Hertfordshire Partnership University NHS Foundation Trust
Board of Directors - PUBLIC

Da Vinci A and B, The Colonnades, Beaconsfield Road, Hatfield, Herts., AL10 8YE

25 January 2018 09:30 - 25 January 2018 12:30

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Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 25th January 2018

The Colonnades, Beaconsfield Road, Hatfield AL10 8YE
Da Vinci A&B

Public Session of Trust Board 10.00hrs to 12.30hrs
to commence with
Service User Presentation 09.30 to 10.00

A G E N D A

PUBLIC

ITEM	SUBJECT	BY	ACTION	
1.	Welcome and Apologies for Absence	Chair		
2.	Declaration of Interests	Chair	Note/Action	Verbal
3.	Minutes of Meeting dated 29th November 2017	Chair	Approve	Attached
4.	Matters Arising Schedule	Chair	Review	
5.	CEO Brief	Tom Cahill Chief Executive	Receive	Attached
QUALITY & PATIENT SAFETY				
6.	Patient Safety Q3 Reports (i) Patient Safety Report (ii) Safeguarding Report	Dr Jane Padmore	Receive	Attached
7.	Report from Integrated Governance Committee	Sarah Betteley	Receive	Attached
8.	PLACE Audit Outcomes 2017 Report	Keith Loveman	Receive	Attached
9.	Service User Experience (i) Q3 Report (ii) Community Survey Results & Action Plan 2017	Jess Lievesley	Receive	Attached Attached
10.	Learning from Deaths Dashboard	Dr Asif Zia	Receive	Attached
	Questions from the Public			
OPERATIONAL AND PERFORMANCE				
11.	Workforce and OD Q3 reports	Jinjer Kandola	Receive	Attached
12.	Finance Q3 Report	Keith Loveman	Receive	Attached
13.	Report from Finance & Investment Committee	Simon Barter	Receive	Verbal
14.	Annual Plan Q3 Report	Karen Taylor	Receive	Attached

Questions from the Public				
GOVERNANCE AND REGULATORY				
15.	**Report from Audit Committee**	**Catherine Dugmore**	**Receive**	**Verbal**
16.	**Board Assurance Framework**	**Jonathan Elwood**	**Receive**	**Attached**
17.	**Trust Risk Register**	**Jane Padmore**	**Receive**	**Attached**
18.	**Sub Committee Terms of Reference Annual Review**	**Jonathan Elwood**	**Approve**	**Attached**
Questions from the Public				
19.	**Any Other Business**	**Chair**		
20.	**Date and Time of Next Public Meeting: 22nd March 2018 09:30hrs to 13:30hrs in Da Vinci A&B**			
21.	**Resolution to hold remainder of meeting in private**	**Chair**	**Approve**	**Attached**

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: Chris Lawrence

Hertfordshire Partnership NHS
University NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING
Held on Wednesday November 29th, 2017
Da Vinci B – Colonnades

PRESENT:

NON-EXECUTIVE DIRECTORS	
Christopher Lawrence	Chair
Catherine Dugmore	Non-Executive Director
Loyola Weeks	Non-Executive Director
Robbie Burns	Non-Executive Director
Sarah Betteley	Non-Executive Director
Simon Barter	Non-Executive Director
Tanya Barron	Non-Executive Director

EXECUTIVE DIRECTORS	
Tom Cahill	Chief Executive
Asif Zia	Director Quality & Medical Leadership
Jane Padmore	Director Quality and Safety
Jess Lievesley	Director Service Delivery & Customer Experience
Karen Taylor	Director Strategy and Integration
Keith Loveman	Director Finance
Jinjer Kandola	Deputy CEO & Director Workforce & Organisational Development
Ronke Akerele	Director of Innovation and Transformation

IN ATTENDANCE	
Jonathan Elwood	Company Secretary
Allison Lerner	Personal Assistant (Minute Taker)
Gill Stevens	Executive Assistant

MEMBERS OF THE PUBLIC	
Barry Canterford	Public Governor
Tap Bali	Public Governor
Meredith Griffiths	Public Governor
Graham Wright	Staff Governor

APOLOGIES	
Michelle Maynard	Non-Executive Director

Item No	Subject	Action
95/17	**Welcome and Apologies for Absence** Chris Lawrence welcomed all present to the meeting. Apologies were received from: Michelle Maynard, Non-Executive Director	
96/17	**SERVICE USER PRESENTATION** The Chair welcomed a Service User, who presented on his personal experiences from diagnosis to recovery. He presented some of his poetry.	
97/17	**Tom Cahill –Awarded CEO of the Year!** CL was pleased to inform the meeting that Tom Cahill, Chief Executive Officer for being named as CEO of the Year by the Health Service Journal (HSJ). This was a wonderful reflection on how well TC leads the Trust, all present passed on their congratulations.	
98/17	**Declarations of Interest –** None declared	
99/17	**Minutes of Meeting dated** The Minutes of meeting dated 27th September 2017, and with minor drafting changes were approved as an accurate record.	
100/17	**Matters Arising:** Agenda item 75/17, There had been a failure in with the evaluation software, . **No further matters arising**	
101/17	**CEO Brief – Tom Cahill** TC presented his brief and expanded on the following points: The Chancellor has increased NHS funding in the budget, but not by as much as had been anticipated. The Treasury has committed an extra £3.5bn to NHS capital spending over the next three years. **DELAYED TRANSFER OF CARE (DTOC) –** There is currently a national drive to free up beds over the coming winter months. NHSI CEO, Jim Mackey, has written to CEO's of all Trusts that provide community services with a list of six actions to be implemented in the next 6 months to reduce DTOC. **NHSI –** TC announced that the new Chair of NHS Improvement is Baroness Harding. CL has invited her to visit HPFT early in the New Year. **ESSEX LD –** A strong bid has been prepared and submitted together with our partners EPUT and ACE to commissioners, we hope to hear back by the end of this month. **CQC –** TC informed the Board that the Well Led inspection will commence on Monday 5th February. They will be working in our offices for three to four days and it is anticipated they will be attending the Board of Directors meeting in January 2018. **CQC Broadlands** – The CQC visit to Broadlands in September had found staff to be responsive, knowledgeable and caring, however some issues had been highlighted and the Trust is responding to these. **CAHMS** – There has been real progress in CAMHS and access waiting times are being further reduced. TC reminded the Board of the Staff Award event taking place on November 30th. **The CEO Brief was noted.**	
102/17	**Report of the Integrated Governance Committee held 13-Sep-17** SB, updated the Board on the work of the IGC and noted the key points from the	

	last meeting. These included the Annual Health, Safety & Security Report noting the significant work that has been done in terms of understanding patients requirements. This will provide clearer definitions and improve the recording of incidents with regards to absconding and AWOL events. SB highlighted a need for better understanding with regards to Lone Workers and the issuing of safety devices. These devices can alert authorities and track location. IGC will carry out a deep dive. This will be brought back to the December IGC meeting. The Board thanked Sarah Betteley for her update, noting its contents.	
103/17	**Q1 2017/18 Patient Safety Report;** JP informed the Board that we remain at the top of the lower band of reporting compared to other Mental Health Trusts. JP confirmed we are reporting the relevant matters appropriately. We have joined the Suicide Alliance and are actively involved in suicide prevention. The Deputy Director of Safer Care and Standards will represent the Trust at the launch event in November. **Serious Incident Report –** A total of 16 SI's were reported externally, a decrease compared with the previous quarter. There were 67 service user deaths reported on Datix in Q2, 50 of which were due to natural causes or pre-existing health conditions. The Hertfordshire and West Essex STP has the lowest rate of SI's in England. In terms of Learning from SI's, there has been significant involvement with carers being offered Risk Training sessions. There has been good communications and joint working with DGL. The Board discussed how we embedding this learning. **Safe Staff Report** – The Trust continues to have some challenges with recruitment with 21% vacancies for registered nursing and 17% for unregistered nursing. The Nursing retirement rate has changed from 17% to 21%. A discussion took place on the accuracy of the figures for vacancy rates and the challenges faced including locations and staff moving across organizations. The Board discussed the figures of staff expected to retire in the future and plans that are in place to keep track on this. JL confirmed we now have a 'live feed' for staffing numbers. **The Board received the report**	
104/17	**WORKFORCE AND OD Q2 REPORTS** JK advised the Board that the overall Trust vacancy rate has declined in Q2 to 14%. Work continues to improve levels of recruitment as well as staff retention. There was a successful Open Day in September which resulted in almost 40 new candidates however there are concerns that people are not generally coming into the nursing profession as before. A discussion took place with regards to retired staff and the options they have if they choose to return to work including pay bands and part-time contracts. It was noted that younger members of staff have a staying period of approximately 2 years. JK confirmed that managers are being equipped to help staff grow in their roles and openly discuss their career goals. TC noted there has been a sense of pressure on staff and noted that past surveys have showed that our staff recognize that we care about their health and wellbeing. There has been a significant amount of work with regards to engagement activities including The Big Listen, Local Listens and the Senior Leaders Forums in order to listen and support our staff. **The Board received the report**	

105/17	**FINANCE REPORT** KL presented his report and informed the Board that the overall position continues to tighten. KL commented on the meeting with NHSI which started next years contract discussions. The overall Trust position reported in October is a surplus of £72k which is better than plan by £59k. The overall Trust position year to date (before STF) is a surplus of £1.017m, which ahead of plan by £550k. **The Board received the report**	
106/17	**PERFORMANCE REPORT** JL informed the Board that we are performing well as an organization. All CAMHS access targets were met in September and this was reflected in a CQC commendation. The SPA referrals target has also shown major improvement in the period and is at its highest level. CATT gatekeeping has reported at 100% in the quarter. There has been an increase of referrals and work is being done to ensure these are appropriate. JL noted that new leadership is in place for North and South and this should address any areas of concern. A recent Government reports has outlined Hertfordshire CAMHS as an area of excellence. **The Board received the report**	
107/17	**Q2 COMPLAINTS AND SERVICE USER EXPERIENCE** JL presented the report and is again delighted to report we receive more compliments than complaints during Q2. Figures show that 88% would recommend our services to family and friends. Many of the complaints were mostly due to waiting times. All of our outgoing letters have been reviewed and where necessary altered to reflect service user feedback comments. This issue was recently mentioned during a carers presentation to Board. ***The Board received the report***	
108/17	**Q2 ANNUAL PLAN REPORT** KT advised the Board the Annual Plan is comprised of ten objectives across the four themes of the Trust's 'Good to Great' strategy. Each objective receives two RAG ratings: 1. An assessment of whether the Trust is on track of achieving the stated outcome by year end. 2. An assessment of whether the milestones and actions planned for that quarter were achieved. At the end of Q2 solid progress has been made. The Annual Plan demonstrates eight out of ten objectives are RAG rated green and are on track. KT noted good progress has been made against the milestones contained within the Annual Plan with 5 rated green and 5 rated amber. The Board discussed progress against the plan and the individual milestones. **The Board received the report**	
109/17	**FREEDOM TO SPEAK UP 6 MONTH REPORT** The Trusts Freedom to Speak up Guardian CP, presented to the Board. CP noted that following national guidance the Trust had rebranded from 'Whistleblowing' to 'Speak Up'. There has been a steady increase in numbers as this has been more publicized and leaflets are being given at staff inductions. Data is reported nationally and all speak up concerns are securely stored on the Datix system.	

	A discussion took place with regards to allegations and process if a staff member speaks to CQC. CP confirmed that the CQC would take a summary and ask us to provide a response. **The Board received the report**	
110/17	**TRUST RISK REGISTER (TRR)** JP informed the Board that the TRR is a live document. Risks escalated to the Risk Register include the unannounced inspection of the Broadland Clinic and Mandatory training compliance. The Board discussed the risks relating to; Broadlands, landscape, recruitment and retention, access to CAMHS and demand on Managers. **The Board received the report**	
111/17	**BOARD ASSURANCE FRAMEWORK** JE is reviewing controls against objectives. BAF is a standing item on the Integrated Governance Committee (IGC) and goes to The Board on a quarterly basis. TC noted the informal audit check and asked if it will be going through a formal audit check in the new year JE confirmed it would. CQC will be requesting the BAF and Risk Register. **The Board received the report**	
	Governors as Mental Health Act managers JE informs the Board that there is no legal reasons why Governors may not be appointed to Mental Health Act Managers. A Mental Health Governor will require an additional check on the suitability of all candidates from the Chair. **The Recommendation has been approved by the Board.**	
112/17	**Amendments to the Mental Health Act under Policing and Crime Act** JL informed the Board of changes to the MHA as a result of the **Policing and Crime Act**. JL outlined the significant work that had been done with all the relevant agencies to prepare for these changes. TC asked as this is new legislation are we ready? JL was very confident that we were.	
	Any Other Business The Chair congratulated JK for graduating from the Aspiring Chief Executive program. JK is very highly regarded and many congratulations for completing this programme.	
	Date and Time of Next Public Meeting: Thursday January 25th 2018 9.30 – 13.30 Da Vinci B&C, Colonnades	

Hertfordshire Partnership NHS
University NHS Foundation Trust

Public Board of Directors Meeting

	25th January 2018	Agenda Item:
Subject:	**CEO Brief**	

National

NHS Under Pressure

As you will be aware NHS England has kicked into gear a series of recommendations to help hospitals handle increased pressure on services, activating the NHS Winter Pressures Protocol.

This includes extending the deferral of all non-urgent inpatient elective care to 31 January, deferring day-case procedures and routine outpatient appointments and advising clinical commissioning groups to temporarily suspend sanctions for mixed sex accommodation breaches. The measures, put forward by the National Emergency Pressures Panel (NEPP), come in response to strains being felt by NHS services across the country over the festive period.

You may have read in the that senior doctors in charge of more than 60 A&E departments have written to the Prime Minister warning of "very serious concerns" about patient safety amid the winter crisis, including a case of patients dying prematurely in corridors. The letter, advised that waiting time performance in some departments was as low as 45% last week and never higher than 75%/ Also that the NHS was "chronically underfunded" and short of beds and that preparations for winter had "failed to deliver anywhere near what was needed".

The CQC have indicated that they are suspending inspections due to winter pressures in acute, GP and emergency providers, the CQC have confirmed that this is not applicable to mental health providers.

http://www.cqc.org.uk/news/stories/cqc-responds-increased-pressure-health-social-care-pausing-some-routine-inspections

Cabinet Reshuffle

In the reshuffle Jeremy Hunt MP, has seen his portfolio expanded and will now be Secretary of State for Health and Social Care. A Green Paper on Social Care is due in May, and the Jeremy Hunt.

National Workforce Strategy Publication

Health Education England has published '*Facing the facts, Shaping the Future'*, a draft health and care workforce strategy for England to 2027. This follows the secretary of state's commitment at the NHS Providers annual conference that for the first time the health and care system would have a long-term national workforce strategy.

A consultation on the draft strategy will run until Friday 23rd March 2018. Regional meetings and webinars will be offered by HEE among other ways to contribute. We will submit a formal response and will engage with you on this early in the New Year. The final version of the strategy will then be published in July 2018.

HEE is proposing a set of six high level principles that will underpin future workforce decisions:

1. Securing the supply of staff, with particular attention on the supply of the UK workforce in order to lessen the need to recruit staff from other countries.
2. Enabling a flexible and adaptable workforce through investment in education and training of new and current staff. While recognising that NHS professionals have distinct roles, HEE has acknowledged there is scope for blending clinical responsibilities which can be rewarding for staff.

3. Providing broad pathways for careers in the NHS, with structured career opportunities to enable staff to progress both within and between professions.
4. Widening participation in NHS jobs, so that people from all backgrounds have the opportunity to contribute and benefit and the NHS workforce of the future more closest reflects the populations it serves.
5. Ensuring the NHS and other employers in the system are inclusive modern model employers, with flexible working patterns, career structures and rewards. Part of this involves addressing the changing expectations of all generations who work in the NHS.
6. Ensuring that service, financial and workforce planning are intertwined. Alignment across these areas is intended to foster realism alongside creativity in considering what the workforce can contribute to a new or changing service.

HPFT will be responding to this consultation, and a session with the IGC (integrated governance committee will be held at their next meeting).

Mental Health Act Review

The Government has commissioned an independent review of mental health legislation and practice to tackle the issue of mental health detention. There have been concerns that detention rates under the Mental Health Act are too high. The number of detentions has been rising year on year, and last year on average there were 180 cases a day where people were sectioned under the terms of the act. People from black and minority ethnic populations are disproportionately affected, with black people in particular being almost 4 times more likely than white people to be detained.

The Government is committed to improving mental health services and ensuring that people with mental health problems receive the treatment and support they need, when they need it. This can mean that people need to be made subject to the Mental Health Act – that is, be detained or 'sectioned'. In these cases, our dedicated professional staff – including psychiatrists, nurses, social workers, and the police – work tirelessly to ensure that people are treated with dignity under the Act, and that their liberty and autonomy are respected as far as possible.

