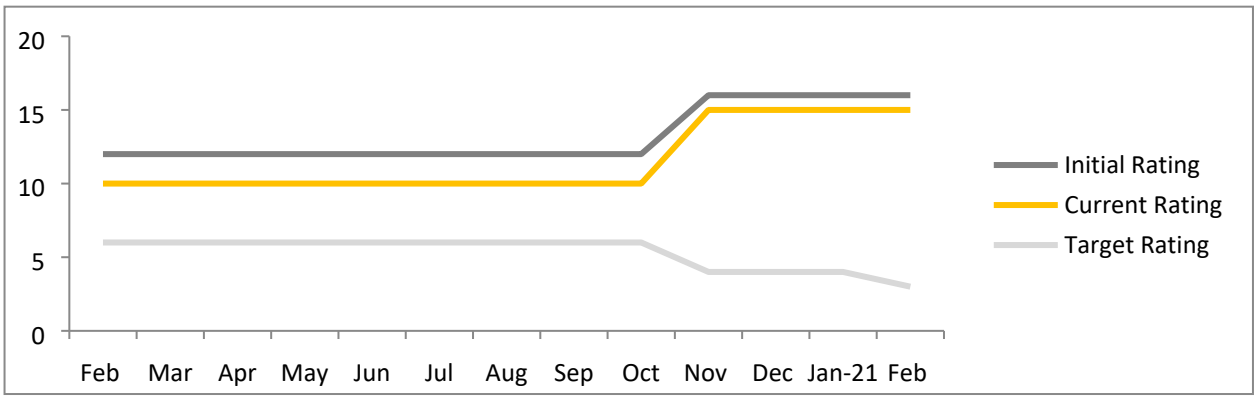
Step 3 Complete the Risk Grading Matrix

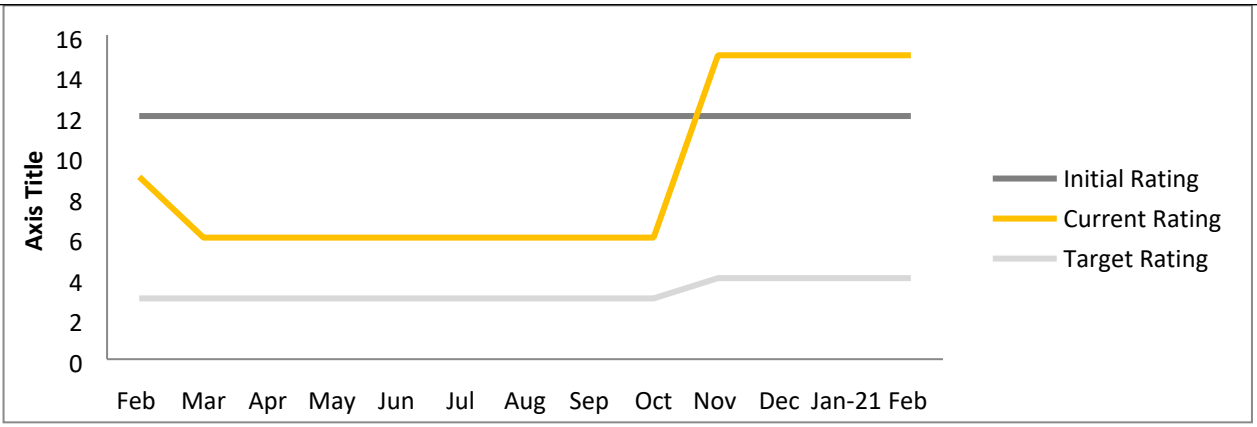
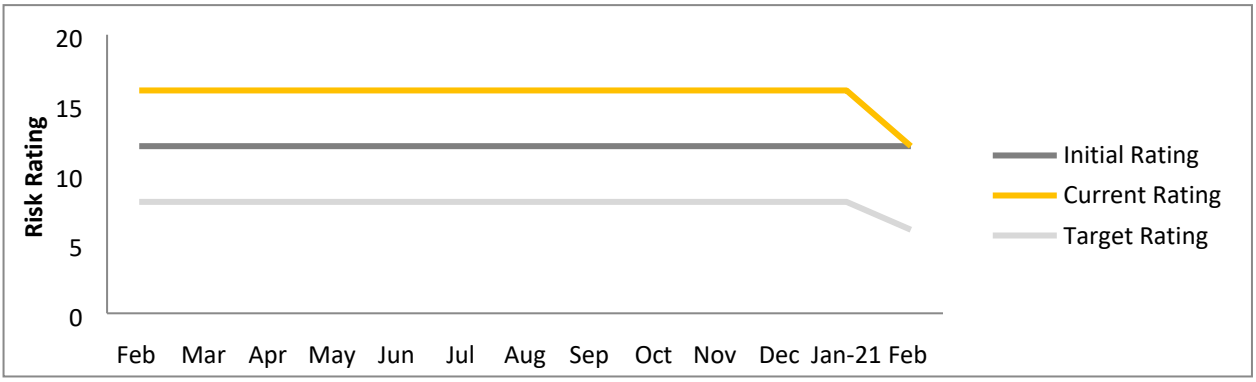
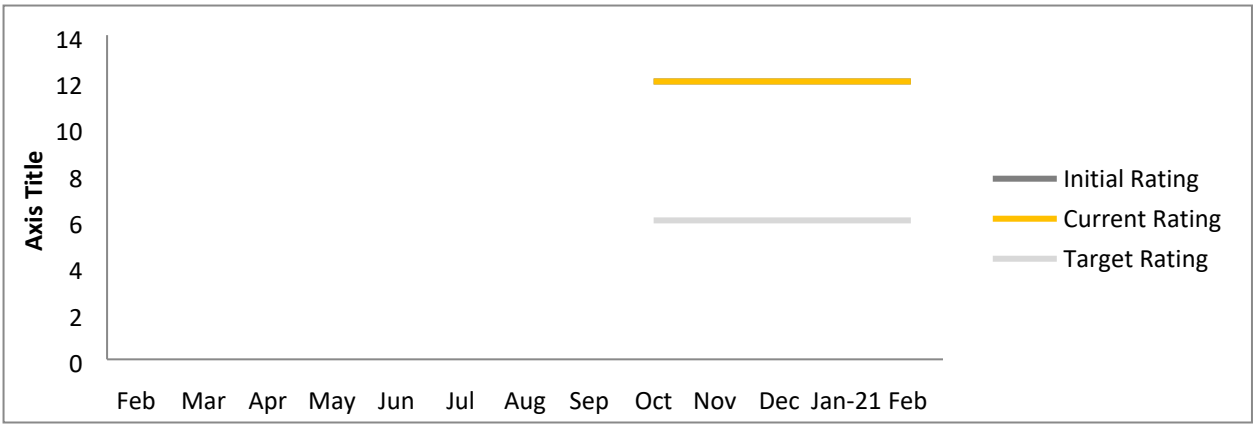
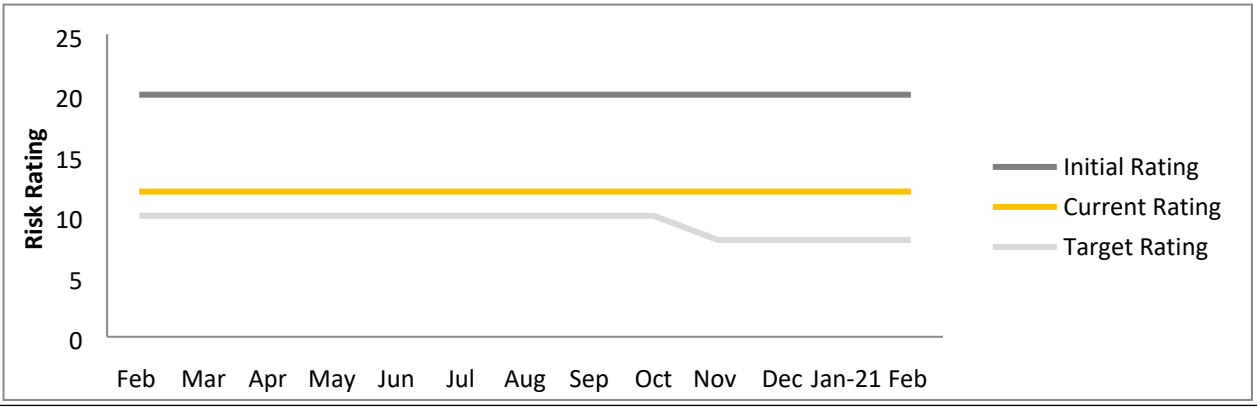
	Consequence				
Likelihood	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 Almost certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

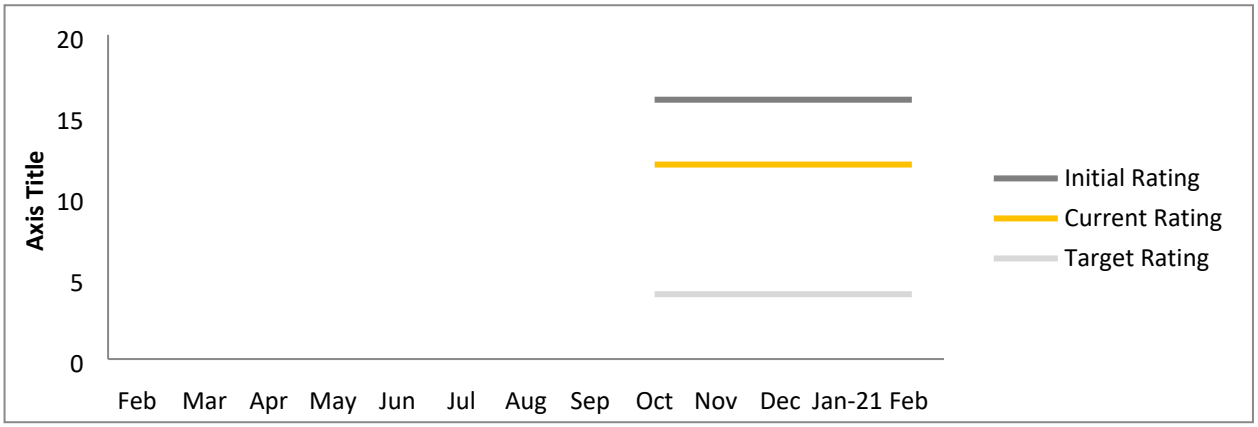
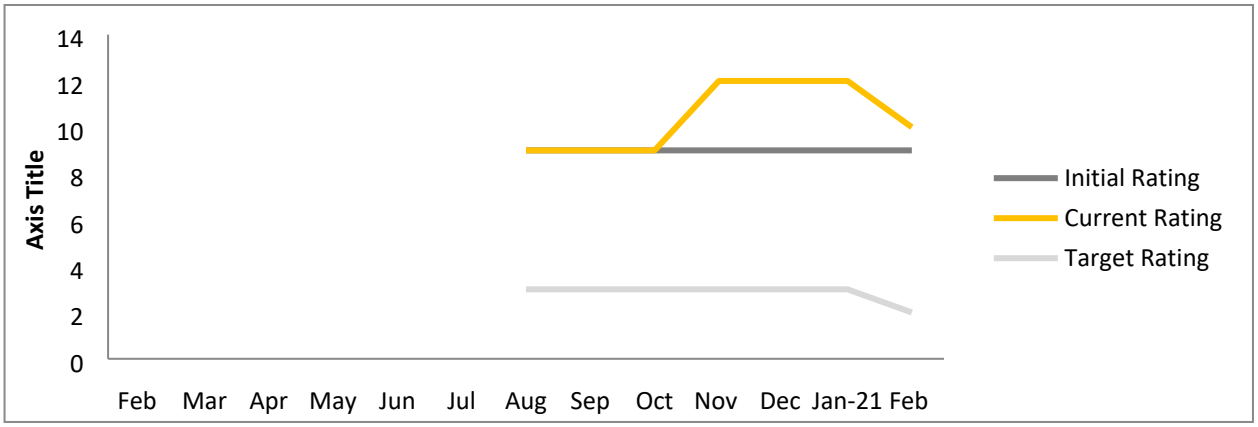
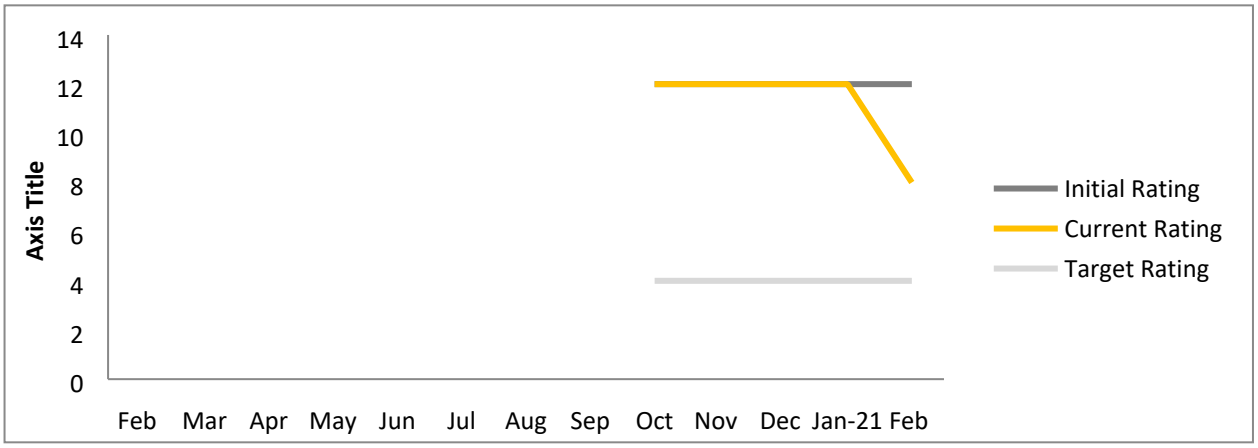
Step 4 Escalation Process

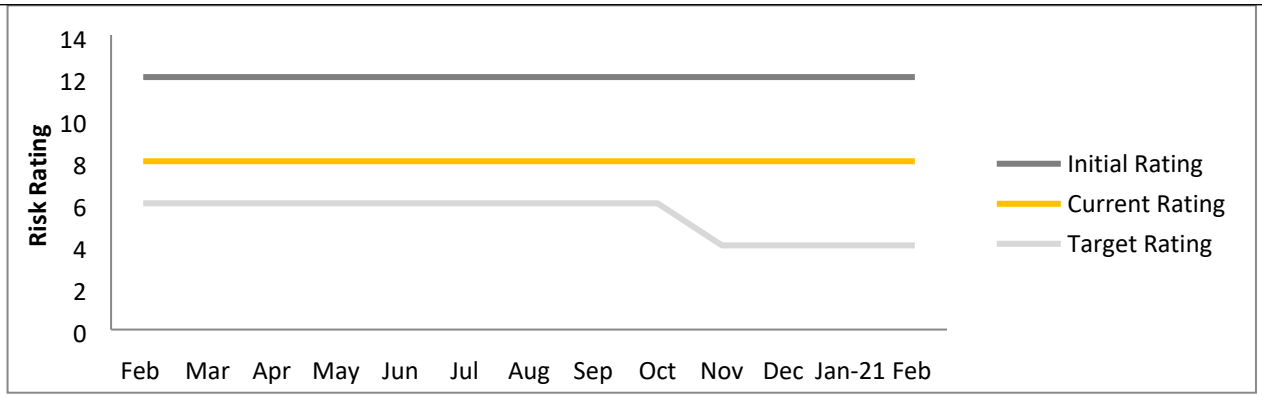
Very Low Risks	Low Risks	Moderate Risks	High Risks
1-3	4-6	8-12	15 - 25
Local Risk Register	Service Line Risk Register	SBU Risk Register	Trust Risk Register

Appendix 2: Trend Analysis – 12months

No	Risk	12 month trend analysis
1	1253	**Quality and Safety:** The Trust may not be able to sustain core operational services and maintain service user and staff safety during the continued COVID19 outbreak.  Risk scored reduced during the summer months.
2	1321	**Workforce:** The Trust is unable to maintain staff wellbeing and staff morale during the pressures of COVID19, with increased demand now and during the recovery phase.  Risk created in October 2020
3	882	**Quality and safety:** S136: Unlawful detention of service users under S136 breaching beyond 24hrs which has legal implications and an impact on service user care, treatment and experience  Slight change in the risk description resulted in a change in the initial rating, the current rating increased at the same time.
4	1147	**Quality and safety:** The Trust may not be able to sustain service user safety due to risks of COVID, flu outbreak and other winter pressures

		 Originally the flu risk, increased in Nov 2020 with a change in the risk description.
5	1001	**Finance:** The Trust may not have sufficient resources to ensure long term financial sustainability 
6	1320	**Workforce:** Insufficient workforce to meet predicted increased demand and deliver commitments in Long Term Plan  Risk created in October 2020
7	749	**External landscape:** The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health and learning disability services provided by HPFT. 