Professor Sir Simon Wessely, former President of the Royal College of Psychiatrists, will lead the review which will deliver recommendations for change to the Government. Sir Simon will look at the evidence, review practice, and above all consider the needs of service users and their families, and how best the system can help and support them. He will identify improvements in how the Act is used in practice, as well as how we might need to change the Act itself. Vice Chairs will be appointed to work with Sir Simon and ensure the leadership of the review has comprehensive professional expertise whilst also being representative of service users and others affected by the Mental Health Act.

Following consultation with stakeholders, Sir Simon will produce an interim report identifying priorities for the review's work in early 2018, and develop a final report containing detailed recommendations on its priorities, by autumn 2018. Further detail on the independent review, including its Terms of Reference, can be found at:
https://www.gov.uk/government/news/prime-minister-announces-review-to-tackle-detention-of-those-with-mental-ill-health

CQC Chief Executive

Sir David Behan has announced his intention to step down as Chief Executive of the CQC in the summer. Sir David joined in 2012, and has made substantial changes under his leadership, many in response to the Francis inquiry into events at Mid Staffordshire Foundation Trust. An appointment process will commence in due course to find his successor.

Hertfordshire & West Essex STP Leadership

As you now, I have decided to step down from the STP, as I recognised that the time was right now for a full-time Chief Executive Lead. Deborah Fielding who is currently Chief Executive of West Essex Clinical Commissioning Group a has been appointed and taken up post from 16 January.

West Herts Hospitals NHS Trust - Special Measures Exit

I am pleased to announce that the CQC found following a review of WHHT they sufficient improvement in the care provided to remove the Trust from its Special Measures Status. This is good news for the trust, Staff and its patients, The Trust had been placed in Special measures a little over 2 year ago. Further details can be found on the CQC website

Internal and Reputation

Operational Services

I am delighted to say that our services planned for and performed extremely effectively through the winter period, with all those who required inpatient care across our services able to access the support they needed. Despite some adverse weather all our services were able to keep running. We have seen higher than expected acuity across our LD inpatient services and via our section 136 suites. Our teams have responded well to ensuring that we are able to support our service users in these environments and we recognise that this has placed additional pressures on these clinical teams.

As a whole system we have seen our acute partners under considerable pressure, particularly in the period immediately after Christmas day. We continue to work with these teams top offer direct support and our clinical teams that interface with the wider system are doing a sterling job in ensuring that we are not contributing to further delays.

We are still experiencing a few difficulties in managing demand and capacity in SW Herts adult services, however progress is being made and we expect them to have recovered their position my mid-January.

Finance

The overall Trust position reported in November is a surplus of £46k, which is below the Plan of £82k by £36k (before STF). The overall Trust position year to date (before STF) is a surplus of £1.063m, which is ahead of the Plan of £549k by £514k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating, the UOR, reports as a 1, the highest rating. A full finance report is on the agenda.

Performance

The summary position for November is positive in terms of the sustained improvement across the broad range of measures. The principal challenges remain within access for 28 days adult community within the SW quadrant, access to Mid- Essex IAPT and the number of our service users with up-to date risk assessment.

November saw changes in the NHSI Oversight Framework with new national measures implemented on Out of Area Placements and data quality with some changes to other existing measures. The full detail of the new measures and the national standards is still awaited however the new data quality measures will require some data issues to be improved upon. A full performance update is on the agenda.

CQC Well-Led Inspection

The board are reminded that the CQC will carry out its “Well Led” review of the Trust week commencing Monday 5th February. The review will include a significant number of face to face interviews with leaders across the organisation including Board members. It is expected that an unannounced inspection of a number of “Core Services” will be undertaken prior to this.

Carillion

The Trust has reviewed our contracts for all services following the events relating to Carillion. We are able to confirm that HFPT have no direct contracts with Carillion, however we are checking that there are no other connections relating to sub-contractors. We are also assessing the situation in relation other contracts and will ensure that appropriate contingencies are in place to mitigate the risks such incidents

Tom Cahill
Chief Executive

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	**25.01.18**	**Agenda Item: 6 (i)**
Subject:	Quarter 3 2017/18 Patient Safety Report	**For Publication: No**
Author:	Bela Da Costa, Legal Services Lead and Nikki Willmott, Head of Safer Care and Standards	**Approved by: Dr Jane Padmore, Executive Director Quality and Safety**
Presented by:	Dr Jane Padmore	

Purpose of the report:

The Quarter 3 Patient Safety Report is being presented to the Board to provide an overview of incident data and serious incidents reported external to the Trust in Quarter 3 of 2017/18 and to provide assurance on how the Trust's patient safety data compares nationally in order to benchmark HPFT with performance of other Trusts.

The Patient Safety Report provides members with an overview of incidents and serious incidents reported on the Trust's Datix incident reporting system during Quarter 3 of 2017/18 (1/10/2017 – 31/12/2017) with the use of safety metrics. Datix is a live data base and therefore the data in this report was taken on 1st January 2018 at 21.30pm.

As part of the Trust's commitment to further develeop the Patient Safety report to provide assurance to the Board of Directors around Trust performance on key aspects of patient safety this report is expected to further develop over time with support from the Trust's Director of Innovation and Transformation and the Executive Director of Quality and Safety.

Action required:

The Board is asked to receive the report.

Summary and recommendations:

The Trust has reported no Never Events in this Quarter or Year to Date.

A total of 3096 incidents were reported on the Datix system in Quarter 3 2017/18; 2354 of these incidents resulted in No Harm, 71 incidents resulted in Moderate Harm. 1 incident reported resulted in Severe Harm in this Quarter. The main report contains information on actins being taken in relation to Ligature, Slips, Trips and Falls and Violence & Aggression Incidents.

There were 82 incidents related to deaths of current service users or those discharged in the previous 12 months of which 58 were confirmed as due to natural causes or a pre-existing physical health condition. The Trust's Mortality Governance Group has oversight of all deaths reported on Datix and those subject to a review. This includes those reported to the Learning Disabilities Mortality Review (LeDeR) programme, which aims to make improvements to the lives of people with learning disabilities.

A total of 18 (17) Serious Incidents were reported external to the Trust in this reporting timeframe and were subject to an internal review in keeping with the Serious Incident Framework. This compares to a total of 16 serious incidents reported external to the Trust in the previous Quarter. One of these serious incidents was subsequently downgraded.

The serious incidents are listed by the StEIS categories as follows:

- Unexpected/avoidable deaths (12)
- Slip/trip/fall meeting SI criteria (2)
- Disruptive/ aggressive/ violent behaviour meeting SI criteria (1)
- Confidential information leak/information governance breach meeting SI criteria (1)
- Unauthorised absence meeting SI criteria (1)
- HCAI/Infection control incident meeting SI criteria (1) (subsequently downgraded)

Trust data on service user deaths receiving a Suicide conclusion at Inquest in 2015 and 2016 is aligned with the Office National Statistics published data, showing a 21% decrease in the number of suicides by date of inquest in 2016 compared with the number of suicides by date of inquest in the previous year.

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

This report sets out how the Trust is performing against Business Plan Priority 1.

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

There are currently no known financial implications arising from this report.

Equality & Diversity /Service User & Carer Involvement implications:

N/A

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

This report provides evidence in relation to the CQC Essential Standards and the Safe KLOE

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

The report has been reviewed by the IGC

HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST (HPFT)

SUMMARY OF PATIENT SAFETY RELATED INCIDENT AND SERIOUS INCIDENT DATA

QUARTER 3 2017/18 REPORT

1. PURPOSE OF THE REPORT

The following report provides a summary of incident data reported between 1st October 2017 and 31st December 2017, alongside a review of trends or themes. It also includes a review of mortality data and serious incidents reported and investigated by the Trust.

The report is split into the following sections:

- Overview of Trust incident data
- Key areas of learning

Datix is a live database; as such, the data in this report is from one point in time. This data was taken from Datix at 9.30pm on 1st January 2018.

2. INCIDENTS REPORTED

GENERAL TRUST WIDE INCIDENT REPORTING

The graph below shows that the number of incidents reported across all Trust services has remained largely consistent since the start of 2017/18. Similar numbers of incidents are reported on weekdays, with fewer incidents being reported on a weekend.

Chart 1 Total number of incidents reported on Datix year to date

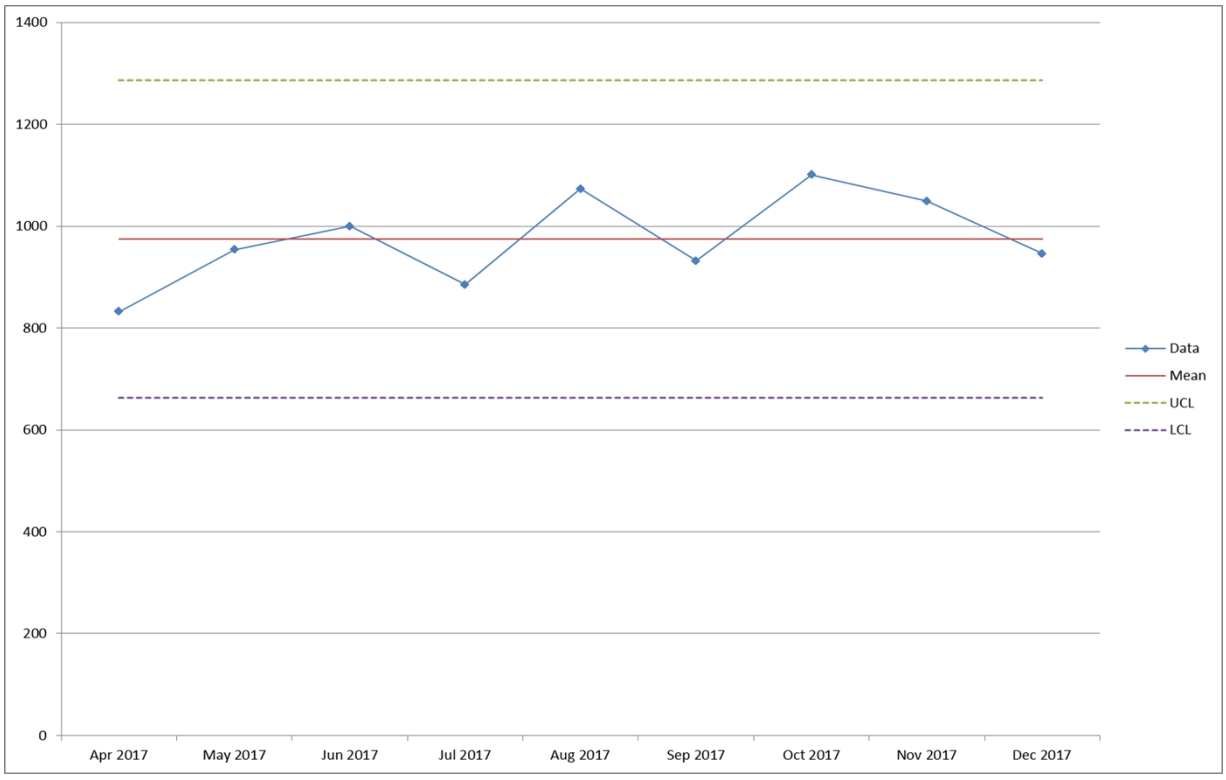
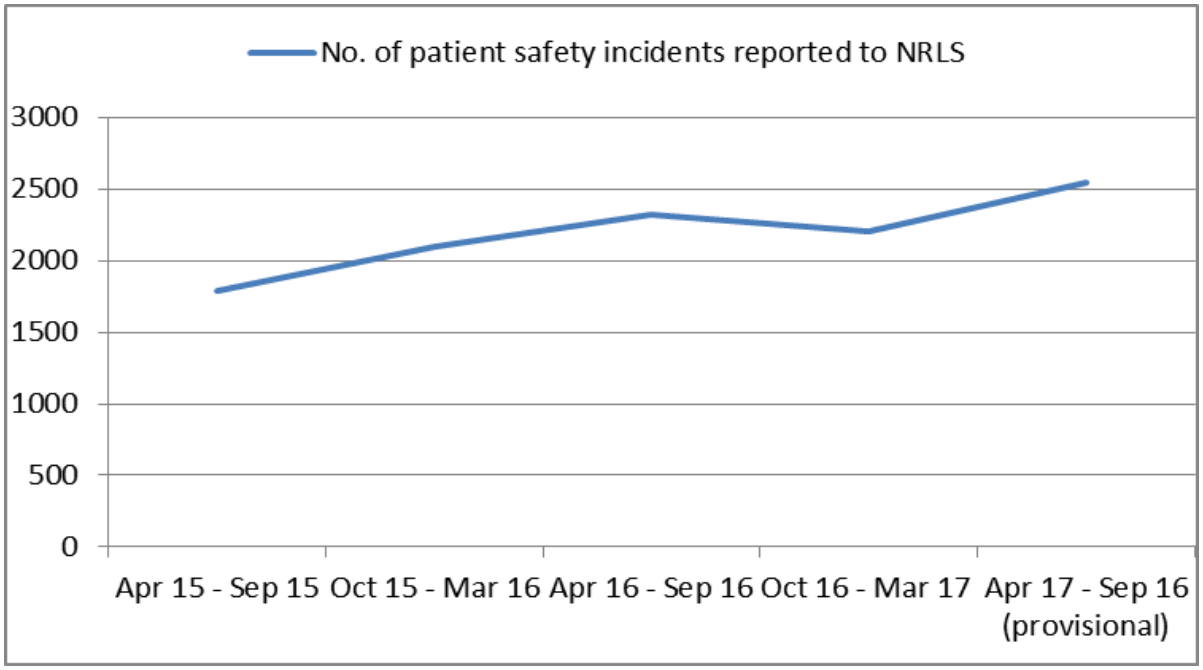


Chart 1 shows that some variances should be expected when comparing incident data over time as this can depend on factors such as ward acuity or an increase in incidents involving a specific service user. It is recognised that variances can also be an indicator of safety concern and interrogation of data at local level is undertaken where an unexpected variance is observed. Datix Dashboards are used by managers to monitor emerging trends or themes and can highlight where a deep dive may be required or actions need to be taken.

The Safer Care Team regularly uploads relevant patient safety incidents to the National Reporting and Learning System. The next release of the Organisational Patient Safety Incident Report data for NHS organisations will be published in March 2018. This release will provide information about incident data reported by the Trust between 1st April 2017 and 30th September 2017. Provisional data is shown in Chart 2, which indicates an increase in the number of patient safety incidents the Trust reported to the NRLS when compared with the previous published report, up from 2,199 to 2,541. There has been a continued increase in the number of patient safety incidents over the past five reporting periods as work has continued to encourage reporting.

Chart 2 Comparative reporting rate per 1,000 bed days



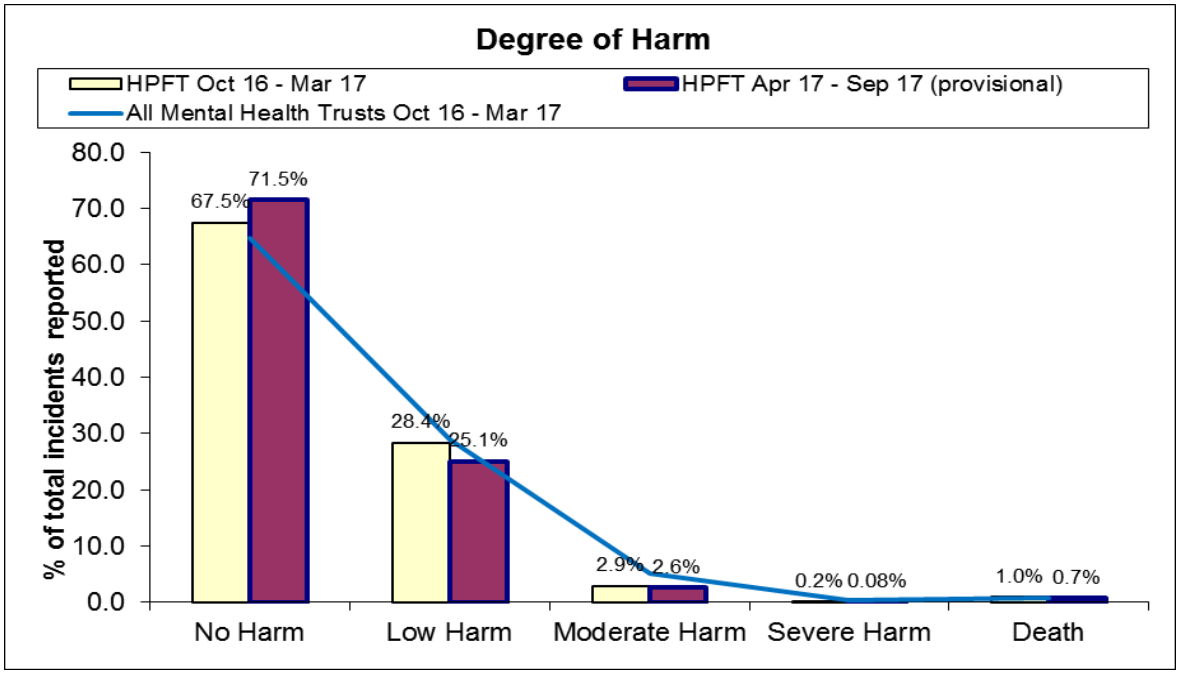
Alongside review, sign off and local monitoring of incident data by managers in each of the Strategic Business Units, the Safer Care Team also undertakes a quality assurance review of incident data; this provides assurance that the Trust is compliant with NRLS reporting criteria and ensures consistency of approach around data quality.

Degree Of Harm – Severity And Impact

Severity

With regard to degree of harm, provisional data shows that 71.6% of all patient safety incidents reported by this Trust to the NRLS between 1st April 2017 and 30th September 2017 resulted in no harm to service users; the average across all Mental Health Trusts in the previous reporting period was 64.8%. The ratio of HPFT patient safety incidents resulting in Severe Harm to service users is expected to be lower in the next published report, down from 0.2% to 0.08%, whilst the proportion relating to service user deaths has fallen from 1% to 0.7%. A comparison with the last published report's data is provided in Chart 3 below.

Chart 3 Incidents reported to NRLS by degree of harm



The Datix Lead continues to deliver Datix training for staff which is expected, over time, to increase awareness of types of incidents that should be reported, how incident reporting has a direct link to highlighting patient safety issues enabling actin to be taken and the importance of data quality. Training is also delivered for Operational managers to highlight how the use of Datix Dashboards enables monitoring of potential trends and themes.

Impact

A total of 3096 incidents were reported on the Datix system in Quarter 3 2017/18; 2354 incidents resulted in No Harm, 71 incidents resulted in Moderate Harm. 1 incident reported in this Quarter resulted in Severe Harm. Appendix 1 contains the definitions of severity of harm.

Within this reporting period, a total of 82 incidents related to service user deaths of which 58 were confirmed as due to natural causes or a pre-existing physical health condition. The Trust's Mortality Governance Group has oversight of all deaths reported on Datix and those which are subject to a structured judgement review or a serious incident investigation; this also includes those deaths meeting criteria for reporting to the national Learning Disabilities Mortality Review (LeDeR) programme which aims to make improvements to the lives of people with learning disabilities.

Specific Actions Taken

Making Our Services Safer - During Quarter 3 the Clinical Risk and Learning Lessons Group has incorporated the work of the Making our Services Safer (MOSS) Group. The rationale for this was to ensure the work to ensure we deliver safe services and learn from incidents is joined up. The terms of reference have been updated to reflect this change. A new template for MOSS reporting and data collection has been provided to the key leads to ensure consistency of approach and comparison so that learning can be strengthened between services and a focus on sharing of key initiatives and data informed care.

Ligature Incidents - There were a total of 71 ligature incidents reported on Datix in Quarter 3 which is an increase in the number reported when compared to the same period last year (55). This is a decrease of 13 incidents reported in the previous Quarter (84). Interrogation of the data by the Health & Safety Manager and the Practice Development & Patient Safety Lead shows that personal items of clothing (shoe laces) and electrical cables are primarily being used by service users in self-harm incidents in our inpatient services. It was also identified that a small number of service users are responsible for multiple incidents. It is recognised that it remains a challenge to manage the risk of self-harm incidents using non anchor point ligatures and the clinicians that are working on the personality disorder care pathway are incorporating work on these types of incidents into the pathway.

Falls Prevention - The Trust Falls Group continues to meet quarterly. Completed serious incident reports for falls or suspected falls resulting in a fracture are reviewed by the group to consider whether any targeted action is required. The Falls Group has focused in the last 18 months on falls occurring within Older People's Inpatient Services which is where the majority of the falls or found on floor incidents occur. Work has also been undertaken in SRS. In the coming year there will be a greater focus on identifying and managing falls risk in Acute Inpatient Services.

Post Incident Staff Support - In Quarter 3 the Trust launched a Staff Support service for teams who have experienced a critical or distressing incident. Facilitators have been trained to deliver the support sessions. A flowchart has been disseminated to Trust managers to outline how support can be requested.

SERIOUS INCIDENT DATA

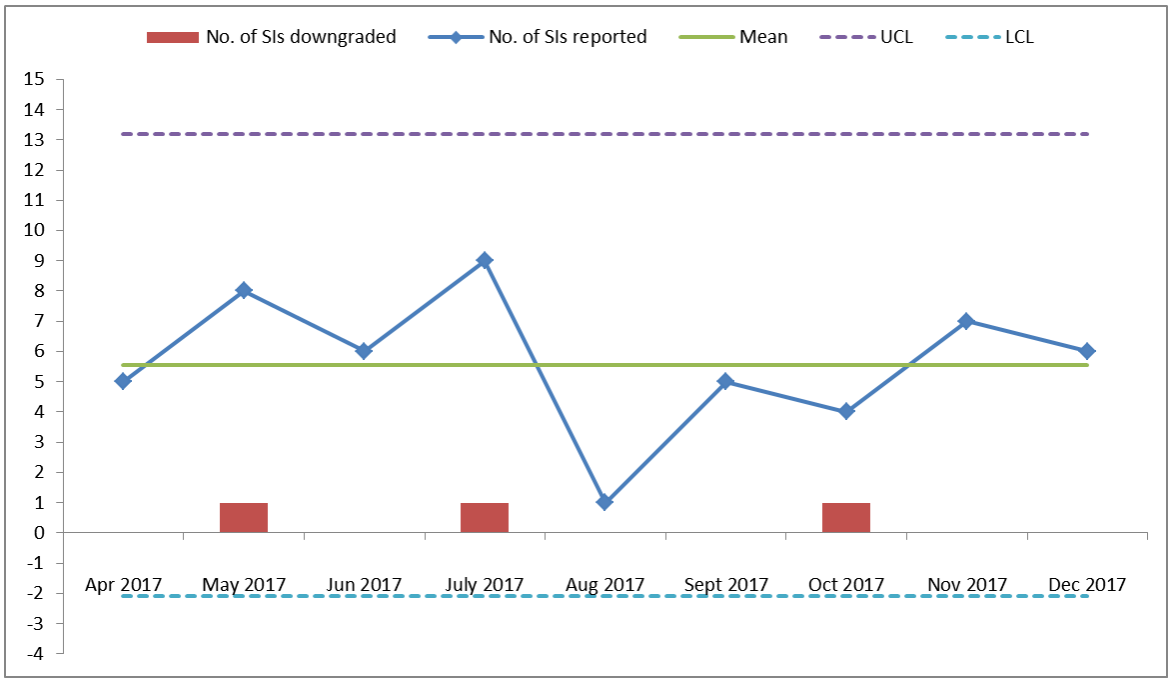
Data is presented by the date the incident was reported externally as a Serious Incident via the national Strategic Executive Information System (StEIS). A total of eighteen Serious Incidents were reported externally in this reporting timeframe. One of these cases was subsequently downgraded when it was confirmed that an outbreak of infection was found not to meet SI reporting criteria following discussion with Trust Commissioners therefore there were 17 SIs in Q3.

The serious incidents reported are listed by the StEIS categories as follows:

- Unexpected/avoidable deaths (12)
- Slip/trip/fall meeting SI criteria (2)
- Disruptive/ aggressive/ violent behaviour meeting SI criteria (1)
- Confidential information leak/information governance breach meeting SI criteria (1)
- Unauthorised absence meeting SI criteria (1)
- HCAI/Infection control incident meeting SI criteria (1) (subsequently downgraded)

It is important to have a longitudinal view with regard to serious incident reporting with some variances expected throughout the year. Where unexpected spikes occur in a particular area a deep dive is commissioned by the Managing Director of that Strategic Business Unit. There is no published comparative data for the number of serious incidents reported. It should be noted that the confident interval and average is for HPFT data only.

Chart 4 Serious Incidents by Reported Month (April 2017 – September 2017)



NEVER EVENTS

The Trust has had no Never Events in this Quarter or year to date. The Never Events policy and framework, March 2015 defines a Never Event as *serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.*

LEARNING FROM DEATHS

Suspected suicides

Local data

Table 1 gives the current position in relation to the deaths that may return a suicide verdict at inquest that occurred during each reporting period. The annual plan sets a target for a 10% reduction in suicides over the year, this would mean no more than 32 in the year. In the first three quarters there were 21 suspected suicides. In addition to this there is one awaiting the results from histology where there is no evidence that the death was a suicide and 4 where it is suspected that the death was a result of substance misuse. Once the inquest for each person is held the data will be adjusted to reflect the outcome.

Table 1 2017/18

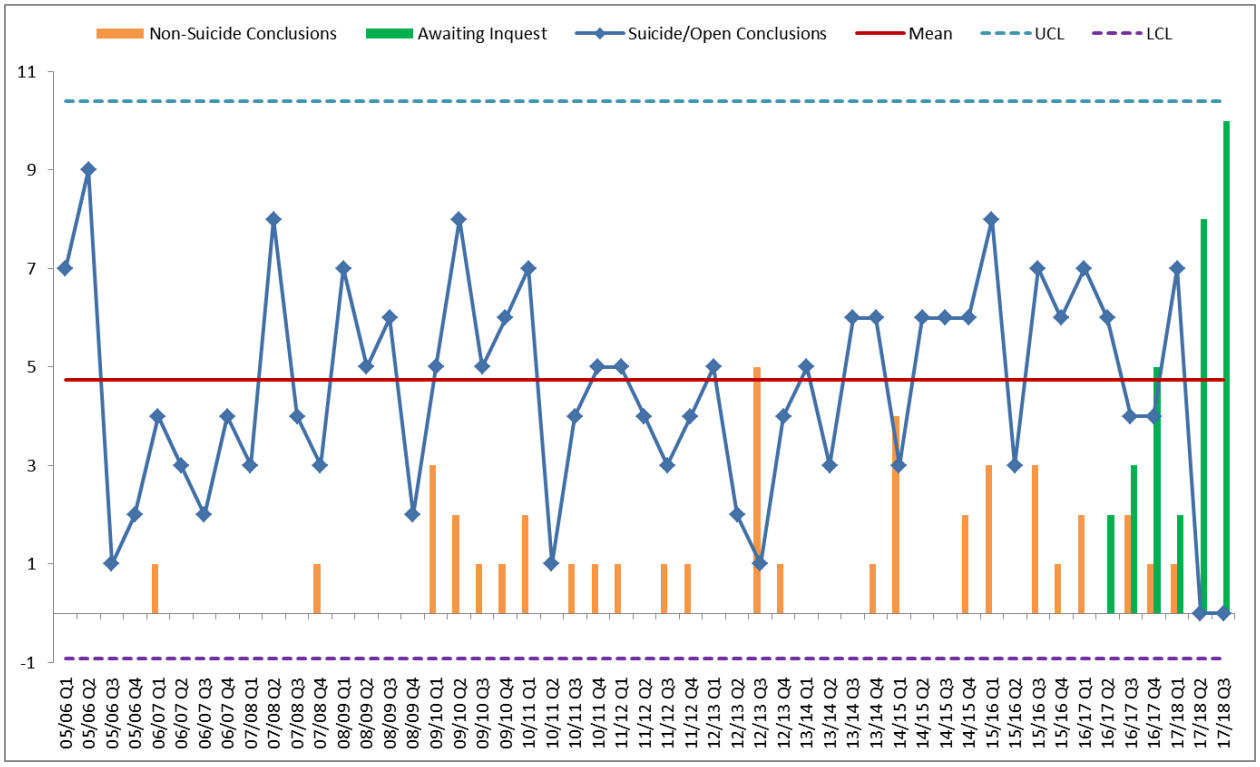
Q	Total unexpected deaths	Number of Suspected suicide	Suspected substance misuse	Not HPFT	Awaiting histology with no indication suicide
1	7	5	2	0	0
2	8	7	0	0	0
3	12 (+1 not HPFT)	9	2	1	1

In order to view the data over time, charts 5 represents the unexpected service user deaths, since 2005, which have

- received a suicide verdict (the deaths recorded in that quarter, not that occurred, as per ONS data, to allow comparisons)
- not yet had the inquest heard (the deaths that occurred in that quarter),
- received a non-suicide conclusion (the deaths recorded in that quarter, not that occurred, as per ONS data, to allow comparisons)

The mean, upper confidence level and lower confidence level relate to the Trust's confirmed suicide data. This graph is a live data set that is updated as the inquests have been heard and the verdict given and represents the data at the time of writing.

Chart 5 Unexpected Deaths by Incident Date (April 2005 – December 2017)

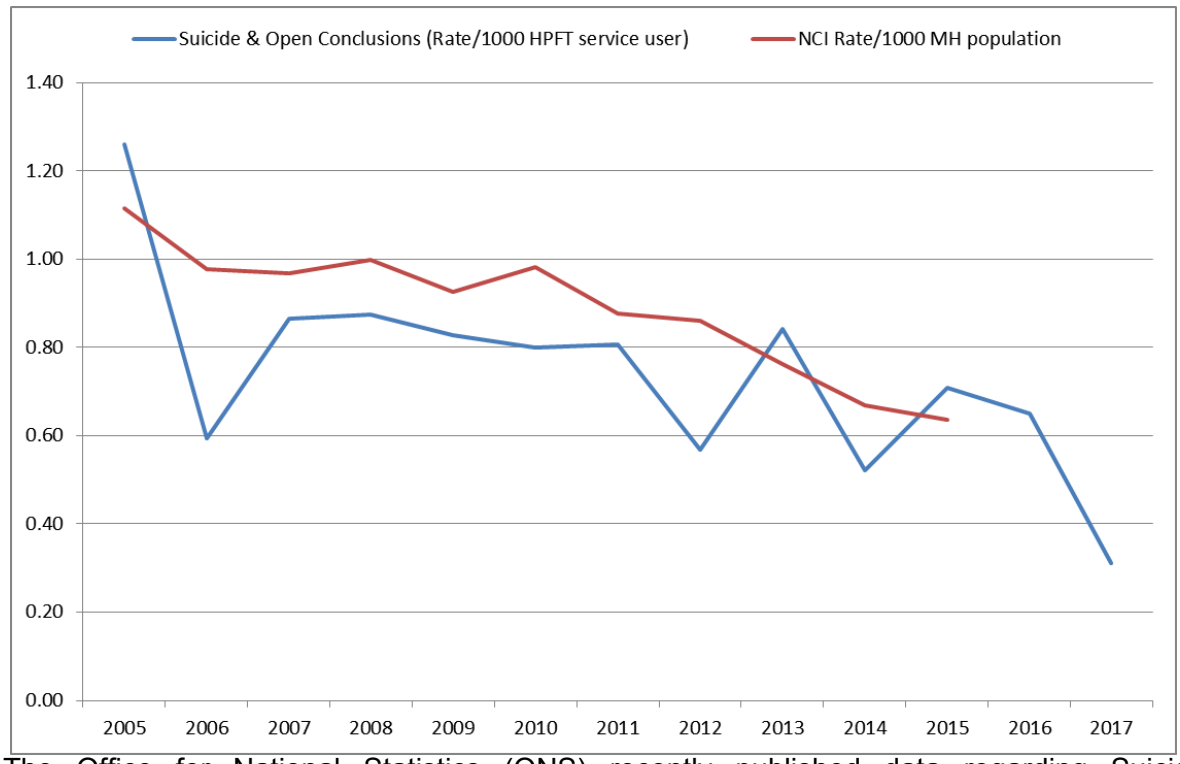


National comparisons

The latest National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report published in October 2017 provides data on Suicide conclusions received by those in contact with mental health services in the 12 months prior to death, up to the end of 2015. The NCISH data shows that Hertfordshire & West Essex has the lowest rate of suicides per 100,000 population in the region.

There are currently 29 HPFT service user deaths where an Inquest has not yet been held from July 2016 to December 2017. Table 6 shows only the results of the inquests that have taken place.

Chart 6 Comparison with National Confidential Inquiry data (2005-2017)



The Office for National Statistics (ONS) recently published data regarding Suicide conclusions in the general population in 2016. The ONS data is provided by the date the death was registered, i.e. once a Suicide conclusion has been recorded by the Coroner. Their findings show a 3.6% decrease in suicides registered in 2016 as compared with 2015.

Trust data on service user deaths receiving a Suicide conclusion in 2015 and 2016 is aligned with the ONS published data, showing a 21% decrease in the number of suicides by date of inquest in 2016 compared with the number of suicides by date of inquest in the previous year.