8	1323	**Operational:** Risk that the sustainability of SRS becomes unviable following the reduction and changing needs of service users leading to an impact on quality and finance.  Risk created in October 2020
9	1301	**Finance:** The Trust is unable to ensure short term financial performance in current financial year.  Risk increased above initial rating in Oct 2020
10	1319	**EU Exit:** Implications for the Trust of unforeseen consequences arising from the end of the EU exit transition period on the 31 December 2020 at which point the UK and EU's relationship will be governed by what is agreed in the future relationship agreement.  New EU risk opened in October 2020, Scored reduced following deal with EU.
11	747	**Information Management and Technology:** Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability.


14
12
10
8
6
4
2
0
Risk Rating
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan-21
Feb
Initial Rating
Current Rating
Target Rating

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 17
Subject:	Board Assurance Framework	**For Publication: Yes**
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	
Presented by:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	

Purpose of the report:

To provide assurance that the Trust's principle risks have been identified and are being appropriately managed.

Action required:

The Board is asked to review and approve the Board Assurance Framework (BAF) to ensure the evidence provides assurance that the principal risks have been identified and appropriate controls and assurance are in place.

Summary and recommendations to the Board:

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and also enable the board to gain assurance about the effectiveness of these controls. The Lead Director for each risk is responsible for assessing the risks assigned to them and providing assurance on the effectiveness of risk controls.

This report provides an update on the latest iteration of the BAF, which has been reviewed and updated by each Lead Director. This version includes updated controls and lines of assurance together with the most recent dates for the assurance evidence.

Appendix 1 details the significant changes to the BAF since it was reviewed at IGC in January and March 2021. In particular the risk controls, assurance and actions have been updated for principle risk 3.2 and 7.2 following feedback from the IGC.

Recommendation:

1. For the Board to review and approve latest iteration of the BAF.

Relationship with the Business Plan & Assurance Framework:

The BAF identifies the risks associated with the strategic objectives as set out in the Annual Plan.

Summary of Financial, IT, Staffing and Legal Implications:

None outlined in the summary report.

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

None.

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

Evidence of robust governance review process for the NHSI/CQC Well Led Standard.

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

Reviewed and recommended for approval by IGC following its meeting on 8 March 2021

Please note the BAF has been updated to include most relevant dates for Board, Committees and other groups, these numerous updates are not included in the table below

Appendix 1

Principle Risks and Lead Director/s	BAF Risk No.	Risk Change in period
Strategic Objective 1: We will provide safe services, so that people feel safe and are protected from avoidable harm		
Failure to comply with the legislative framework for the care and treatment of individuals with mental health problems will impact on quality of care and could lead to regulatory sanctions.	1.4	**New Actions** New actions added relating to implementing **recommendations from Safeguarding internal audit report**
Failure to provide safe working environment for staff, adversely impacting on staff wellbeing.	1.5	**New Assurance** CQC TMA process

Strategic Objective 3. We will improve the health of our service users through the delivery of effective evidence based practice		
Do not provide appropriate assessment and treatment of physical conditions which will impact on service user wellbeing and outcomes.	3.1	**New Assurance** Finance and Investment Committee deep dive.
Do not provide appropriate psychological intervention and treatment, leading to poorer outcomes.	3.2	**New Controls** • Psychology Services Development Strategy • Implementation Plan • Clinical outcome measures • Transformation Programme **Assurances updated highlighted in yellow**

		New Actions: • Roll out of additional psychology resource to target areas • New lead psychology and lead AHP posts for each SBU. • Development organisation wide performance metrics

Strategic Objective 4. **We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment**		
Unable to recruit and retain the right numbers of people with the right skills, which will impact on quality of care for our service users and our staff satisfaction levels.	4.1	**New Assurance** External Well-led review **New Actions** Relating to Well Led Review action plan
Failure to improve employment experience for all our staff, including health and wellbeing support which will mean staff do not feel valued or enabled to reach their potential	4.4	**New Assurance** External Well-led review **New Actions** Relating to Well Led Review action plan
Fail to deliver the promises within the NHS People Plan ('we are the NHS') resulting in increased regretted attrition	4.6	**New Assurance** External Well-led review

Strategic Objective 5. **We will improve, innovate and transform our services to provide the most effective, productive and high quality care**		
Staff do not have access to accurate and timely information to assist clinical and non-clinical decision making and planning, will impact on ability of Trust to innovate and transform.	5.2	**New Assurance** CQC TMA

Strategic Objective 7. **We will shape and influence the future development and delivery of health and social care to achieve better outcomes for our population(s)**		
Changing external landscape regionally and nationally leads to a shift of influence and resources away from MH and LD, the services users and communities served by HPFT	7.2	**New Risk Control** Structures and systems in place for East of England Provider Collaborative. **New Assurance** NCM Collaborative Board

Board Assurance Framework (BAF)

March 2021

Reviewed by:

- Integrated Governance Committee
- Board Assurance Committee: Covid19
- Audit Committee
- Trust Board (TB)

Introduction

This Board Assurance Framework brings together the principle risks potentially threatening the Trust's Strategic Objectives and outlines specific control measures that the Trust has put in place to manage the identified risks and the independent assurances relied upon by the Board to demonstrate that these are operating effectively.

Explanation of Assurance types and levels

Assurance Type - The identified source of assurance that the Trusts receives can be broken down into a three line model (1st, 2nd and 3rd line assurances)**. The assurance type column RAG rating records the highest level available for each control**

1st Line	2nd Line	3rd Line
Assurance from the service that performs the day to day activity E.g. Reports from the department that performs the day to day activity, Departmental Meetings, Departmental Performance Information	Assurance provided from within the Trust - Internal assurance E.g. Management Dashboards, Monthly monitoring	Assurance provided from outside the Trust - Independent assurance E.g. Internal Audit, External Audit, Peer Review, External Inspection, Independent Benchmarking

Assurance Level - For each source of assurance that is identified you can rate what it tells you about the effectiveness of the controls

High	Medium	Low
One or more of the listed assurance sources identify that effective controls are in place and the TB are satisfied that appropriate assurances are available Substantial assurance provided over the effectiveness of controls	One or more of the listed assurance sources identify that effective controls are in place but assurances are uncertain and/or possibly insufficient Some assurances in place, or substantial assurance in place, but controls are still maturing so effectiveness cannot be fully assessed at this time.	The listed assurance sources identify that effective controls may not be in place and/or appropriate assurances are not available to the Board Assurance indicates poor effectiveness of controls.