An analysis of HPFT service user deaths receiving a Suicide or Open conclusion in 2016 showed that:

- men accounted for 79% of the total number of deaths (22 out of 28 deaths)
- the majority of service users were in the age range of 45 to 54 years (10 service users)

Suicide Prevention

The Trust continues to be active partners in the implementation of the Hertfordshire Suicide Prevention Strategy. In addition to this the Trust is a member of the Zero Suicide Alliance and attended the launch event in this quarter. In quarter 4, the action plan, will be developed from the learning from across the membership of the alliance.

Coroner's Regulation 28 Reports

The Trust has received no Regulation 28 Prevention of Future Deaths reports from HM Coroners in this Quarter or Year to Date.

3. AREAS OF LEARNING HIGHLIGHTED FROM COMPLETED SERIOUS INCIDENT INVESTIGATION REPORTS IN QUARTER 3, 2017/18

On completion of serious incident reports, where learning has been identified, an action plan is put in place which is monitored until all recommendations are completed. In additional, a reflective learning session is held with the team/s. A learning note is then produced and disseminated across all Trust services to widen opportunities for learning from serious incidents.

The Trust completed and submitted 10 serious incident reports to Trust Commissioners in this reporting period. Actions plans are in place where learning was identified and learning has been shared across the Trust. There were no trends or themes arising from these completed investigations. The reviews highlighted the importance of:

- Robust handover/transfer of care between shifts and between teams
- Signposting on to other services where clinically indicated
- Offer of post incident support for staff involved in a critical incident
- Updating of risk assessment documentation
- Completion of Induction checklist for Bank and Agency staff

During Quarter 3 the following are examples of how the Trust can be assured that learning from serious incidents is being implemented and embedded into clinical practice and policy:

1. Monthly audit by PACE of cases in the South West Quadrant to audit the local systems, oversight and management of adult safeguarding cases is in line with the Trust Adult Safeguarding Policy and Procedures with results fed back to senior operational managers in South West.
2. Development of an attendance protocol for the Acute Day Treatment Units
3. Audit and re-audit of the quality of risk assessment documentation to ensure it captures the service user's mental health history, relapse signatures, early warning signs and symptoms and diagnosis.

4. CONCLUSION

There were 82 incidents related to service user deaths of which 58 were confirmed as due to natural causes or a pre-existing physical health condition. The Mortality Governance Group reviews all deaths reported on Datix including those reported to the Learning Disability Review (LeDeR) programme which aims to make improvements to the lives of people with learning disabilities.

Trust data on service user deaths receiving a Suicide conclusion in 2015 and 2016 is aligned with the Office National Statistics published data, showing a 21% decrease in the number of suicides by date of inquest in 2016 compared with the number of suicides by date of inquest in the previous year. Trust data on service user deaths receiving a Suicide conclusion at Inquest in 2015 and 2016 is aligned with the Office National Statistics published data, showing a 21% decrease in the number of suicides by date of inquest in 2016 compared with the number of suicides by date of inquest in the previous year.

The Trust has had no Never Events in this Quarter or Year to Date and there have been no Prevention of Future Death reports from HM Coroners received by the Trust in this reporting period.

A total of 18 Serious Incidents were reported external to the Trust in this reporting timeframe and were subject to an internal review in keeping with the Serious Incident Framework. This compares to a total of 16 serious incidents reported external to the Trust in the previous Quarter. One of these serious incidents was subsequently downgraded.

5. ACTION REQUESTED

The Committee is asked to note the content of the report.

Appendix 1

Glossary and definitions of terms used in the report

- **Datix** – Incident reporting & safety learning system used by the Trust
- **Datix dashboards** – Real time visual representation of incident data
- **NRLS** – National Reporting & Learning System, a central database of patient safety incident reports, who analyse reported incidents to identify hazards, risks and opportunities to continuously improve the safety of patient care
- **Patient Safety Incidents (PSI)** – Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care (excluding harm caused in the community)
- **Organisational Patient Safety Incident Report** – Six-monthly statistical breakdown for NHS providers on patient safety incidents they have reported to the NRLS
- **Bed days** – The number of occupied beds as published by NHS England
- **Degree of Harm** – Severity of actual harm caused to, or impact on, patients from a particular incident (including injury, suffering, disability or death)
- **No Harm** – A patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care (near miss), or a patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care
- **Low Harm** – Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care
- **Moderate Harm** – Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care
- **Severe Harm** – Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons
- **Deaths reportable to NRLS** – Any unexpected or unintended incident that directly resulted in the death of one or more persons
- **LeDeR programme** – Learning Disabilities Mortality Review Programme delivered by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England. It requires providers of learning disabilities services to review the deaths of people with learning disabilities in their care, with the aim of making improvements to the lives of people with learning disabilities by working to ensure that potentially modifiable factors associated with a person's death are not repeated
- **StEIS** – Strategic Executive Information System, national system used by NHS Organisations to report serious incidents as defined in the National Serious Incident Framework, March 2015
- **Serious Incident** – 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
- **Never Events** – Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented

- **NCISH** – National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. As the UK's leading research programme in this field, the Inquiry produces a wide range of national reports, projects and papers – providing health professionals, policymakers, and service managers with the evidence and practical suggestions they need to effectively implement change.
- **ONS** – Office for National Statistics
- **Regulation 28 Prevention of Future Deaths Report** – Report issued by a Coroner on action to be taken by a named person or Organisation to prevent other deaths

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Subject:	**SAFEGUARDING QUARTER 3 REPORT**	**Agenda Item: 6 (ii)**
		For Publication: No
Author:	**Kate Linhart , Head of Social Work and Safeguarding**	**Approved by: Dr Jane Padmore, Director of Quality and Safety**
Presented by:	**Dr Jane Padmore**	

Purpose of the report:

The purpose of this report is to provide an overview of Safeguarding activity for quarter three 2017/18 outlining both the key activities and the challenges and how we will move forward to improve during quarter four and 2018/19.

Action required:

To receive the report and noting the achievements of the past quarter and approving the areas for further work

Summary and recommendations:

This report provides an overview of safeguarding activity and developments over quarter 3 2017/18. The report outlines activity, performance, areas of concern and how these are being addressed as well as key achievements in the period.

Over 2017/18 there has been an increased level of safeguarding activity for both adults and children. This is in response to the increased awareness through training, practice development and improvement in reporting. During quarter 3 referrals have stabilised indicating the embedding of improved practice and consistency of reporting

During quarter three the Trust has been involved in three serious case reviews in the period with no significant practice concerns regarding HPFT raised through these. The learning that has occurred across the partnerships will be taken from these reviews and integrated into the safeguarding improvement plans and disseminated throughout the organisation.

Annual external assurance visits took place during quarter three and we demonstrated safe and effective safeguarding practice for both adults and children to the satisfaction of the CCGs. The reviews supported our identification of areas of good practice and opportunities for continuous improvement. The recommendations will be developed into an action plan and form part of the safeguarding improvement plan 2018/19.

In quarter 2 it was identified that we were not on course to achieve our mandatory training compliance of 90% by March 2018. A review of all safeguarding training was undertaken and a new e-learning package has been purchased from Skills for Health. This will be delivered to staff as an alternative to face to face training enabling us to achieve 90% compliance by March 2018. Prevent Level three training will also be delivered through a new NHS England e-learning package released in December 2017. This will provide an alternative to the current face to face (WRAP) training and is accessible to staff from January 2018.

Over the past three months the Safeguarding Team has worked to increase awareness and knowledge of safeguarding across the organisation. Our response to safeguarding concerns have been strengthened through supervision, practice development, training and audit/improved management oversight. Where practice concerns have been identified we have taken positive steps to address them.

During the quarter four period the safeguarding improvement plan 2018/19 will be developed to build on the achievements of quarter three and move HPFT further towards our vision of *"preventing harm and enabling safety through vigilance, competence and personalised outcomes focused practice"*

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

Links to Trust strategy to provide safe and effective services, achieving a good experience for service users, carers, and referrers, transforming our services, staff having a positive experience of work, and having an enviable reputation for quality and innovation

Meeting the ongoing compliance requirements of the CQC Essential Standards for Quality & Safety plus contract & quality schedules

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

N/A

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

Safeguarding is of particular relevance to minority groups who are often the victims of hate crime and bullying.

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

The issues of patient safety and information sharing with statutory agencies are central to safeguarding practice. Wellbeing is a key concept in the Care Act with particular relevance to adult safeguarding practice expressed via the principal of Making Safeguarding Personnel

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

1. Introduction

1.1. This report provides an overview of safeguarding activity and developments over quarter three 2017/18. The report will outline activity, performance, areas of concern and how these are being addressed as well as key achievements in the period.

1.2. HPFT have responsibilities for Safeguarding Adults and Children in all geographical areas that services are provided. Additionally, in Hertfordshire, the Trust has responsibilities, in partnership with Hertfordshire County Council (HCC), for undertaking Safeguarding Adult enquiries and decision making for adult mental health cohort and their carers. These were formally part of the delegated responsibility but now form part of a s113 Agreement whereby HPFT staff undertake Reserved Safeguarding Functions under new governance arrangements.

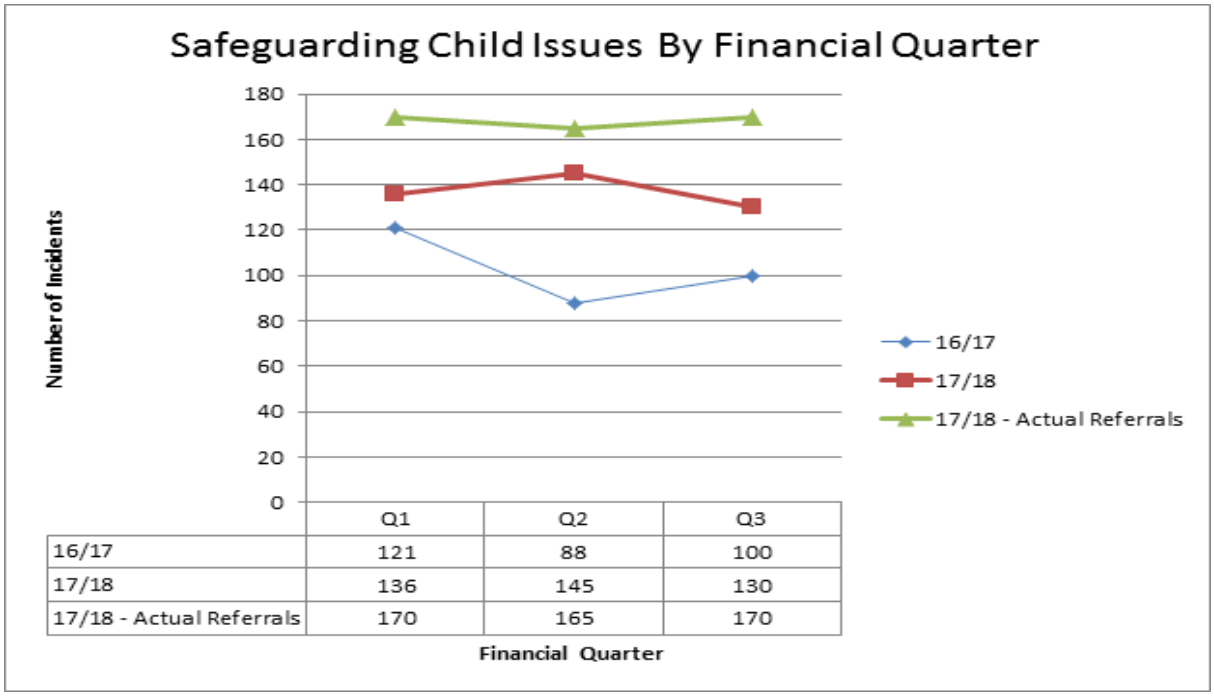
2. Safeguarding Activity for Children

Referrals for safeguarding children

2.1. Chart 1 shows that the number of referrals has remained stable over the 2017/18 period to date, when the improvement initiatives commenced. This shows a significant increase in referrals from the same periods in 2016/17, demonstrating increased radar for safeguarding issues.

2.2. There were a higher number of Child Safeguarding referrals made to Children's Service than incidents reported (actual referrals). This indicates that concerns are not always being recorded on the incident reporting system (Datix) despite action being taken to address the risks.

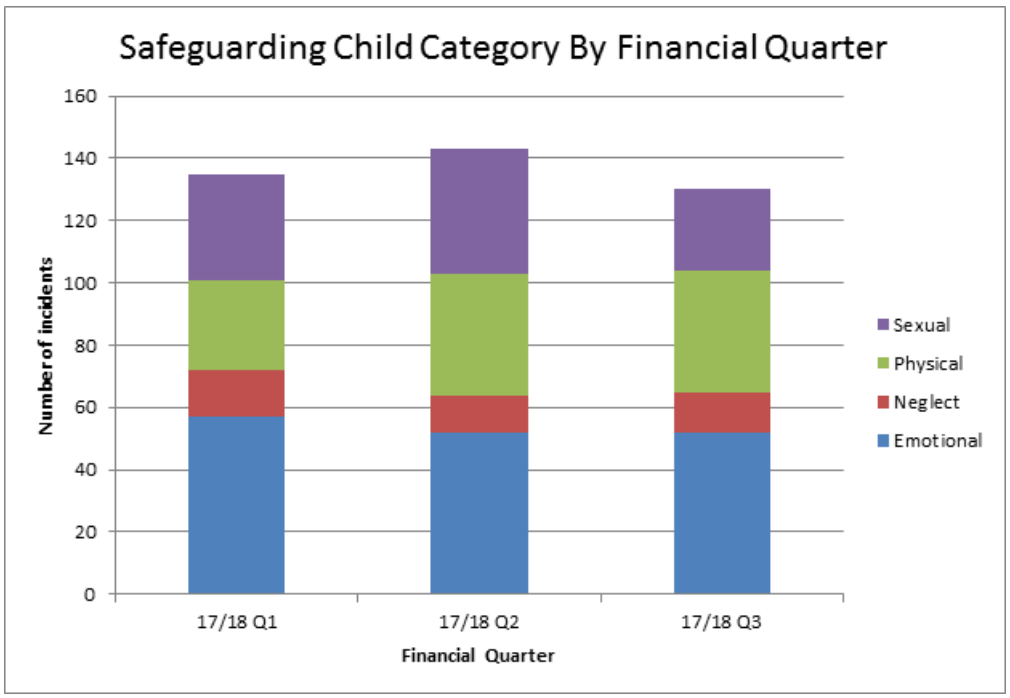
Chart 1 - Child Safeguarding Incidents by financial quarter



	Q1	Q2	Q3
16/17	121	88	100
17/18	136	145	130
17/18 - Actual Referrals	170	165	170

2.3. The emotional and physical abuse categories remain the highest reported categories of abuse across quarter 3 of 2017/18 and across the whole of the 2017/18 period. This is consistent with the national report of child abuse with sexual abuse being consistently under reported. Chart 2 breaks down this data.

Chart 2 – Child Safeguarding by Category of abuse



Safeguarding Children Practice Development

2.4. During quarter 3 the process for tracking children at risk of abuse and neglect was improved to enable, routinely, to evidence outcomes for children referred to Child Protection Service and validate information held within our system for children where child protection concerns have been identified.

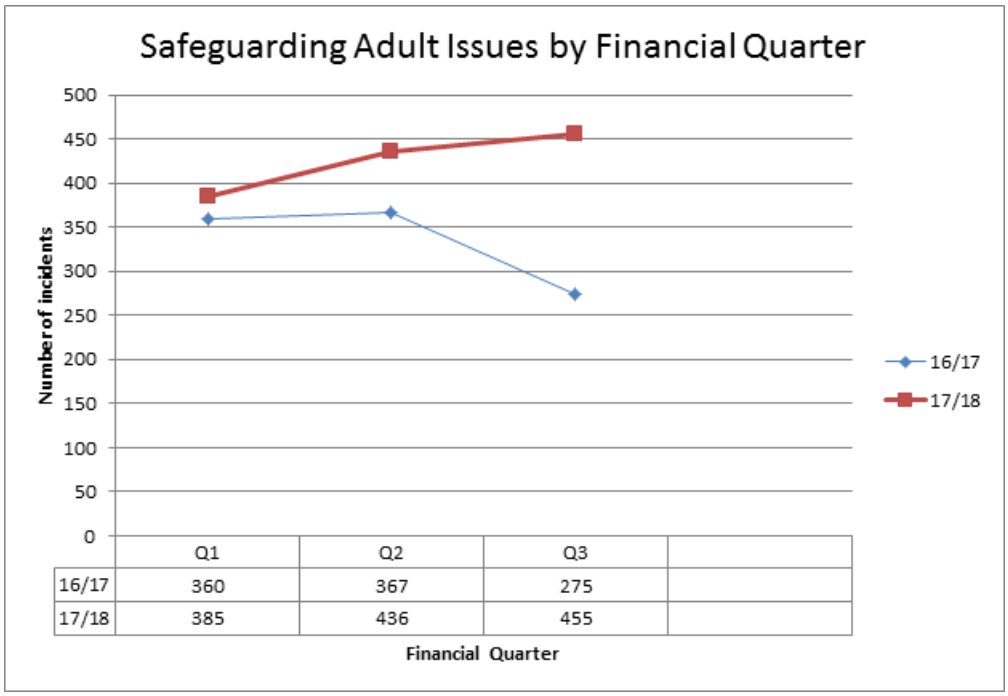
2.5. Information management systems have been strengthened to ensure there is oversight of all the children referred to Children's Services due to concerns about safeguarding. These systems enable the safeguarding team and operational services to monitor and report on children subject to child protection enquiries or plans, Children in Need, Looked After Children and Care Leavers.

2.6. Further work is being undertaken to clarify and embed recording practice, including the use of Datix. This is supported by work in CAMHS and adult services on the the Electronic Patient Record system (PARIS) which has been enhanced to facilitate the effective tracking of cases at team and caseload level.

3. Safeguarding Activity for Adult

3.1. Chart 3 shows that is quarter three there were 455 , 66% increase, reported relating to adult safeguarding. This was a significant increase on the same period last year when 275 incidents were reported.

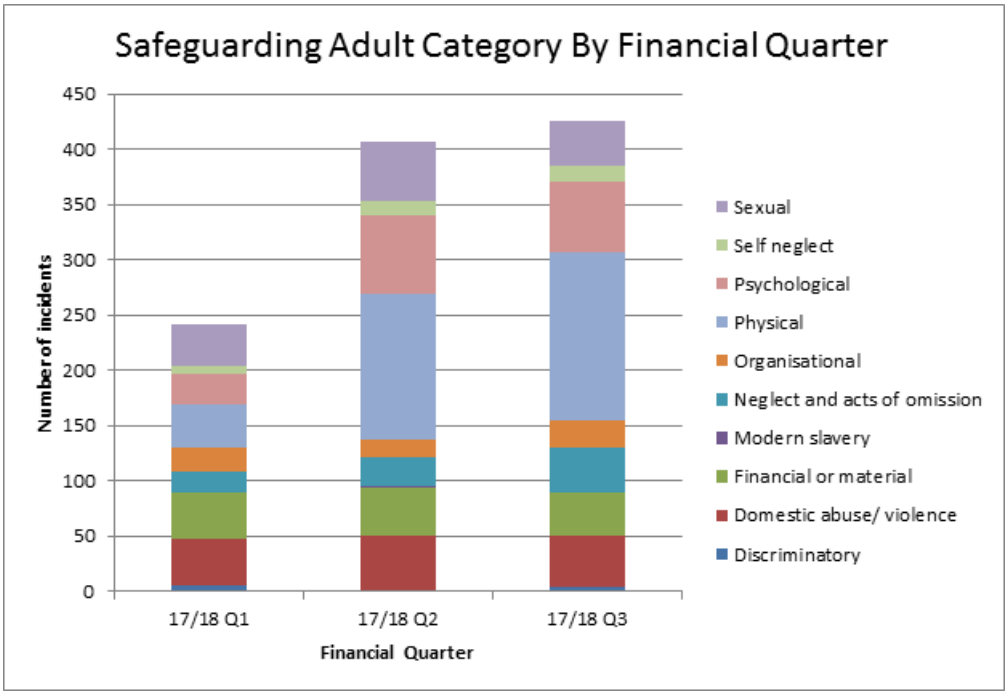
Chart 3 – Safeguarding Adult incidents by financial quarter



	Q1	Q2	Q3	
16/17	360	367	275	
17/18	385	436	455	

3.2. Chart 4 shows that there has been a significant increase in incidents in quarter 2 and 3 relating to physical abuse. This is in line with an overall increase in reporting, indicating a greater level of awareness and reporting practice within our in-patient service where physical abuse is most prevalent or observed type of abuse.

Chart 4 – Safeguarding Adult by category of abuse



Safeguarding Adult Practice Development

3.3. There has been an improvement plan in place since January 2017 to increase awareness and improve practice and reporting in relation to safeguarding. This increase in reporting reflects the progress made in this area.

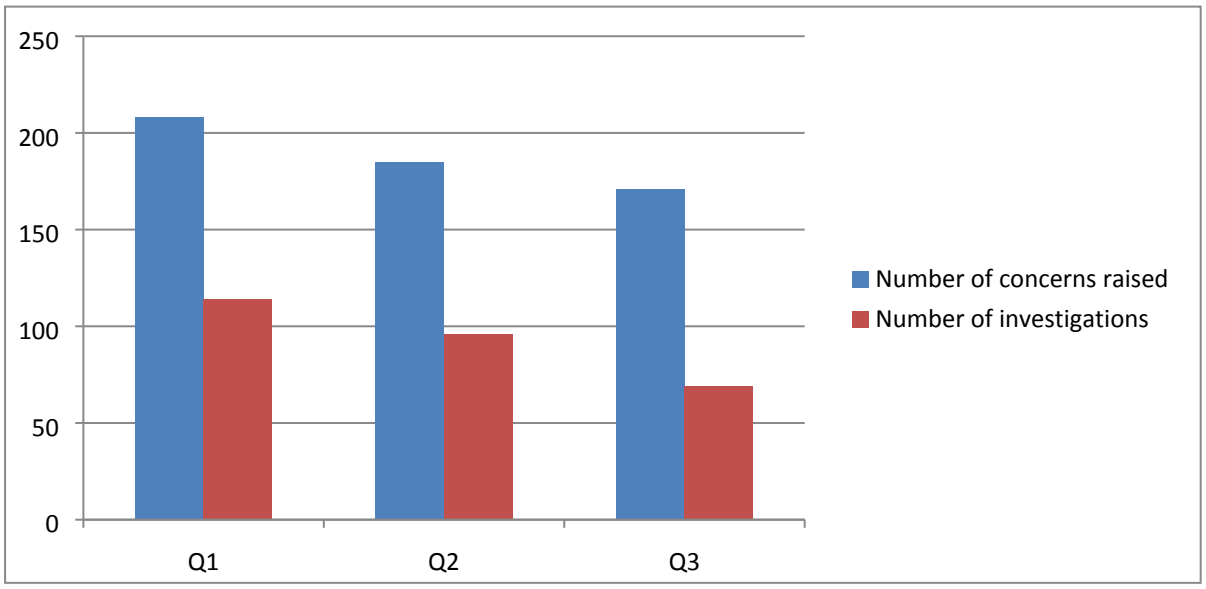
3.4. There is a significant programme of work underway, as part of the MOSS strategy and wider patient safety initiative, to reduce overall incidents of service user on service user abuse in in-patient services and improve people's experience of "Feeling Safe." Over Quarters 2 and 3 the new methodology was applied resulting in an increase in both the number of service users responding and the % saying they feel safe.

4. Statutory Safeguarding Adults in Hertfordshire

4.1. Statutory safeguarding relates to the cohort of service users for whom HPFT have additional statutory safeguarding responsibilities (Adult Safeguarding for people with functional mental illness residing or placed with Hertfordshire).

4.2. Safeguarding activity has decreased over the three quarters. It is important to note that quarter 1 saw the instigation of the Serious Concerns process which involved reviewing open Safeguarding cases and also reopening some closed cases in order to undertake fresh enquiries. This reflects the higher number of concerns and enquiries during the first two quarters of the year. It is expected that there will be a stabilisation of these figure going forward.

Chart 5 – Statutory safeguarding adults concerns and enquiries



	Q1	Q2	Q3
Number of concerns raised	208	185	171
Number of investigations	114	96	69

5. Serious Concerns Process

5.1. In May 2017 the Trust was placed under the serious concerns by Hertfordshire County Council (HCC) when it was identified that safeguarding referrals to Borehamwood team had no evidence of progress made against each referral. As a result of the serious concerns the Trust took action to remedy the issues and undertook a significant programme of review of safeguarding practice across the whole county.

5.2. In September 2017, HCC and the CCG were assured that safeguarding practice had improved and HPFT were taken out of Serious Concerns.

5.3. As part of the Trust internal audit plan, RSM were commissioned to audit the delegated safeguarding case work that had taken place following the closure of the serious concerns process. This took place shortly after the serious concerns were concluded.

5.4. The RSM audit gave partial assurance as the improvements had not been embedded. It highlighted:-

- HPFT safeguarding policy was not compliant with HSAB safeguarding policy
- The new monthly audit tool was ambiguous in some areas, not sufficiently defining standards.
- There continued to be delays in decision making in safeguarding cases.

5.5. The following actions have been taken to address the priority recommendations:-

- The Trust audit tool has been amended in line with all recommendations.
- A communication was sent out re-enforcing timeframes for decision making and practice standards.
- A spot check audit has been carried in October and we achieved 100% compliance with in time decision making. This will be carried bi-monthly going forward.
- The HPFT Safeguarding Policy is currently being re-written and will be completed by end of January.

6. High profile safeguarding cases

6.1. High profile cases relate to people who have suffered death or serious injury through suspected abuse or neglect. There are three main categories of

- serious case review for adults (Serious Adults Review),
- children (Serious Case Review)
- domestic homicide (Domestic Homicide Review).

<u>Serious Adult Reviews (SAR)</u>

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

6.3. The Trust has been involved in a SAR in quarter 3 regarding a man with complex health and social care needs who died shortly after discharge from HPFT to the care of HCC. The Trust took part in a multi-agency learning event which commended HPFT's joint working with HCC.

6.4. The main learning points were in relation to care planning and considering people's holistic needs and wider support networks.

6.5. The final report will be presented to the Hertfordshire Safeguarding Adult Board (HSAB) sub group and then to HSAB in February 2018. Any further recommendations will be identified at this point action taken including a learning note being disseminated.

Serious Case Reviews (SCR)

6.6. Local Safeguarding Children's Boards (LSCB) are required to consider undertaking a Serious Case Review (SCR) whenever a child dies and abuse or neglect are known or suspected to have taken place.

6.7. During quarter 3 the trust has been involved in three SCRs, at various stages in the process.

Family H

6.8. A review into the care and treatment of Family H was initiated because three children had suffered serious harm. It was alleged that they had been sexually abused by their brother and there was concern about the ways in which agencies had worked together.

6.9. The review showed that whilst there was no evidence that professionals had not responded to indicators of sexual abuse there were other aspects of safeguarding practice that could be improved.

6.10. The key learning points for HPFT were:-

- Ensure attendance of senior health clinicians, such as CAMHS consultants, at multi-agency meetings about children.
- Children who are subject of a Child in Need plan to be readily identified at the point when a referral is being assessed. This would enable decisions to be made about allocation in a more informed way.
- Strengthening of working relationships between CAMHS and Children's Social Care, particularly in high risk and complex cases.

6.11. The key actions we are taking to address the above points are:

- Strengthening safeguarding supervision within CAMHS to challenge practice and ensure that issues relating to wider family and joint working are addressed. This is monitored through a supervision monitoring tool and audit.
- Established the use of alerts in the Electronic Patient Record (EPR) for Children in Need (CiN) and Children subject to Child Protection. This is supported by regular cross referencing with Children's Social Care database.
- CAMHS are now members of the Complex Case panel that discusses and works on complex cases known to CAMHS and Children Social Care.

- The Safeguarding Children Named doctor (CAMHS consultant psychiatrist) is collaborating with the CCG designated doctor (paediatrician) to explore working closer together on a new pathway for Children and Young People with behavioural problems.

Child KH

6.12. On 4 October the Community Perinatal Team reported the death of baby KH whose mother was under the care of the Community Perinatal Team. The family were under the care of Children's Services and HCT's Health Visiting services. KH was subject to a Child Protection Plan.

6.13. This case is currently subject to Police investigation and has been opened as a Serious Case Review that will commence in January 2018.

Child TM

6.14. TM, a 2 year old, drowned while in the bath on 26th April 2017 at the family home and there was evidence of neglect. TM's mother was known to HPFT in 2008 but not since.

6.15. The Serious Case Review Panel met in July and the SCR Panel chair recommended that a SCR should be undertaken. This review is due to commence in January 2018.

Domestic Homicide Reviews (DHR)

6.16. A Domestic Homicide Review (DHR) is a review of the circumstances in which the death of a person (aged 16 or over) has, or appears to have, resulted from violence, abuse or neglect by a relative, household member or someone he or she has been in an intimate relationship with a view to identifying the lessons to be learnt from the death.

6.17. During quarter 3 the trust has been involved in two DHRs, at various stages in the process.

Adult ND

6.18. ND was the father of a woman (SO) who was under the care of HPFT Crisis Assessment & Treatment Team. SO's husband murdered ND in January 2017.

6.19. HPFT were not involved in the care or support of either victim or perpetrator, however were identified as an 'interested party' and therefore contributed to the review. The review has been concluded and the Trust is awaiting the final report which will be published.

6.20. One recommendation has been made for all agencies to raise awareness of control and coercive behaviour and the effect on family dynamics. This has been integrated into our safeguarding training.

Adult HW

6.21. This review commenced in quarter 2 and relates to a woman (HW) who was resident in Hampshire at the time of the incident. HW had historical contact with HPFT CDAT services only. Care transferred to voluntary sector drug and alcohol service provider (CGL) in 2013. There was one contact with RAID in 2016 following presentation in A&E after taking an overdose.

6.22. On initial review there was no indication of domestic abuse disclosed or identified. HW had moved to Bournemouth shortly before her death. She was in a relationship with her paternal uncle who was convicted of her death. He has launched an appeal.

6.23. HPFT are an 'involved party' and will be represented in this DHR. A Panel member has been identified and an Independent Management Review (IMR) report writer has been commissioned. The Panel will have their initial meeting at the end of January 2018.

7. Broadland Clinic Safeguarding Review

7.1. Following the unannounced Care Quality Commission (CQC) inspection of Broadlands Clinic and the concerns outlined in the inspection report a review of the safeguarding processes and practices at the Little Plumstead services has taken place.

7.2. This review was carried out by the Safeguarding Consultant Social Worker, whose key finding was that safeguarding was not fully embedded within the culture of the service through clinical and operational processes. An example of this being that staff made decisions within the team and did not consistently refer concerns to the local Norfolk statutory safeguarding team for consideration for independent investigation.

7.3. Following this review, recommendations have been made and accepted by the services. These include

- ensuring staff are confident in their knowledge of when and where to refer safeguarding
- strengthening links with the local Multi-agency safeguarding hub (MASH).

7.4. These recommendations are being implemented and reviewed at the SBU quality and risk meeting which reports to the Quality and Risk Management Committee (QRMC).

8. External Assurance

8.1. As part of the statutory and contractual obligations in Hertfordshire the Trust is subject to annual external assurance visits from commissioners; one for adults and one for children.

8.2. This year HPFT demonstrated safe and effective safeguarding practice for both adults and children and identified areas of good practice and opportunities for continuous improvement.

8.3. In this quarter the adult safeguarding assurance visit took place. In conclusion the outcome was:

'We found the review informative and were assured overall regarding the standard of adult safeguarding within the Trust and acknowledge that significant progress has been made this year. However, the CCG remains concerned as to whether HPFT will meet safeguarding adult and Prevent training compliance and will monitor this on a monthly basis.'

8.4. Areas of good practice were identified particularly in relation to our partnership working, development of daily safeguarding dashboard (SPIKE) and provision of domestic abuse training. The review team commended HPFT on our response to serious concerns raised about a provider service which required an immediate multi-agency response.

8.5. The outcome letter also noted that:

'Before the meeting begun I raised a safeguarding concern regarding a large care home in the Herts Valleys area where we required an immediate response from HPFT to work with other partners to review residents to ensure their safety. As part of this letter I wanted it noted that I and other partners were extremely impressed with the response received to this request and the professional way that this was managed by you.'

8.6. This statutory assurance visit took place on the 26th September 2017, with the outcome in quarter 3. HPFT provided assurance on the arrangements in relation to safeguarding and promoting the welfare of children.

8.7. The CCG stated "It is clear from the evidence submitted and your self-assessment that the newly formed safeguarding team are transforming the safeguarding children service and will strive to improve practices in collaboration with the staff".

8.8. Recommendations were made by commissioners following both assurance visits that majority of which were already identified on our safeguarding improvement driver diagram. These will form part of the 2018/19 safeguarding improvement plan. The improvement plan will be agreed and reviewed in the Safeguarding Strategy Group which includes commissioner representation.

9. Training

9.1. At the beginning of the year it was identified that the existing e-learning safeguarding training was not fit for purpose and it was decided that all clinical staff required face to face training for both Safeguarding Children and Adults.

9.2. During quarter three it was identified that the Trust are not making the progress at the necessary pace. Trajectory modelling showed that, at the rate of progress being made 90% compliance for Safeguarding training would not be made by 31st March 2018. In addition, releasing staff at the rate needed to attend face to face sessions would result in compromising the safety of services.