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	1.1 Risk that do not provide safe standards of care, meaning service users to not feel safe and are not protected from avoidable harm or deaths through suicide.	Briefing of all Serious and potential serious Incidents Moderate Harm Panel	Executive Committee Board CCGs QRMs Safety committee reporting into QRMC	Moderate harm panel/ datix notes Internal review of incidents during Covid19	Serious Incident Briefing Report. Weekly to exec and Board Exec and Board reports and minutes of meetings	CCG SI reviews Independent Authors from selected SI investigations CQC Whistleblowing	High	Weekly SI report to Exec and monthly report to TB Weekly moderate harm panel Exec Team April 2020		Director of Quality and Safety [IGC]
		Mortality Governance processes (including LEDER	IGC TB Brd Ass Sub-Cttee Covid		Mortality Governance Reporting Quarterly Integrated Safety Report	Externally Reporting	High	IGC 19.8.20 11.11.20 20.1.21 TB 25.06.20 30.7.20 24.9.20 Assurance Cttee 11.06.20		
		Quality Report Processes (including Annual Report)	Executive Committee IGC Brd Ass Sub-Cttee Covid TB Commissioner's Eternal Audit	Service reports on Quality priorities Covid 19 Update reports Clinical and Professional Advisory Committee	SBU, ICG and Board reports on Quality priorities and Quality Account	Quality Account 19/20 (published) Annual Report 19/20 (externally audited) External audit advisory report	High	Assurance Cttee 09.07.20 IGC 6.4.20 Audit Committee 13.02.20 30.04.20 19.06.20 TB 19.06.20 30.07.20	**Action** **Development of Quality framework to triangulate information from visits.**	
		CQUIN Processes	TMG Executive Committee IGC Brd Ass Sub-Cttee Covid TB CCG QRM	Trust Management Group update reports Service and SBU reports on CQUIN	CQUIN Reports – Part of quarterly Performance Report	CCG CQUIN reports as part of the Quality report	High	IGC 06.04.20 19.08.20 11.11.20 TB 30.7.20 Assurance Cttee 09.07.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
1. We will provide safe services, so that people feel safe and are protected from avoidable harm		Training Recruitment process Professional standards adhered to Clinical Outcomes	Executive Committee IGC TB QRM	Quarterly Safe Staffing Levels report CCG Contract reporting (quarterly) Supervision Appraisals			High	IGC 06.04.20 19.08.20 11.11.20 20.2.21 QRMC 10.1.20 4.3.20 30.6.20 14.8.20 10.11.20 24.2.21 TB 27.02.20 23.04.20 30.7.20 26.11.20		
	1.2 Risk that do not deliver restrictive practice in line with best practice, therefore impacting on patient safety and experience	Freedom to Speak Up Practice and Processes	Integrated Governance Committee Brd Ass Sub-Cttee Covid Quality and Risk Management Committee CCG QRM	Service audits Service feedback from FSUG	Freedom to Speak up – 6 monthly review & Annual Report	CQC MHA Inspections Freedom to speak up Guardian Concerns raised with the Trust via the CQC (CQC Concerns) Duty of Candour Audit	High	IGC 6.4.20 11.11.20 Ass Cttee 11.6.20 TB 25.6.20 26.11.20	**Action** **Review of Management of Incidents. Implementation of recommendations** **Action** **Board level self assessment 2020/21.**	
		Making Our Services: MOSStogether Strategy	QRMC Executive Committee IGC TB CCG QRM	Peer review (SBU to SBU) of seclusion practice.	Quarterly & Annual Integrated Safety Reports MOSS Together strategy Use of Force Act and Restrictive Practice Committee Clinical and Professional Advisory Committee	Independent reviews of Respect Seclusion) Assurance visits from CQC & CQC, MHA team. Ongoing involvement in Restrictive Practice Peer Review Collaborative.	High	IGC 6.4.20 19.8.20 11.11.20 20.1.21 TB 25.06.20 30.7.20 24.9.20 Brd Ass Cttee 11.06.20 Ongoing. unannounced & announced visits	**Action** **Implementation of Strategy 20/21**	
	1.3 Failure to implement Infection Prevention and Control policies and behaviours.	Infection Prevention and Control Board Assurance Framework	Infection Prevention & Control Committee Brd Ass Sub-Cttee	Reports to IGC IPC audits Outbreak	Annual Infection Prevention & Control Report Reports on	CQC external review of IPC Externally commissioned	Medium	Assurance Cttee 14.05.20 11.06.20 9.7.20	**Action** **Implement actions to support IPC BAF** **Action** **Implement recommendations of**	DIPC [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
			Covid IGC	management	emerging issues	review of IPC BAF		IGC 6.4.20 19.8.20 11.11.20 20.1.21 TB 27.02.20, 26.03.20 23.04.20 25.06.20 30.07.20 24.9.20 22.10.20 26.11.20	**independent external review of IPC BAF**	
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	1.4 Failure to comply with the legislative framework for the care and treatment of individuals with mental health problems, will impact on quality of care and could lead to regulatory sanctions.	Mental Health Act & DoLs Act Guidance is updated and followed.	CCG QRM IGC TB QRMC Safeguarding Strategic Committee	MHA Quarterly Newsletter (themes & actions)	HPFT Quality Visits & CCG Quality Visit reports. CCG Adult and children's safeguarding reviews Deprivation of Liberty using MHA & DoLS Quarterly Report Mental Health Legislation Quarterly Update from MH Legislation Quality and Policy Group (attended by CCGs) Mental Health Act Managers Annual Report 2019/20	Assurance visits from CQC and CQC MHA team – Provider Action Statements Herts-wide assurance group	High	QRMC 4.3.20 30.6.20 14.8.20 10.11.20 24.2.21 IGC 6.4.20 19.8.20 11.11.20 20.1.21 Assurance Cttee 14.5.20 11.6.20 9.7.20		Director of Quality and Safety [IGC]
		Major Incident Policy	Executive Committee IGC TB	Service Business Continuity plans Core standards compliance Implementation of Business Continuity Plan during Covid 19	Emergency preparedness, Resilience and Response Annual Report 2019 reported to TB Table top exercises	Emergency Planning and Business Continuity EPRR Core Standards compliance – CCG & NHSE approval Quarterly meetings and reports from Herts wide Local	High	TB 26.3.20 23.4.20 28.5.20 25.6.20 22.10.20 IGC 6.4.20 20.1.21	**Action** **Action plan to ensure Trust meets one partial compliance area of self-assessment**	Director of Service Delivery and Experience [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
						Resilience Partnership				
		Safeguarding processes and monitoring	Safeguarding Strategic Committee		Safeguarding Reports (Annual and quarterly)	Section 11 safeguarding assessment Annual CCG safeguarding assurance assessment Adults and Childrens Quality Assurance Visit Internal Audit report	High	IGC 19.8.20 11.11.20 TB 24.9.20 30.7.20 Audit Ctte 3.2.21	**Action** **Implement recommendations from internal audit report**	Director of Quality and Safety [IGC]
1. We will provide safe services, so that people feel safe and are protected from avoidable harm	1.5 Failure to provide safe working environment for staff, adversely impacting on staff wellbeing.	Safe Care Standards processes and policies	CCG QRM		Quality Assurance Visit Programme Quarterly & Annual Integrated Safety Reports	Integrated Health and Care Commissioning Team (IHCCT) Volvina annual audit programme (ligatures)	High	CCG QRM 11.2.20		
			Health Safety and Security Committee Audit Committee		Health, Safety and Security Report (Annual / Quarterly Report) Health & Safety Annual Report	Health & Safety Executive Inspection Report May 2019 & Action Plan Internal Audit Report – H&S Service User Contact		TB 30.7.20 24.9.20 IGC 19.8.20 11.11.20 Audit 30.4.20 15.9.20		
			Quality and Risk Management Committee		Quarterly Safety Reports Policy Compliance Report CQC Action Plan	CQC Insight Reports CQC TMA		QRMC 4.3.20 30.6.20 14.8.20 10.11.20 Feb date IGC 6.4.20 19.8.20 11.11.20 20.1.21 TB 28.1.21		
			IGC	Clinical and Professional Advisory	Reporting Quarterly Integrated Safety Report	Internal Audit Reports - CQC Action Plan		IGC 6.4.20 19.8.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
				Committee				11.11.20 20.1.21 Audit Cttee 30.4.20 19.6.20		
		Quality Strategy	QRMC IGC Board	Service and SBU objectives related to the Quality Objectives as defined in the Strategy Covid19 Risk Register	HSCC QRMC IGC Quality Improvement reports Quality Strategy launched	CCG performance reports related to Quality Objectives	High	IGC 6.4.20 19.8.20 11.11.20 20.1.21 TB: 26.3.20 23.4.20 28.5.20 19.6.20 25.6.20 30.7.20 24.9.20 22.10.20 26.11.20 28.1.21	**Action** **Quality strategy being roll out. Leads identified for four domains and reporting back to IGC.**	
		Quality Measures including Quality Strategy	IGC TB CCG QRM		Trust performance KPI report on Workforce Quality Strategy review & approval Quarterly Claims Reports Briefing & Annual Claim Report	POM UK Accreditation Quarterly CCG Quality Review Meeting/Reports	High	IGC 6.4.20 19.8.20 11.11.20 20.1.21 TB: 26.3.20 23.4.20 28.5.20 19.6.20 25.6.20 30.7.20 24.9.20 29.11.20 28.1.21	**Action** **Roll out of Quality Strategy**	
2. We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience	2.1 Service Users unable to access the right services in a timely way, meaning a poor experience and or outcomes for service users.	Performance Monitoring Processes - Implementation of Accurate Clinical Information Strategy - SPIKE	Service Line Leads & Modern Matrons Executive Committee TMG TB SBU Core Management PRM Contract review meetings Internal & External Audit FIC	Spike Performance Reports Service Experience team reports Complaints seen in real-time Datix and local reporting of incidents	Trust Performance KPI report – Access Times. Re-admission rates. SBU Quarterly Performance Reviews Live Data Performance Dashboards Performance Audit Performance against Annual Plan	Internal Audit Data accuracy and data quality report to Audit Committee Quality Account		FIC 17.3.20 18.8.20 17.11.20 19.1.21 TB: 26.3.20 23.4.20 28.5.20 19.6.20 25.6.20 30.7.20 24.9.20 22.10.20		Director of Service Delivery and Customer Experience / Director of Finance [IGC]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
				SBU performance reporting and local PRM service line reporting structures Agreed service changes to meet Covid 19 pandemic	Internal & External Audit SPIKE live data Spike data quality reports QIAs of service changes to respond to Covid19	19/20 externally published Audited Annual Report 2019/20		26.11.20 Assurance Cttee 9.7.20 Audit Cttee 30.4.20 19.6.20 AGM 15.7.20		
		Quality Impact Assessments	QRM – reports to Commissioners IGC Brd Ass Sub-Cttee Covid	Datix Complaints in real-time Experience reports Friends and Family results Having Your Say	Individual Quality Impact Assessments External Commissioner scrutiny Quality Impact Assessment reports to IGC		High	QRMC 4.3.20 30.6.20 14.8.20 10.11.20 24.2.21 IGC 15.1.20 19.8.20 11.11.20 Assurance Cttee 14.5.20 11.6.20		
	2.2 Failure to engage effectively with service users and carers will impact on Trust's ability to transform services to best meet their needs	Service User Feedback	QRMC Executive Committee IGC Brd Ass Sub-Cttee Covid TB	Complaints in real-time Experience reports Friends and Family results Having Your Say	Peer listening reports and feedback Friends and Family Test data Feeling Safe data	Community Mental Health Annual Survey Commissioner reviews by carers in Herts and View Point	High	TB 30.1.20 27.2.20 24.9.20 26.11.20 Exec 26.2.20 IGC 19.8.20 11.11.20 20.1.21	**Action** **Community Survey action plan and task and finish Group**	
		Outcomes Framework for Carers Pathway Development	QRMC TMG	Reporting via Experience Team Feedback from the Council of Carers	Carer Pathway report	CQC inspection CCG reports	High	May 2019		
	2.3 Failure to invest to improve the standard of Trust's environments will impact on patient experience and quality of	Capital Plan	FIC TB	Quarterly reports to FIC and TB			High	Exec Qly reports on capital plan FIC		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	care.							17.3.20 18.08.20 17.11.20 19.1.21 TB 24.9.20 26.11.20 28.1.21		
3. We will improve the health of our service users through the delivery of effective evidence based practice	3.1 Do not provide appropriate assessment and treatment of physical conditions which will impact on service user wellbeing and outcomes.	Physical Health Strategy CQUIN IAPT Adult Community FEP Dedicated consultant for physical health Tool kit to support the physical health and wellbeing of people with severe mental illness	TMG TB Physical Health Committee IGC QRM QRMC	Audit of care plans and records Structured Judgement reviews Clinical and Professional Advisory Committee Covid19 Risk Register	CQUIN achieved and agreed with commissioners quarterly SBU Physical Health Leads Annual Physical Health Strategy Report Mortality Harm Panel FIC deep dive	CQC inspection CCG reports on CQUIN STP Ethics Committee	Medium	IGC 6.4.20 19.8.20 11.11.20 20.1.21 Assurance 14.5.20 11.6.20 9.7.20 FIC 19.1.21 TB: 26.3.20 23.4.20 28.5.20 25.6.20 30.7.20 24.9.20 22.10.20 26.11.20	**Action** **Implemented training to identify physical health needs, including recording and monitoring.** **Implement new guidance to identify and manage physical health needs of services users as a result of Covid19**	Director of Quality and Medical Leadership [IGC]
	3.2 Do not provide appropriate psychological intervention and treatment, leading to poorer outcomes.	Psychology Services Development Strategy Implementation Plan Clinical outcome measures Transformation Programme	TMG Transformation Board Exec	Implementation Plan Departmental review of clinical outcomes	Transformation Board TMG Performance monitoring and KPIs	Internal Audit programme	Medium	Monthly and quarterly perf reports Monthly transformation updates to Exec	**Action** **Roll out of additional psychology resource to target areas** **New lead psychology and lead AHP posts for each SBU.** **Development organisation wide performance metrics**	
	3.3 Do not use latest research or evidence to inform clinical practice which means we don't deliver the optimum outcomes for service users.	Annual Programme of Clinical Audit (Practice Audit and Clinical Effectiveness) inc NICE Guidance Policy	Executive Committee QRMC IGC Audit Committee TB CCG QRM Brd Assurance Committee	Individual Clinical Audits Audit of Care Plans & records	Annual Audit Programme Practice Audit Clinical Effectiveness Progress Reports (PACE) PACE Annual Report	NICE Progress Reports Internal Audit Report Jan 20	High	IGC 19.8.20 11.11.20 20.1.21 Audit Committee 3.12.20		
		Medicines Management	QRMC Executive Committee	Service level feedback Datix reports	DTC Annual Report 6 monthly	CCG Quality report	High	IGC 15.1.20 19.8.20	**Action** **Implementation of Medicines Management Strategy**	

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
			IGC TB		committee update Pharmacy & Medicines Optimisation Annual Report Medicines Management Strategy	Internal Audit Report – Medicines Mgt.		11.11.20 TB 30.1.20 27.2.20 Exec 15.1.20		
4. We will attract, retain and develop people with the right skill and values to deliver consistently great care, support and treatment	4.1 Unable to recruit and retain the right numbers of people with the right skills, which will impact on quality of care for our service users and our staff satisfaction levels.	People and OD performance metrics Safe Staffing levels People and OD strategy – implementation programme	TMG Executive Committee PODG TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB	Internal Audits	Medium	WODG& PODG 6.3.20 15.5.20 4.8.20 3.9.20 27.10.20 TB 26.3.20 23.4.20 30.7.20 24.9.20 22.10.20 26.11.20 IGC 19.8.20 11.11.20 20.1.21	**Action** **Implement actions to ensure improved employment experience**	Director of People and OD [IGC]
		Organisational Development Strategy	Executive Committee PODG IGC TB	Supervision Appraisal	People and OD Reports Pulse Survey Good to Great Road Shows Big Listen and Local Listen.	CQC inspection Internal audits External Well Led Review	High	TB 26.3.20 23.4.20 30.7.20 24.9.20 22.10.20 26.11.20 IGC 19.8.20 11.11.20	**Action** **Well Led Review action plan**	
		Appraisal / PDP Reward and Recognition Processes	TMG SBU Core management SLL's Executive Committee PODG Workforce Board IGC TB	Performance by team/service reported monthly from Discovery system	Quarterly PODG reports to IGC Monthly Inspire and annual awards Staff awards Long Service Recognition Awards	External award nominations and awards	High	WODG& PODG 6.3.20 15.5.20 4.8.20 3.9.20 27.10.20 1.3.21 TB 26.3.20 23.4.20 30.7.20 24.9.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								22.10.20 26.11.20 28.1.21 IGC 19.8.20 11.11.20 20.1.21		
	4.2 Failure to develop a sustainable, adaptive and resilient workforce model that will impact on Trust's ability to deliver safe and effective care.	Revalidation and appraisal of medical staff	IGC TB		Annual Report on Revalidation and Appraisal of Doctors	Internal Audit – Doctor Revalidation	High	TB 24.9.20		
	4.3 Failure to provide an inclusive and diverse workforce with equality of opportunity and experience	People's Plan Implementation Plan	Executive Committee PODG IGC TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB Pulse Survey	Internal Audits	Medium	TB 27.2.20 (National Staff Survey) TB 26.3.20 23.4.20 30.7.20 24.9.20 22.10.20 26.11.20	**Action** **Trust implementation plan for NHS People's Plan**	
		External Systems for Staff Feedback	Executive Committee PODG IGC TB	FSUG report	PULSE quarterly report	National Staff Survey	High	TB 25.6.20 25.2.21		
		People and OD performance metrics, including Gender Pay Analysis, WRES and WDES and Clinical Excellence Awards Inclusion Strategy	Executive Committee PODG IGC TB		CEA awards	WRES and WDES Gender Pay Analysis	Medium	WODG& PODG 6.3.20 15.5.20 4.8.20 3.9.20 27.10.20 1.3.21 Exec June 2020 TB 25.6.20 24.9.20	**Action** **Action plan to support Inclusion strategy**	
	4.4 Failure to improve employment experience for all our staff, including health and wellbeing support which will mean staff do not feel valued or enabled to reach their potential	Appraisal / PDP Reward and Recognition Processes	TMG SBU Core management SLL's Executive Committee PODG Workforce Board IGC TB	Performance by team/service reported monthly from Discovery system	PODG reports to IGC Monthly Inspire and annual awards Staff awards Long Service Recognition Awards		High	WODG& PODG 6.3.20 15.5.20 4.8.20 3.9.20 27.10.20 1.3.21 IGC 19.8.20 11.11.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								20.1.21 TB 26.3.20 23.4.20 30.7.20 24.9.20 26.11.20		
		Workforce Health and Wellbeing Strategy Action Plan New Occupational Health provider	Executive Committee PODG IGC TB	Service and SBU objectives related to Strategy Wellbeing offer for staff during Covid 19 Well being bulletins	People and OD Report 24/7 staff helpline Interactive Q&A sessions for staff	CQC inspection Well Led Review	High	WODG& PODG 6.3.20 15.5.20 4.8.20 3.9.20 27.10.20 1.3.21 IGC 19.8.20 11.11.20 20.1.21 TB 26.3.20 23.4.20 30.7.20 24.9.20 Workshop 22.10.20 25.2.21 Twice weekly bulletins	**Action** **Implement Well Led Review Action plan**	
		External Systems for Staff Feedback	TMG Executive Committee WODG IGC TB	OD activity plan for year 2, bullying and harassment	Equality review meetings with commissioners (annually)	National Staff Survey 2018 Report on Key Findings and action plan in place	High	Staff Survey TB 27.2.20 Exec Jan and Feb 2020		
		People and OD strategy – implementation programme	TMG Executive Committee PODG TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB	Internal Audits CQC visit	High	TB 30.7.20 24.9.20 IGC 19.8.20 11.11.20 20.1.21		
		Staff Feedback systems		Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Well Led Review Report	High	WODG& PODG 6.3.20 15.5.20 4.8.20 3.9.20 27.10.20 1.3.21		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
				Forum Q&A Interactive Sessions				TB 27.2.20 28.5.20 30.7.20 24.9.20 26.11.20 Exec Cttee Monthly reports Oct 2020 April 2020 onwards		
	4.5 Unable to provide appropriate learning, development and training opportunities to enable staff to be skilled to the right levels, both clinically and managerially	Discovery Learning Management System (easier access to e-learning and training compliance)	PODG IGC FIC	Training Compliance to PODG Training Compliance to IGC		Internal Audits	High	IGC 19.8.20 11.11.20 20.1.21 FIC 17.3.20 18.8.20 17.9.20 19.1.21		
		Organisational Development Plan Continuous Quality Improvement Implementation	Executive Committee PODG IGC TB FIC	Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum Team Leaders Development Programme Exec. Committee Update	People and OD Reports	Internal Audit	High	WODG& PODG 6.3.20 15.5.20 4.8.20 3.9.20 27.10.20 1.3.21 IGC 19.8.20 11.11.20 20.1.21 FIC 17.3.20 18.8.20 17.11.20 19.1.21	**Action** **Continued roll out of Great Teams.**	
		Clinical leadership within teams – clinical & management leadership aligned in teams including nurse leadership & modern matrons.	Trust Management Group Senior Leadership Team Senior Leadership Forum	SPIKE Audits Supervision Appraisal	Guardian of safe working report QRMC PACE report IGC Quality report Audits	Focus Group feedback to CQC	High	IGC 18.8.20 11.11.20 20.1.21 TB 27.2.20 28.5.20 24.9.20 26.11.20 28.1.21		
		Mandatory Training Programme	IGC Executive Committee	Performance by team/service reported	Quarterly Workforce and Organisational	Internal Audits	High	WODG& PODG 6.3.20 15.5.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
		Statutory & Essential Training Policy	TMG SBU Core management SLL's	monthly from Discovery system	Development KPI Report (to services monthly) Bi-annual statutory & mandatory training report Quarterly report to WODG & TB Statutory & Essential Training Policy Ratification			4.8.20 3.9.20 27.10.20 Feb date TB 27.2.20 28.5.20 30.7.20 24.9.20 22.10.20 26.11.20 IGC 11.11.20 20.1.21 Assurance Cttee 9.7.20 19.8.20 Monthly flash reports to Exec		
	4.6 Fail to deliver the promises within the NHS People Plan ('we are the NHS') resulting in increased regretted attrition	People and OD strategy – implementation programme	TMG Executive Committee PODG TB	POCG monitoring	Monthly Executive reports Quarterly reports to IGC and TB	Internal Audits CQC visit	Medium	TB 27.2.20 28.5.20 30.7.20 24.9.20 22.10.20 26.11.20 IGC 11.11.20 20.1.21 Assurance Cttee 9.7.20 19.8.20 Audit Cttee 3.12.20	**Action** **Implement action plan to support People and OD strategy**	
		Staff Feedback systems		Team meetings Local Listens Good to Great Roadshows Big Listen Senior Leaders Forum Q&A Interactive Sessions	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Well Led Review	High	WODG& PODG 6.3.20 15.5.20 4.8.20 3.9.20 27.10.20 Feb date TB 27.2.20 28.5.20 30.7.20 24.9.20 22.10.20 26.11.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								Exec Cttee Monthly reports Oct 2020 April 2020 onwards		
		External Systems for Staff Feedback	TMG Executive Committee WODG IGC TB	OD activity plan for year 2, bullying and harassment	Equality review meetings with commissioners (annually)	National Staff Survey 2018 Report on Key Findings and action plan in place	High	Staff Survey TB 30.1.20 27.2.20 Exec Jan and Feb 2020		
5. We will improve, innovate and transform our services to provide the most effective, productive and high quality care	5.1 Failure to deliver a sustainable financial position and longer term financial plan, will impact on Trust's sustainability and ability to deliver quality improvements.	Annual Operational & Financial Plan Strategic Investment Programme NHSI Control Total NHSI Agency Cap	Executive Committee TB FIC Trust Management Group Modernising our Estate Board Executive Committee FIC Audit Committee	Monthly 'flash' reports from finance dept Weekly monitoring of key financial indicators Departmental Budget Reports (monthly) Bi-monthly FIC reports. Board Finance Reports	Financial summary report monitoring performance against plan including the NHSI Use of Resources Risk Rating and the Agency Cap Progress report on Delivery of Strategic Investment Programme	CQC reports Internal Audit Reports – CRES Planning & Delivery Internal Audits External Audit	High	FIC : 17.3.20 18.8.20 17.11.20 19.1.21 Exec Team Monthly reports Board 27.2.20 26.3.20 23.4.20 28.5.20 30.7.20 24.9.20 22.10.20 26.11.20 28.1.21		Director of Operational Finance [FIC and Audit]
			TB Audit Committee			Annual Governance Statement Annual Financial Statements & Audit Report Head of Internal Audit Opinion External Audit	High	Audit committee 30.4.20 19.6.20 Assurance Ctte 14.5.20 TB 19.6.20 AGM 15.7.20		
		Productivity Monitoring Processes	Executive Committee FIC IGC IM&T Programme Board	Monthly 'flash' reports from finance dept Weekly monitoring of	Financial summary report Annual Accounts Finance Reports CRES Programme Assurance Board	Internal and External Audit Benchmarking	High	FIC 17.3.20 18.8.20 17.11.20 Exec team	**Action** **Implement use of Model Hospital** **Delivering Value programme**	Director of Operational Finance [FIC & TB]