9.3. Safeguarding leads have been working closely with Learning and Development to create a flexible and nuanced approach to delivery of the curriculum including:

- Roll out of e-Learning for Safeguarding Adults and Children (Level 2) packages purchased from Skills for Health which are fit for purpose, in line with the requirements of the Intercollegiate documents.

- Pilot use of 'Go-To' meetings for delivering off site training.
- Approval of the NHS England/Home Office online training for WRAP which staff can access remotely as e-Learning to improve the compliance in this area.
- Specific on-site face to face training sessions to be offered in geographical areas to improve compliance rates (for example, Level 2 Safeguarding Adults for Wellbeing Teams).
- The development of a one day face to face training programme which combines Safeguarding Children and Adults (this has been successfully trialled in Norfolk).
- The Home Office Prevent and WRAP e-learning training is approved by NHS England to be used by all NHS Organisations and has an e-learning specific for Mental Health NHS Organisations which is the preferred choice for our staff.

9.4. In addition to mandatory training, the Safeguarding Team have been offering specific workshops on the following topics:

- Training on reporting Historical Child Abuse for Wellbeing Teams (with Hertfordshire Police)
- Safeguarding Practice Groups sessions on Historical Abuse, Modern Slavery and Radicalisation.
- Safeguarding training for medical staff

10. Other improvement and developments

10.1. In quarter 3 the safeguarding team structure was restructured to align with the Hertfordshire Safeguarding Boards. This means that:

- Kate Linhart continues as the Head of Social Care and Safeguarding with overarching responsibility for safeguarding.
- Cathy Honnah, Consultant Nurse, manages the safeguarding team and is the lead for safeguarding children and Prevent.
- Karen Hastings, Consultant Social Worker, is the lead for both the provider and the delegated safeguarding responsibilities.

10.2. A policy has been written specifically for Domestic Abuse and safeguarding training has been developed to highlight this most recent learning and developments in this area. The policy will be launched in quarter four 2017/18.

10.3. The process for information requests and engagement in Domestic Homicide Reviews has been strengthened. These are now managed in partnership with the Safer Care Team, the Safeguarding Team and operational services enabling better delivery to timescales and higher quality.

10.4. The PREVENT Policy, Child Safeguarding Policy, Information Sharing Policy and Child Visiting Policy have all been updated and ratified at the Safeguarding Strategy Committee, providing the workforce with clearer practice guidance in these areas.

11. Conclusion

11.1. Over this quarter the Safeguarding Team has worked to increase awareness and knowledge of safeguarding across the organisation taking us out of serious concerns in relation to our statutory safeguarding adult functions.

11.2. The responses to safeguarding concerns have been strengthened through supervision, practice development, training and audit / improved management oversight. Where practice concerns have been identified positive steps have been taken to address them.

11.3. The Trust has been able to provide assurance to the CCG and HCC that robust safeguarding arrangements are in place and further opportunities for improvement have been identified that will be taken forward in quarter four 2017/18 and into 2018/19.

11.4. During the quarter four period the safeguarding improvement plan 2018/19 will be developed to build on the achievements of quarter three and move HPFT further towards our vision of *"preventing harm and enabling safety through vigilance, competence and personalised outcomes focused practice".*

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	**25th January 2018**	**Agenda Item: 8**
Subject:	2017 Patient Led Assessments of the Care Environment (PLACE) Audit outcome	**For Publication: Yes**
Author:	**Keith Loveman**	**Approved by: Keith Loveman**
Presented by:	**Keith Loveman** **Director of Finance**	

Purpose of the report:

To update the Board on the 2017 Patient Led Assessments of the Care Environment (PLACE) scores carried out across HPFT sites.

Action required:

To:

- Critically consider, appraise and review the information provided
- Seek any additional information or clarification required
- Advise any further action considered necessary

Summary and recommendations to the Board:

Summary

Overall the 2017 PLACE outcomes show a general improvement on 2016 with significant improvement in Privacy and Dignity, Dementia environments, and Disability Access Compliance scores. Key areas of concern are condition and maintenance work and the quality of meals in inpatient settings. Catering scores are significantly below national and MH Trust averages and show deterioration on 2016. Interserve, our TFM contractor, has been formally written to in relation to these specific issues and high level meetings with Interserve Directors continue.

Action plans have been developed in response to the PLACE outcomes and Service Managers and Modern Matrons take these forward with support from the Facilities Department.

An estimate of investment against specific PLACE issues has been included as part of the action planning and taken forward through Modernising our Estate.

Background

Who carries out the audits?

PLACE audits were carried out between March and June 2017. The Trust was able to set the actual audit date for each site, provided the results were submitted by the audit process end date. Audits are facilitated and outcomes reported by the Trust's Monitoring Officer (Facilities Department) who liaises with local Healthwatch and the Customer Inclusion and Engagement Team to provide 3 people to go to each site as well as a member of the clinical team for the relevant service to act as guide and escort. Once completed the scores are submitted to the Department of Health who then publish the results benchmarked against a national average and

against other Mental Health Trusts.

8 Topics scored

The audits are scored over eight key headings:

Cleaning
Condition, appearance and Maintenance
Privacy Dignity and Wellbeing
Food and Hydration
Organisation Food
Ward Food
Dementia Environment
Disability Access

Detail required

PLACE scores reflect what is seen on the day when the auditing team visit with a significant number of questions to be answered against each section, but noting that the Trust is able to set the date. Healthwatch and the Service User representative write a short summary report at the end which is submitted as part of the audit to DH. The Trust Monitoring Officer makes notes of the issues reported for each site to identify any need for action, including potential investment.

The questions are answered on a database but the final score cannot be viewed until issued nationally. At this point no change can be made.

Action plans are developed in response to the PLACE outcomes and Service Managers and Modern Matrons take them forward with support from the Facilities Department.

Overall Outcomes 2017 – shows the average for each key heading together with the National and Mental Health averages and comments are as follows:-

Category	Trust	National average	MH average	Movement on 2016
Cleaning	**98.60%**	**98.38%**	**98.00%**	**+0.10%**
Condition and Maintenance	**88.69%**	**94.02%**	**95.20%**	**-2.36%**
Food and Hydration	**87.06%**	**89.70%**	**89.70%**	**+0.93%**
Organisational Food	**89.18%**	**88.80%**	**87.70%**	**+3.42%**
Ward Food	**84.80%**	**90.20%**	**91.50%**	**-0.25%**
Privacy and Dignity	**90.93%**	**83.68%**	**90.60%**	**+5.23%**
Dementia	**88.69%**	**76.71%**	**84.80%**	**+13.62%**
Disability	**81.86%**	**82.56%**	**86.70%**	**+7.32%**

Appendix 1 sets out the detailed results by site with a comparison to 2015 and 2016.

Key Movements

Condition and Maintenance - 12 sites improved their scores, 2 were closed and 7 site scores deteriorated (although Victoria Court was in the process of redecoration at the time).

Specific issues noted:

- One of the standards requires all sites to have hand rails and the Trust has decided that for Acute Mental Health these have been taken out due to the risk of ligatures. Points are taken away for this.

- Poor scores from Astley Court and Warren Court reduced the overall average due to Service User damage that had not been repaired at the time of the visits.

- Hampden and Gainsford were having new doors fitted (now complete) which will lift scores next year.

- Victoria Court was in the middle of their redecoration and HealthWatch could not go back to evaluate before the PLACE scores had to be presented.

- The Thumbswood score fell by 10% from last year. The main issue raised was that a comment was made that the garden area was not safe and the pathways uneven. This is a large grassed area with a small paved area that is safe but there is work to do to make the environment more pleasant.

Ward Food - 9 sites scored better than last year, 2 were closed and 10 sites had worse scores than last year, some significantly lower.

The sites scoring low presented a poor selection of food to the assessors and in some cases the food was cold and poor in taste. Further investigation has been undertaken to identify the extent to which this reflects the standard regularly provided to Service Users and the findings reflect inconsistencies on a day-to-day basis.

Significant improvements were noted in relation to **Privacy and Dignity, Dementia** environments**,** and **Disability** access compliance scores. This reflects the investment in environments over the last financial year.

ACTIONS

General Condition and Maintenance

A headline assessment of work required to improve environments and address the findings of the audits has been completed. Modernising our Estates Programme Board has agreed investment of operational capital to enable this work to be progressed and a programme of works agreed and commenced. It is expected that these will be completed within the current financial year. The budget sums are set out as follows:

	£k
Albany Lodge	6
Astley Court	5
Aston	4
Beech	8
Broadlands	10
Elizabeth Court	12
4 Bowlers	3
Forest House	To be addressed following commissioning of Place of Safety
Gainsford	33
Hampden	30
Kingfisher Court	Decorator & Maintenance worker employed
Lambourn Grove	3

Lexden	10
Logandene	Snagging work to be completed
Oak	30
Seward lodge	3
The Beacon	10
Thumbswood	15
Victoria Court	Major redecoration completed
Warren Court	10
Total £k	**192**

Interserve - Facilities Management

Discussions with Interserve have progressed in relation to two key issues – Interserve's claim for retrospective payment for claimed 'additional' services above contract baselines and the requirement by the Trust that moving forwards the service provided improves.

These discussions are continuing with improvement being required in the following areas:

- More varied and appropriate menus
- Additional out of hours supervision to assist in the delivery of a consistent service
- Revised stock levels on site to avoid shortages
- Agreed deadlines and outcomes for delivery of improvements

Interserve have provided a plan setting out how improvements will be achieved and this is being closely monitored. Some additional investment will be required to achieve the improved performance and to ensure financial stability within the contract. This is linked to the performance improvements required. In addition, alternative providers for the cafeteria function at Kingfisher Court are being sought.

Conclusion

Additional investment has been agreed for 2017/18 to fund the areas identified as requiring new curtains, flooring and decorating in the PLACE audit. By continuing with this strategy the results in 2018 should reflect upward movement in Maintenance and Condition. Work will be undertaken on the Thumbswood garden area.

Monitoring of the TFM contract with Interserve remains constant in an effort to maintain and drive standards up.

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

The PLACE report is reviewed by the CCG and CQC and will be used for further visits. Talks with Interserve around ward food will continue to ensure sustained improvement in this category.

Summary of Implications for:

1 Finance There is a need to ensure that there is regular investment in the Trust Estate and further investment in this financial year will improve our sites to the level required when 2018 PLACE starts again in April 2018.
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 5th December 2017

Hertfordshire Partnership University NHS Foundation Trust

PLACE comparison between 2015- 16- 17 against National Averages and like for like Trusts both over all and by each site.

	Cleaning (I.C.C).			Maintenance & condition (I.C.C).			Food & hydration (D&N).			Organisation Food (D&N)			Ward Food (D&N).			Privacy & Dignity (E&D).			Dementia (E&D).			Disability (E&D).	
Audit year.	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2016	2017
National % averages .	*97.60%*	98.10%	98.38%	*90.10%*	93.40%	94.02%	*88.50%*	88.20%	89.70%	87.20%	87.00%	88.80%	89.30%	89.00%	90.20%	*86.00%*	84.20%	83.68%	*74.50%*	75.30%	76.71%	78.80%	82.56%
Mental Health % Nat' Ave'		97.80%	98.00%		94.50%	95.20%		89.70%	89.70%		86.60%	87.70%		91.90%	91.50%		89.70%	90.60%		82.90%	84.80%	84.50%	86.70%
HPUFT over all %.		98.50%	98.60%		91.05%	88.69%		86.13%	87.06%		85.76%	89.18%		85.05%	84.80%		85.70%	90.93%		75.07%	88.69%	74.54%	81.86%
East and North SBU.																							
Elizabeth Court.	*100.00%*	98.16%	98.62%	*89.58%*	90.34%	95.96%	*91.95%*	84.59%	89.39%	91.71%	82.66%	91.58%	92.08%	85.96%	87.35%	*82.03%*	90.18%	93.75%	*85.61%*	78.71%	87.62%	88.39%	93.35%
Forest House.	*96.29%*	99.74%	96.17%	*84.09%*	94.07%	95.08%	*88.28%*	82.90%	87.09%	92.12%	84.51%	91.60%	84.91%	81.29%	83.15%	*91.01%*	89.65%	87.38%		70.11%		65.65%	85.03%
Lambourne Grove.		97.47%	92.25%		97.95%	99.22%		87.43%	92.25%		85.71%	89.83%		89.32%	94.23%		94.17%	100.00%		90.55%	94.89%	88.07%	92.26%
Logandene	*94.40%*		100.00%	92.75%		97.22%	89.14%		91.37%	83.90%		90.55%	93.24%		92.15%	94.17%		97.50%	*82.40%*		93.48%		89.81%
Prospect House.	*98.71%*	100.00%		*88.41%*	95.00%		*89.91%*	93.72%		88.70%	90.86%		90.73%	96.52%		*83.62%*	87.07%		*86.91%*	78.40%		88.56%	
Seward Lodge.	*99.50%*	97.75%	98.63%	*96.00%*	92.98%	96.12%	*92.00%*	84.80%	82.03%		83.52%	90.88%		85.52%	75.05%	*94.50%*	91.37%	97.22%	*95.00%*	91.25%	93.73%	85.93%	89.80%
The Stewarts.	*100.00%*	99.65%		*93.08%*	93.20%		*87.28%*	85.76%		88.70%	85.41%		86.14%	86.08%		*95.00%*	93.97%		*89.22%*	83.89%		91.90%	
Victoria Court.	*100.00%*	100.00%	**96.62%**	*94.78%*	94.09%	89.29%	*91.89%*	88.55%	89.91%	88.70%	87.54%	89.16%	93.71%	91.67%	83.51%	*97.79%*	79.46%	86.61%	*92.01%*	82.85%	87.82%	87.57%	86.57%
West SBU.																							
Albany Lodge.	*100.00%*	98.14%	97.57%	*86.43%*	83.33%	85.45%	*96.01%*	80.52%	70.25%	90.07%	87.84%	87.16%	100.00%	73.82%	48.93%	*89.65%*	85.28%	80.56%		74.16%		76.44%	70.69%
Aston ward.	*98.43%*	99.78%	97.99%	*88.86%*	92.48%	90.32%	*88.45%*	89.74%	88.95%	83.90%	87.60%	87.39%	93.24%	91.57%	90.61%	*88.25%*	81.30%	88.68%		73.63%		67.52%	66.71%
Gainsford House.	*100.00%*	99.74%	100.00%	*92.74%*	93.60%	91.25%	*95.70%*	89.26%	88.42%	90.89%	83.48%	84.60%	100.00%	93.91%	92.25%	*86.11%*	80.56%	88.22%		67.45%		71.74%	74.68%
Hampdon House.	*98.64%*	99.43%	98.68%	*82.84%*	92.37%	91.73%										*75.25%*	81.13%	84.77%		76.67%		73.91%	72.00%
The Beacon.	*100.00%*	100.00%	99.18%	*90.00%*	92.17%	94.76%										*89.95%*	82.53%	91.37%				71.43%	78.26%
Thumbswood M&B (2BG).	*98.58%*	99.24%	98.56%	*88.18%*	93.91%	83.21%	97.25%	91.39%	88.18%	90.07%	84.56%	91.27%	84.43%	97.91%	85.89%	*78.61%*	90.71%	95.45%		72.57%	83.21%	73.88%	85.24%
LD & F SBU.																							
Astley Court Little Plumstead.	*99.62%*	100.00%	99.74%	*90.91%*	96.55%	92.54%	*93.13%*	90.65%	86.75%	93.13%	86.83%	93.35%	98.94%	95.50%	78.44%	*95.11%*	91.37%	95.43%		93.20%		79.08%	83.07%
Beech & Oak wards .	*92.51%*	97.28%	**97.50%**	*84.68%*	83.51%	87.73%	*86.60%*	83.64%	89.36%	86.60%	83.56%	86.88%	90.07%	83.72%	92.23%	*86.20%*	80.50%	89.15%		66.05%		71.49%	73.89%
Broadlands Clinic Little Plumstead.	*96.02%*	98.40%	**96.48%**	*83.54%*	88.73%	96.62%	*85.72%*	82.88%	91.03%	85.72%	76.17%	90.55%	81.78%	91.18%	91.53%	*85.10%*	84.98%	92.07%		66.45%		67.48%	81.64%
Eric Shepherd unit (4BG).	*99.62%*	99.02%	99.17%	*92.97%*	91.38%	86.97%	*80.94%*	78.24%	90.53%	88.70%	80.81%	90.67%	74.61%	75.92%	90.39%	*91.94%*	84.77%	97.12%		70.41%		69.72%	78.73%
Lexdon Hospital.	*99.01%*	98.15%	**98.21%**	*82.46%*	90.11%	93.84%	*84.78%*	78.59%	84.17%	84.78%	86.83%	92.38%	90.07%	70.93%	77.64%	*85.95%*	90.00%	91.24%		82.71%		72.02%	85.82%
Warren Court.	*100.00%*	98.94%	98.99%	*82.65%*	88.55%	95.25%	*71.98%*	90.11%	82.83%	71.98%	86.88%	87.16%	82.87%	93.33%	77.72%	*81.67%*	84.08%	84.08%				63.44%	71.72%
Kingfisher Court (all wards	*100.00%*	97.35%	99.04%	*88.18%*	91.27%	95.40%	*68.17%*	85.24%	89.29%	88.70%	88.54%	89.16%	62.38%	83.78%	89.43%	*93.84%*	88.13%	94.35%	*82.00%*	69.79%	86.69%	65.17%	86.66%

Key.