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
			TB	key financial indicators ICT Service Improvement Update	Trust Performance KPI report			monthly flash reports		
		Trust Contracts with Commissioners	TB FIC		Contract Update Reports	5 Year contract signed with commissioners	High	FIC 17.3.20 18.8.20 17.11.20 19.1.21 TB 30.7.20 24.9.20 26.11.20 28.1.21		
		Cash Releasing Efficiency Programme Delivering Value Programme	Executive Committee FIC TB Trust Management Group	Delivering Value Group Monthly updates to TMG	Part of Financial Summary Report Updates to CRES Assurance Board		High	FIC : 17.3.20 18.8.20 17.11.20 19.1.21 Trust Board 27.2.20 26.3.20 23.4.20 28.5.20 30.7.20 24.9.20 22.10.20 26.11.20 28.1.21		
	5.2 Staff do not have access to accurate and timely information to assist clinical and non-clinical decision making and planning, will impact on ability of Trust to innovate and transform.	Monitor, validate and audit data quality against standards	TMG Digital Strategy Board IM&T Programme Board MSC Executive Committee	Progress reports against project plan Accurate Information Group		Internal Audit Data accuracy and data quality report to Audit Committee	High	TB 7.11.20 Audit Cttee: 15.9.20 3.12.20 Covid Brd Ass Cttee 14.5.20 11.6.20 9.7.20	**Action** **Data Quality Maturity Index dashboard has been developed and added to BI reporting at team level.** **Implement findings from 20/21 internal audit programme**	Deputy CEO [FIC & TB]
		Performance Monitoring Processes	Executive Committee FIC TB	Weekly and Monthly 'flash' performance KPIs	Quality Dashboard Performance Review Process Operational Services Report Quarterly Performance Report Trust Performance KPI report	CCG Quality reports CQC inspection CQC TMA	High	Exec: Monthly and quarterly FIC: 18.8.20 11.12.20 Trust Board 27.2.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
								26.3.20 23.4.20 28.5.20 30.7.20 24.9.20 22.10.20 26.11.20		
	5.3 Failure to implement and embed digital technology will impact on service user and carer experience and our ability to transform services and support staff to respond to changing needs.	Opportunities for staff to develop ideas and implement through and innovation fund. Implementation of Digital Strategy	IM&T Programme Board Executive Committee IGC TB	Service level reports	Pulse Survey Report– Part of the Workforce & Organisational Development Report PARIS/BI Development Group – progress reports IM&T Strategy External review	Benchmarking with like organisations	High	Exec 29.4.20 IGC 17.1.20 19.8.20 Audit Cttee Deep dive 3.12.20 Trust Board 27.2.20 26.3.20 23.4.20 28.5.20 30.7.20 24.9.20 22.10.20 26.11.20		
	5.4 Do not enable or encourage people to continuously improve care provided	Continuous Quality Improvement	Executive Committee PODG IGC FIC TB	Improvement & Innovation Fund Updates Transformation Update	CQI Update Reports		High	Weekly to Exec IGC 19.8.20 11.11.20 FIC 17.3.20 18.8.20 17.11.20		Director Quality and Safety [IGC]
6. We will deliver joined up care to meet the needs of our service users across mental, physical and social care services in conjunction with our partners	6.1 Failure to develop and sustain partnerships with other organisations which will improve access to joined up services and outcomes.	Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans in year as necessary	CCG QRM Strategy Group Exec FIC TB	Stakeholder bulletins		Bi-monthly Joint Delivery Boards (Hertfordshire) Feedback from Clinical Commissioning Group Minutes (Reviews)	High	At least monthly		Director of Strategy and Integration [FIC or IGC]
		Stakeholder Map and plans	Exec Committee	Intelligence sharing via EC	Exec Buddies for ICPs	Feedback from Commissioners	Medium	Exec Team December 2020	**Action** **Stakeholder plans to be updated to reflect changing external landscape**	
	6.2 Fail to develop relationships with Primary Care Networks which means primary mental health services are	Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans	CCG QRM Exec TB	Stakeholder bulletins	Aligned NEDs and EDs to emerging system infrastructure	Bi-monthly Joint Delivery Boards (Hertfordshire)	High	At least monthly Weekly to		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
	fragmented and disjointed for service users	in year as necessary				Feedback from Clinical Commissioning Group Minutes (Reviews)		Executive Committee SLT		
	6.3 Fail to deliver integrated mental health services for older people which detrimentally impacts on their recovery and wellbeing	Integrated Care projects and plans (e.g. primary mental health, LTC, older peoples, frailty)	Executive Committee FIC TB	Complaints seen in real-time Performance data via SPIKE GP feedback Contract hotline via CCG Integrated care Systems Board Workshop Service Changes in response to Covid19	ICS Participation Project reports Aligned NEDs and EDs to emerging system infrastructure	ICS Updates to Trust Board	High	TB: 27.2.20 28.5.20 25.6.20 30.7.20 24.9.20 22.10.20 26.11.20 28.1.21 System meetings March – May 2020 Sept 2020 FIC 17.3.20 18.8.20 17.11.20 19.1.21 Covid Brd Ass Cttee 14.5.20 11.6.20 9.7.20	**Action** **Ensure appropriate representation and engagement at system meetings**	
	6.4 Fail to develop and deliver integrated services for CYP across partners, which would provide earlier intervention and suitable treatment options for young people	CAMHs transformation CYP Emotional Wellbeing work stream MH & LD ICP	TMG Exec TB	PRM SBU reporting	Executive reports Monthly TMG reports	ICP reporting ICS reporting OSM with NHSI/E Scrutiny	Medium	Weekly to Executive Committee FIC 17.3.20 18.8.20 17.11.20 19.1.21 Qly PRMs	**Action** **Continued active involvement in system wide work for Children and Young People** **Delivery of relevant MH & LD ICP work stream**	
	6.5 Fail to work with the third sector and other organisations such as the police which would lead to poor crisis response and services being available when they are at their most unwell.	Crisis concordant MH &LD ICP work stream Transformation programme	TMG Exec FIC TB	PRM Transformation programme	TB reports	Scrutiny	Medium	Weekly to Executive Committee FIC 17.3.20 18.8.20 17.11.20 19.1.21 Qly PRMs	**Action** **Continued active involvement in system wide work for Crisis services, and external partners e.g police** **Delivery of relevant MH & LD ICP work stream**	
7. We will shape and influence the future development and	7.1 Fail to develop the Hertfordshire MH and LD	MH & LD ICP Partnership Board	Exec FIC		Exec monthly updates	ICS CEO Board ICS Partnership	High	Weekly to Executive		Director of Strategy and Integration

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
delivery of health and social care to achieve better outcomes for our population(s)	ICP, which may mean voice of service users not represented and has adverse impact on resources available and care provided in the future	ICP Development Group New Co Chair of MH & LD ICP	TB		Board updates	Board E&N and West Partnership Boards		Committee Trust Board: 27.2.20 28.5.20 25.6.20 30.7.20 24.9.20 22.10.20 26.11.20 28.1.21 FIC 17.3.20 18.8.20 17.11.20 19.1.21		[FIC]
	7.2 Changing external landscape regionally and nationally leads to a shift of influence and resources away from MH and LD, the services users and communities served by HPFT	Visibility and leadership by HPFT across the ICPs ICP Leadership of MH and LD streams ICP Partnership Board ICP Transition Group East of England Provider Collaborative Locality Board membership across Herts	Executive Committee FIC TB	Clinical staff involved in system meetings Executive Committee Minutes	Updates to TB Board workshop to agree approach to emerging system architecture	Local Delivery Partnership Boards ICP local delivery group ICP Transition Groups for East & North Herts and West Herts NCM Collaborative Board	High	Weekly to Executive Committee Trust Board: 27.2.20 28.5.20 25.6.20 30.7.20 24.9.20 22.10.20 26.11.20 28.1.21 FIC 17.3.20 18.8.20 17.11.20 19.1.21	**Action**	
	7.3 Fail to develop relationships with the geographical ICPs to ensure the needs of those with LD and/or SMI, services users and communities served by HPFT are appropriately addressed	Relationships with all Key Stakeholders to drive and deliver key priorities	Executive Committee	Update to Executive Team	Weekly reports Stakeholder map and plan Aligned NEDs and EDs to emerging system infrastructure		Medium	Weekly to Executive Committee	**Action** **Stakeholder plans to be updated given changing external landscape** **Develop relationships with emerging PCNs**	
	7.4 Fail to develop the required relationships with the developing ICS to ensure there is not a shift of influence /resources away from MH & LD	Annual Plan	Executive FIC TB		Annual plan Quarterly reports CCG Commissioning Intentions. Aligned NEDs and EDs to emerging system	ICS CEO Board	High	Exec Quarterly reports on Annual Plan FIC 17.3.20 18.8.20 17.11.20		

Strategic Objective	Principal Risk	Risk Controls	Reported to	Line of assurance			Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead Lead Committee
				1st line	2nd line	3rd line				
		Emerging system strategy for MH and LD New Care Model Collaborative (leadership role for CAMHS)	Executive Committee FIC TB	Partnership Advisory Board for ICS MH and LD	infrastructure New Care Model Collaborative Directors Group	New Care Model Collaborative CEO Group		Trust Board: 27.2.20 28.5.20 25.6.20 30.7.20 24.9.20 22.10.20 26.11.20 Board workshop 17.12.20		

Hertfordshire Partnership University NHS Foundation Trust

Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 18
Subject:	Review of Terms of Reference	**For Publication: Yes**
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** David Atkinson, Non-Executive Director
Presented by:	David Atkinson, Non-Executive Director, FIC Committee Chair	

Purpose of the report:

The purpose of this report is to present the reviewed Terms of Reference for the Finance and Investment Committee for approval.