Shaded box, scores are below the group average (likewise Trusts), both overall and by each site.

Coloured text, scores are below the NHS national average, both overall and by each site.

HPFT Committees that use results/ information.

I.C.C	Infection Control Committee.	**D&N.**	Dysphagia & Nutrition.	**E&D.**	Equality and Diversity.

Note.

Oak and Beech wards have combined scores to enable comparisons across all three years. For individual scores please refer to Trust Space PLACE 2017 unit scores.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board of Directors

Meeting Date:	**25th January 2018**	**Agenda Item:**
Subject:	**Complaints and Service Experience Report Q3 2017-18**	**For Publication: Yes**
Author:	**Mary Stephenson, Complaints and Service Experience Manager**	**Approved by: Jess Lievesley, Director –Service Delivery and Customer Experience**
Presented by:	**Jess Lievesley, Director – Service Delivery and Customer Experience**	

Purpose of the report:

This report provides information on compliments, PALS contacts, complaints and responses to patient experience questionnaires, especially Having Your Say questionnaires, received during Quarter 3 2017/18.
It provides assurance about how the Trust learns from complaints and other service experience information.

Action required:

Board are requested:

- To note progress.
- To advise on areas for improvement.

Summary and recommendations:

This report provides an overview of complaints, compliments and service experience performance during Quarter 3 2017/18. Information is provided over time to help identify themes, trend and learning for the Trust. The report contains more detailed information on complaints received as well as elements of learning that the Trust has undertaken in response to the complaints and other feedback.

The report highlights the continued benefit to services on receiving feedback on the care they provide as we as providing a summary and the themes of the issues that are being raised in both compliments and complaints.

The quarter has seen a continued maintenance of the Trust's overall position with regard to the experience and satisfaction rates reported by service users and carers about the trust.

Areas with high numbers of both compliments and complaints tend to be those where referral and clinical activity is highest, however in Q3 we have seen an increase within the E&N SBU. Work is underway to evaluate any themes or issues arising from this and a further update will be provided to the board in the Q4 report.

Board are asked to note.

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

The report related to the following strategic objectives:

1. Deliver safe and effective services
2. Service users, carers, referrers and commissioners will have a positive experience of

our services

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

Financial implications with financial remedy recommended to acknowledge distress and inconvenience caused by failings in service delivery and complaints handling. Also claims for property that is lost while in the safe keeping of the Trust.

Equality & Diversity /Service User & Carer Involvement implications:

The report concerns feedback and complaints from service users and carers and the information and as a result is monitored closely by Engagement and Inclusion Team

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

CQC Key Lines of Enquiry Responsive R4 How are people's concerns and complaints listened and responded to and used to improve the quality of care?

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

Inclusion and Engagement Group Integrated Governance Committee

*On receipt, complaints are risk assessed against a 5x5 matrix, as low, medium and high risk. The rating is reviewed and adjusted, if necessary, once the investigation is complete. High and moderate risk complaints are itemised in this report

Service User & Carer Experience Report

Quarter 3 - 2017 / 2018

1. Introduction

This report provides an overview of complaints, compliments and service experience performance during Quarter 3 2017/18. Information is provided over time to help identify themes, trend and learning for the Trust. The report contains more detailed information on complaints received as well as elements of learning that the Trust has undertaken in response to the complaints and other feedback.

2. Compliments & Trust Values

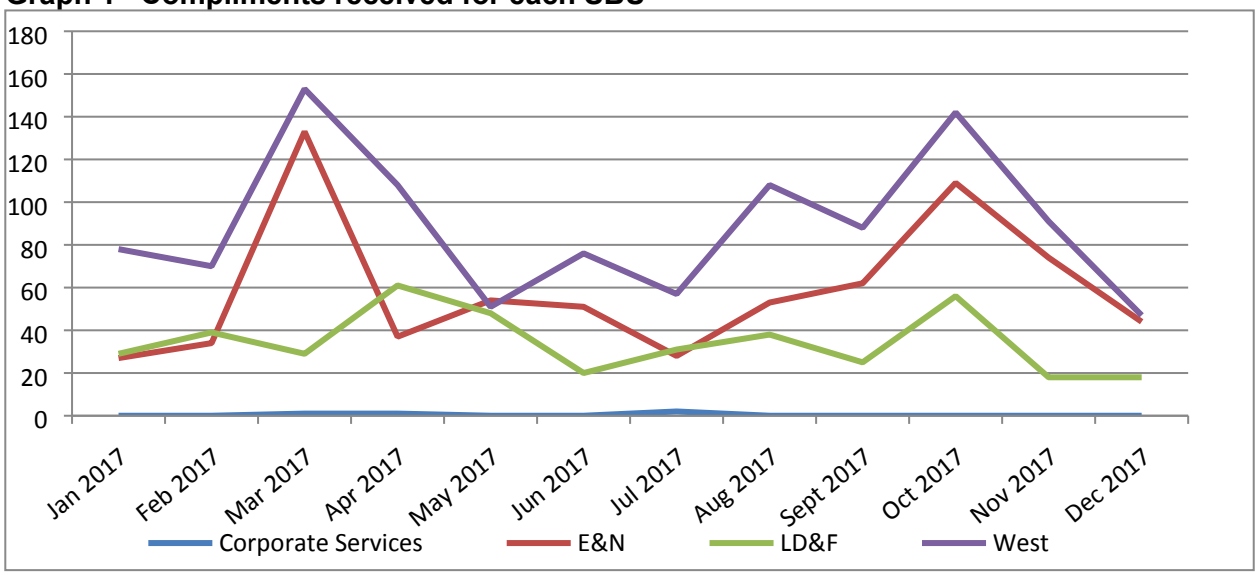
Table 1 shows the number of compliments received each quarter over the last 12 months.

Table 1 Compliments received over the last 12 months (rolling year)

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	TOTAL 2017/18
Compliments received	593	507	492	599	1598

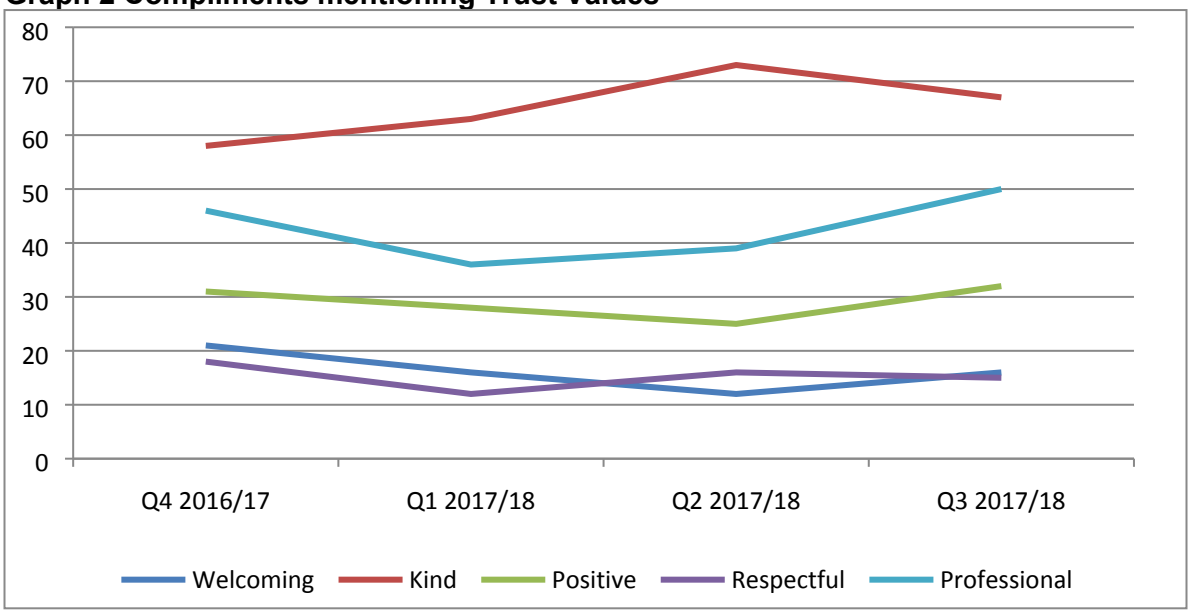
In the Q3 89% of compliments came from service users, 8% from carers/relatives and 2% from professionals outside the organisation. Three compliments were posted on NHS Choices. Consistently the Trust receives more compliments than complaints about the services it provides. During Quarter 3 the Trust received almost 10 times more compliments than complaints.

Graph 1 Compliments received for each SBU



Most compliments generally refer to good or excellent care. During Q3 310 compliments mentioned that staff were helpful or helped them and 124 that staff were caring. All compliments received by the PALS team are recorded and assessed for reference to the Trust Values. Graph 2 shows the number of references to the Values. Consistently staff are being complimented on being kind and professional. A selection of comments is also provided below.

Graph 2 Compliments mentioning Trust Values



They are very positive about helping me. I'm happy I have people who care. *(Forest House Adolescent Unit)*

> Everyone is always polite, the building has a great atmosphere, and coming here has helped me a lot more than other places I've been to. *(Dacorum Wellbeing)*

I have had excellent care throughout my time with the community services. Staff were very considerate, attentive and helpful. I am so truly grateful to the team at Waverley Road for all their kind help. At a time where I felt incredibly vulnerable, CP and JG gave me security, support and hope for my future. I will be forever grateful for their kind, considerate, and friendly manners *(NW Support and Treatment Team St Albans).*

> Thank you all so much for all the help and support I have received from all you at ADTU. I started here with a new journey not knowing what was happening but I leave here with a new outlook on life and many new experiences. There are no words which will ever say thank you enough for all you have done for myself and my family, as you have given them their daughter, wife, sister and mother back do an amazing job. Thank you. *(ADTU West)*

3. Having Your Say and Trust Values

All Having Your Say (HYS) surveys have the questions broken down into sections by Trust values. Based on the results of each question a satisfaction score is calculated for each Trust value.

Table 2: % satisfaction scores for Trust values

Value	Q4 16/17	Q1 17/18	Q2 2017-18	Q3 2017-18	Total
Respectful	86%	88%	91%	92%	**92%**
Welcoming	89%	89%	90%	92%	**91%**
Professional	79%	76%	76%	78%	**78%**
Kind	81%	77%	81%	82%	**79%**
Positive	95%	91%	89%	95%	**91%**

Examples of positive comments referring to Trust values, made by service users are shown below: -

"Teresa's interaction with mum was supportive, caring and very respectful."
"Staff were very helpful and welcoming."
"All the staff in Aston Ward were very professional and caring…"
"This service has been so helpful with my daughter; they are very kind and compassionate."
"I found the experience very helpful and positive and not too difficult to cope with…"

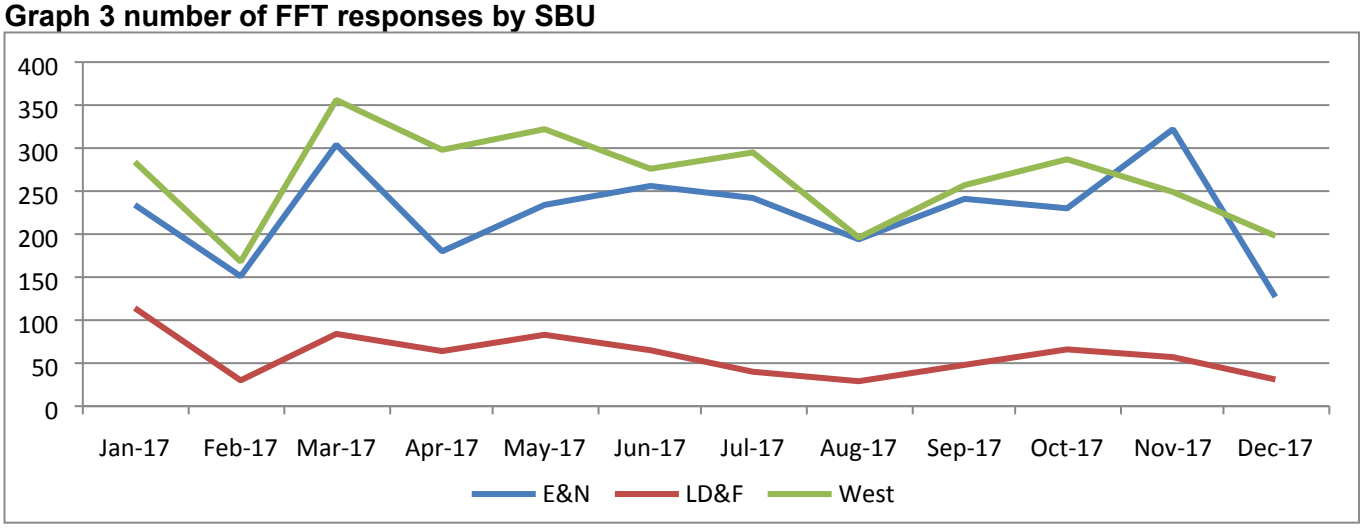
Friends & Family Test (FFT)

Table 3: FFT scores for each quarter

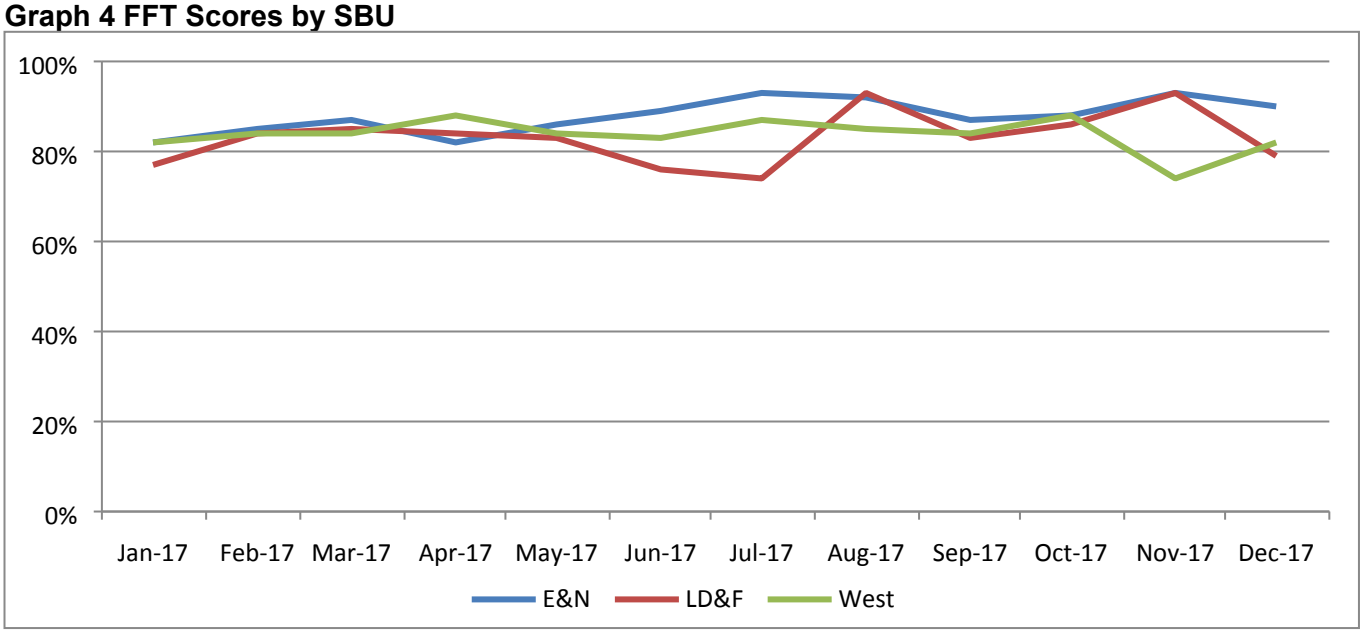
	Q4 2016-17	Q1 2017/18	Q2 2017-18	Q3 2017-18	Total
FFT would recommend	86%	85%	88%	86%	**88%**
FFT would not recommend	7%	6%	5%	5%	**5%**

The Friends & Family Test satisfaction score for the quarter was 86%. Service users who said they would not recommend our services scored 5%.