Action required:

The Board is to consider and approve the recommended Terms of Reference.

Summary and recommendations to the Board:

Summary

Each year the Finance and Investment Committee is required to review its Terms of Reference and suggest any updates it wishes to make. No changes have been made to the Terms of Reference following a review. The recent Committee self-assessment and external well led review demonstrated that the Committee is working effectively and in line with its Terms of Reference.

The FIC are recommending the Terms of Reference for approval by the Board.

Recommendation

The Board is asked to consider and approve the Terms of Reference.

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

Committee provides assurance across risk described in the BAF

Summary of Financial, IT, Staffing & Legal Implications:

None

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:

Evidence for Independent and CQC well led review

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

Considered by FIC at its meeting on 16 March 2021

TERMS OF REFERENCE

Finance and Investment Committee

Status:	The Finance & Investment Committee is a sub-committee of the Trust Board
Chair:	**Non–Executive Director**
Membership:	The Committee shall be appointed by the Board and shall consist of: Open to all Non-Executive Directors but three Non-Executives, identified by the Chair to attend, one of which will be the Committee Chair. Executive Director Finance Executive Director Quality and Safety/Executive Director Quality & Medical Leadership Executive Director Service Delivery and Customer Experience Executive Director Strategy & Integration In attendance: Head of Corporate Affairs and Company Secretary
Frequency of Meetings:	6 meetings per annum
Frequency of Attendance:	Members will be expected to attend at least three meetings each year. If members miss two consecutive meetings, membership will be reconsidered by the Committee Chair (subject to exceptional circumstances).
Quorum:	A quorum shall be three members including at least one Executive Director and two Non-Executive Directors

1. Remit

1.1 The Finance & investment Committee is a Standing Committee of the Board.

1.2 The remit of the Group is to:

"To conduct an independent and objective review of financial and investment policy and performance issues including the assessment and monitoring of risk in respect of financial and performance issues".

2. Accountability

2.1 A report will be made by the Chair to the Trust Board following each committee meeting. The report will contain:

- A note of all the items discussed by the Committee
- Matters for noting by the Board
- Recommendations to the Board regarding decisions to be taken by the Board
- Any other issues as agreed by the Chair & Company Secretary.

2.2 The minutes of the Finance & Investment Committee meetings shall be formally recorded and submitted to the Board and Audit Committee.

2.3 A six monthly report from the Finance & Investment Committee shall be submitted to the Audit Committee.

3. Responsibilities & Duties

3.1 Financial Policy, Management and Reporting

3.1.1 To consider the Trust's financial strategy, in relation to both revenue and capital.

3.1.2 To consider the Trust's annual financial targets and performance against them.

3.1.3 To review the annual budget, before submission to the Trust Board of Directors.

3.1.4 To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets.

3.1.5 To review proposals for major business cases and their respective funding sources.

3.1.6 To commission and receive the results of in-depth reviews of key financial issues affecting the Trust.

3.1.7 To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and contractual safeguards.

3.1.8 To oversee and receive assurance on the financial plans of significant programmes.

3.1.9 To consider the Trust's tax strategy.

3.1.10 To annually review the financial and accounting policies of the Trust and make appropriate recommendations to the Audit Committee Board of Directors.

3.2 Investment Policy, Management and Reporting

3.2.1 To approve and keep under review, on behalf of the Board of Directors, the Trust's investment strategy and policy.

3.2.2 To maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and NHSI's requirements.

3.3 Performance Monitoring and Reporting

3.3.1 To consider the Trust's the full range of annual performance targets and performance against them.

3.3.2 To consider the Trust's performance including performance against national, local and internal targets and contractual requirements.

3.3.3 To commission and receive the results of in-depth reviews of key performance issues affecting the Trust.

3.4 Other

3.4.1 To make arrangements as necessary to ensure that all Board of Directors members maintain an appropriate level of knowledge and understanding of key financial and performance issues affecting the Trust.

3.3.2 To examine any other matter referred to the Committee by the Board of Directors.

3.3.3 To review performance indicators relevant to the remit of the Committee.

3.3.4 To monitor the risk register and other risk processes in relation to the above.

4. Other Matters

The Committee shall be supported administratively by the Head of Corporate Affairs and Company Secretary, whose duties in this respect will include:

- agreement of agenda with Chair and collation of papers
- ensuring minutes and accurate record of matters arising and issues to be carried forward
- advising the Committee on pertinent areas

5. Monitoring of Effectiveness

5.1 The group will review its own performance and terms of reference at least once a year to ensure it is operating at maximum effectiveness.

Terms of Reference agreed by FIC: 16 March 2021

Terms of Reference agreed by Board: xx

Date of Review: tbc

NHS
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Board of Directors PUBLIC

Meeting Date:	25 March 2021	**Agenda Item:** 19
Subject:	Six monthly report from Nominations and Remuneration Committee: covering the period July 2020 to February 2021.	**For Publication: Yes**
Author:	Helen Edmondson, Head of Corporate Affairs and Company Secretary	**Approved by:** Sarah Betteley, Chair
Presented by:	Sarah Betteley, Chair	

Purpose of the report:

To provide the Board with an overview of the work undertaken by the Nominations and Remuneration Committee in the period July 2020 to February 2021.

The report is required by the Committee's Terms of Reference.

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.

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

List specific risks on BAF – 2.1, 4.1, 7.1

Summary of Implications for:

None

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

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

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

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

Not applicable

1. Introduction

1.1 The Nominations and Remuneration Committee is a Committee of the Trust Board of Directors and is responsible for:

- Reviewing and making recommendations to the Board of Directors on the composition, balance, skill mix and succession planning of the Board. It recommends to the Board of Directors the appointment of Executive Directors.

- Setting the remuneration policy for the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

- Approving contracts of employment for the Chief Executive, Executive Directors, and non-voting Directors and other senior managers reporting directly to the Chief Executive.

- Agreeing arrangements for termination of contracts, including severance payments paid to the Chief Executive, Executive and non-voting Directors and other senior managers reporting directly to the Chief Executive.

2. Meetings from July 2020 to February 2021.

2.1 Since July 2020 the Committee has met four times:

- 22 July 2020
- 10 November 2020
- 6 January 2021
- 9 February 2021

2.2 Each meeting was quorate as outlined in the Committee's Terms of Reference. Please note that the Trust's Annual Report will detail the attendance for each Committee member for 2020/21.

2.3 At the beginning of each meeting any conflicts of interests were reviewed and mitigating action taken as appropriate.

2.4 The Committee forms part of the overall governance framework for the Trust which supports the assurances and controls detailed in the Board Assurance Framework.

2.5 During the past six months a range of topics were discussed in line with the Committee's responsibilities, namely:

- Changes to the Executive team and structure
- Recruitment to the Executive Team, including skills required, remuneration and terms & conditions
- Update on relevant employee relations cases
- Executive Team objectives: setting and performance against
- Succession planning for the Executive Team

3. Committee Effectiveness

3.1 Each meeting in the past six months has been minuted and matters arising logged and followed up.

3.2 The Committee's agendas have been in line with the Terms of reference and papers distributed in advance of the meeting.

3.3 The Terms of Reference for the Committee are scheduled to be reviewed in quarter one of 2021/22 and will be recommended to the Trust Board for ratification.

3.4 Committee members and attendees are scheduled to undertake an effectiveness self-assessment questionnaire in first quarter of 2021/22 and will be reported to a future Committee meeting.

4. Next Steps

4.1 The Committee will review the outcome of the self- assessment, identifying and agreeing any actions as required.

4.2 The Committee will review and recommend their Terms of Reference for approval by the Trust Board.

4.3 The Committee will consider and agree its annual work plan(?) to ensure it complies fully with its terms of reference and consider all required areas e.g. gender pay; Fit and Proper Person and remuneration policy.