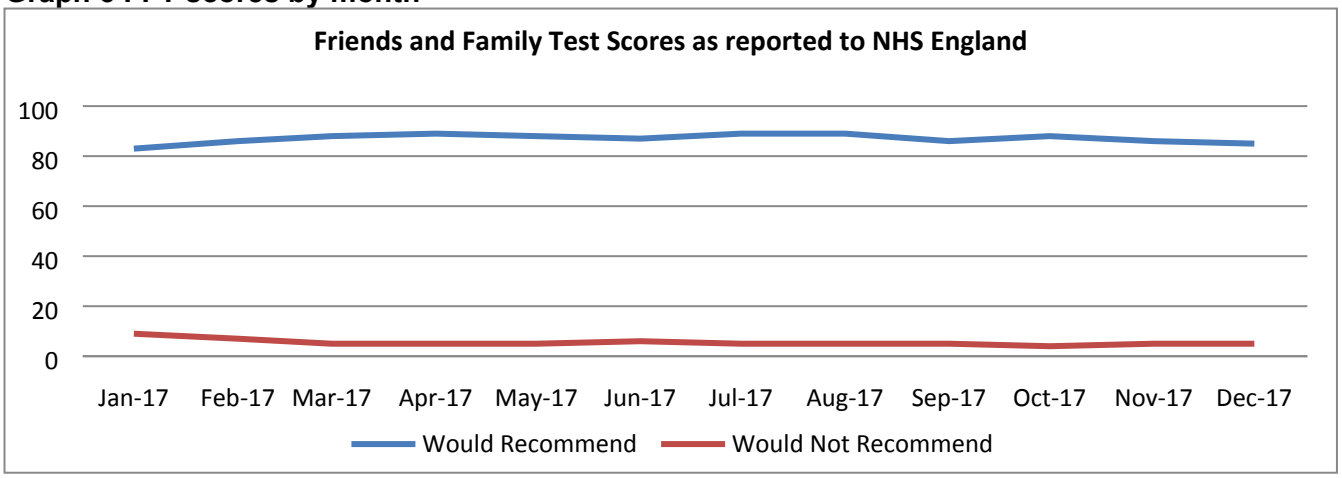
Graph 3 number of FFT responses by SBU



Graph 4 FFT Scores by SBU



Graph 5 FFT scores by month



4. Stories to the Trust Board

The purpose of the presentations is to ensure that the Board and Governors have a chance to hear the service user and/or carer experience of services first hand and also to learn more about the issues and practice from the services themselves, as this enables the Board and Council to triangulate this information with the reports and data they receive at meetings.

They have helped the Board members, particularly the Non-executive Directors, to gain a real understanding of the services we deliver and the impact we have on people's lives.

Following the presentations the Chair sends a letter to the individual involved, which references any action agreed at the meeting and how this will be reviewed. A quarterly update on the Board Stories and outcomes is given to the Inclusion and Experience Group and reported onwards to the Quality and Risk Management Committee. This reporting structure exists to ensure that service user and carer involvement is happening effectively across the organisation and that the Trust understands service user and carer experience, both in terms of strategic development and delivery of operational services in order to ensure a continual improvement in quality.

Date & Service	Issues raised by service user/carer	Outcomes
19-10-17 CAMHS	• Confusing "tiers" and "steps" in CAMHS service, unhelpful to families. • More collaborative – joined up working between services.	• Agreement from Board that terminology can be confusing, to be reviewed. In process
16-11-17 Wellbeing Service	• No option for face to face initial assessment. • Electronic literature was not preferred style • The out of hours helpline was not particularly helpful. • The effects of retirement on your mental health – could HPFT provide more support?	• Service user agreed to join the SPA Reference Group to give advice about the helpline. • HPFT to consider re-starting "Keeping Well in Retirement" workshops.
29-11-17 Older Peoples' Services	• GPs need better understanding about mental health and the need for early referral. • Involving specialists at an early stage. • Supporting carers.	• Exec talked about working with primary care and providing more information for GPs about mental health.

5. Having Your Say

The Trust received 1,567 pieces of feedback under the "Having Your Say" umbrella during Quarter 3 2017/18 showing an increase of 2% compared to the previous quarter.

Table 5: Overview of data received in Q3 compared to previous three quarters

	Q4 2016-17	Q1 2017/18	Q2 2017-18	Q3 2017-18	Total 2017/18
Service User Feedback Surveys completed	1458	1406	1175	1247	**5286**
Carer Feedback Surveys completed	297	358	367	320	**1342**

This quarter the Service Experience Team began a review of the HYS community survey, following the success of last year's inpatient review, a process that is fully co-produced. The new survey will be used from 1 April 2018.

The team has also been shortlisted for a Patient Experience Network National Award (PENNA) for the inpatient review.

6.1 Trends

This quarter we are able to see increases in the satisfaction scores for 8 teams. Having provided actions based on HYS results in Q1 we can track progress of feedback through HYS with the results seen below. These actions are displayed on the Quality Improvement website and in the SBU Sharing Good Practice newsletters. The table below lists actions showing a significant increase in satisfaction in Q2 compared to Q1.

Table 6 Summary of actions taken in response to HYS feedback showing significant increase in satisfaction

Team	*Q2 Scores*	*Q3 We Did…*	*Increase in Satisfaction*
Robin Ward	89% Kind and caring	**1. Review the activities on the ward and base it on needs.** A new activity plan has been put in place by the recreational worker and there are increased activities provided by the Occupational Therapist. **2. We will ensure that your physical health needs are met.** The team continues to do weekly observations in addition to the junior doctors observations. **3. Staff will plan 1:1 sessions with you.** There are now more 1:1 sessions happening on the ward. The team leader is also discussing feedback at team meetings to see what further improvements can be made..	**12%**
Stevenage CAMHS Clinic	70% FFT	**1. Aim to improve your experience by making CAMHS feel more welcoming.** • The team leader spoke to the manager of the homeless shelter next door as young people had told us they felt intimidated by people hanging around the entrance. • Email circulated to staff about not smoking on site as people were congregating around the entrance for cigarette breaks. • We are being more flexible when offering appointments. **2. Aim to make changes based on what you tell us including improving ventilation in the waiting room during the summer months.** Unfortunately we will not be able to install air conditioning but the team leader is exploring the options of purchasing fans.	**17%**

6.2 **Comments from HYS and FFT**

In Quarter 3, 2017-18 we received over 1,300 comments. Teams use these free text comments together with the quantitative data to produce their "you said, we did" action posters.

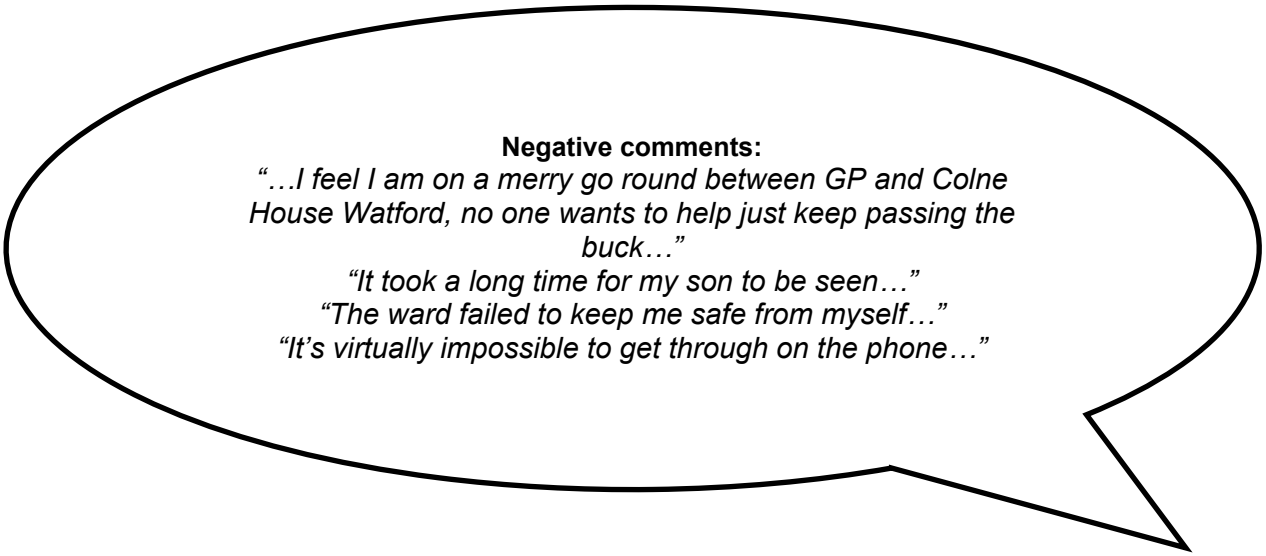
Positive comments:

"The lady who came to visit me really took time to evaluate my condition. She was very helpful."

"Excellent, timely care."

"I visited Kingsley Green to see a friend, WOW sure has changed for the better."

"A team of excellent, kind people, kind people that care about ill people."



6.3 Wellbeing patient experience questionnaire (PEQ) report

255 Patient Experience Questionnaires (PEQs) were returned. Compared to the last quarter, the PEQ return rate has increased in the West (Q2 - 10%, Q3 - 12%) and reduced in the NE (Q2 - 10%, Q3 - 7%), leading to a consistent return rate across the county (Q2 - 10%, Q3 - 10%).

Client satisfaction remains high within the Wellbeing Service. This is in line with previous PEQ results from 2016/17. During Q3, satisfaction was highest for client perception of the listening skills of their therapist (95% responding that they felt staff listened to them and treated their concerns seriously "at all times"). Satisfaction was higher for understanding of the patients' difficulties than in Q2 (69% responding that they felt the service helped them to better understand and address their difficulties "at all times"). Across the 5 questions the "rarely" and "never" response was used only 6 times (2%). However, data and learning statements should be interpreted with caution given the low return rates for the PEQ.

7. PALS (including contact through NHS Choices and HPFT App)

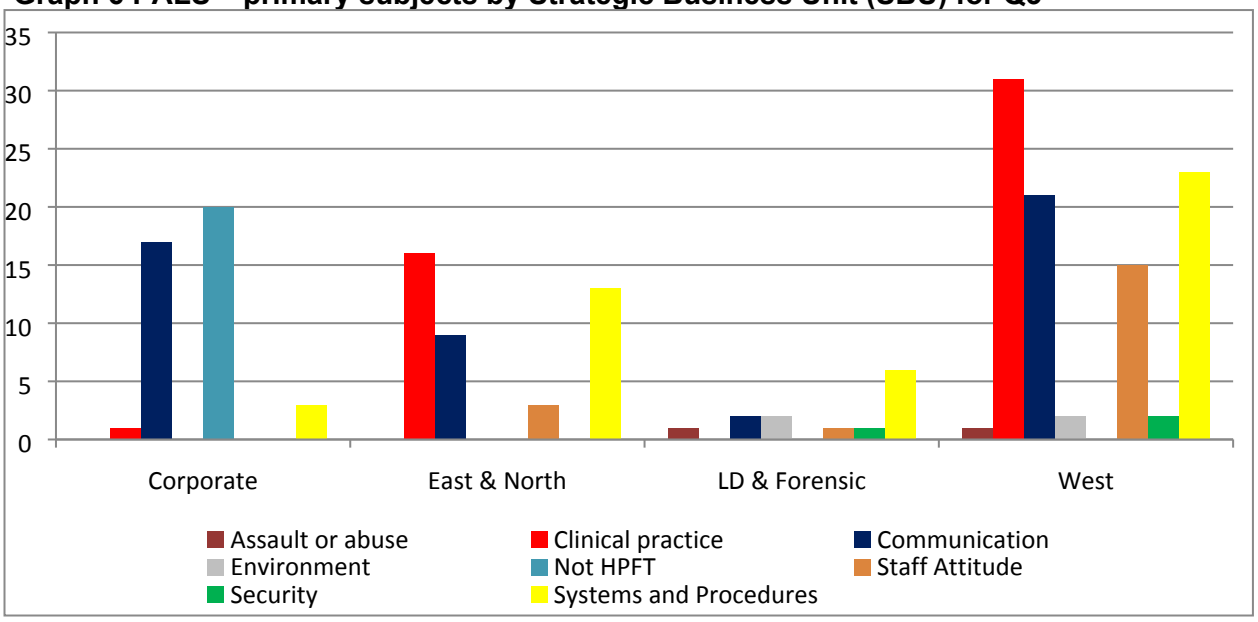
Table 7: PALS contacts received in the last 12 months

	Q4 2016/17	Q1 2016/17	Q2 2017/18	Q3 2017/18	Total 2017/18
PALS contacts received	214	217	219	190	**626**

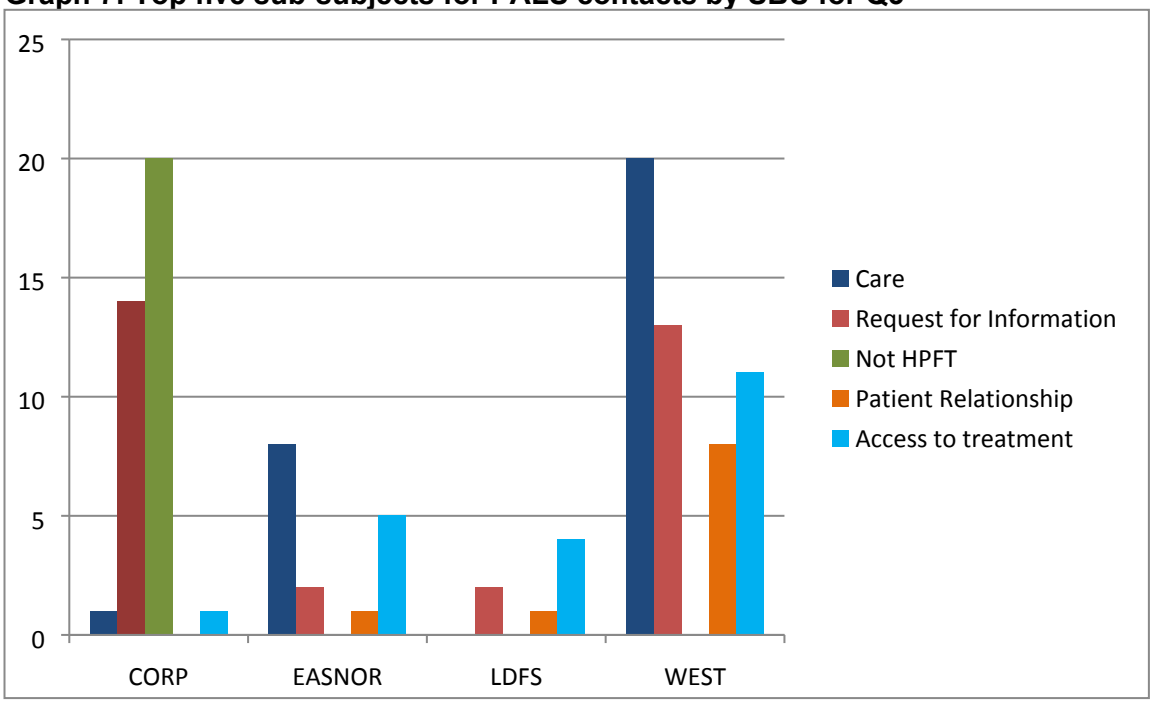
There were 190 Patient Advice and Liaison Service (PALS) contacts during the quarter, a 13% drop compared to Q2. These include contacts direct to the Trust through the PALS and Complaints team, Having Your Say forms, NHS Choices and external organisations.

The issues raised are shown in graph 6. 20 contacts were not about HPFT services and were referred on to the correct organisation. 63 contacts were informal complaints, 16 were issues for resolution, 34 provided feedback on services, 40 were enquiries and 15 requested advice/information, there was 1 request for access to records and 1 from a staff member which was referred to HR.

Graph 6 PALS – primary subjects by Strategic Business Unit (SBU) for Q3



Graph 7: Top five sub-subjects for PALS contacts by SBU for Q3



The top five sub-subjects were requests for information (31 contacts), care (29 contacts), access to treatment (21 contacts) Non-HPFT (20 contacts) and service user relationship (10 contacts). Any queries or issues related to HPFT services, are passed to the relevant team leader (copied to the managing director and service line lead) to provide the necessary information or to try to resolve concerns locally.

Negative feedback received through NHS Choices and Care Opinion is recorded as PALS contacts because it is anonymous. There were 8 negative postings; 4 were about South West Wellbeing Services (and 1 each were about Community Services at St Pauls Community Services, Waverley Road and Cygnet House and 1 was about the Mental Health Helpline. When NHS Choices posts a comment about the Trust, the comment is forwarded to the relevant Managing Director and Service Line Lead so appropriate action can be taken and, if the person can be identified, contact is made with the individual. Otherwise we respond by advising the individual to contact the PALS and Complaints team to enable the Trust to investigate the matter further.

6. Complaints

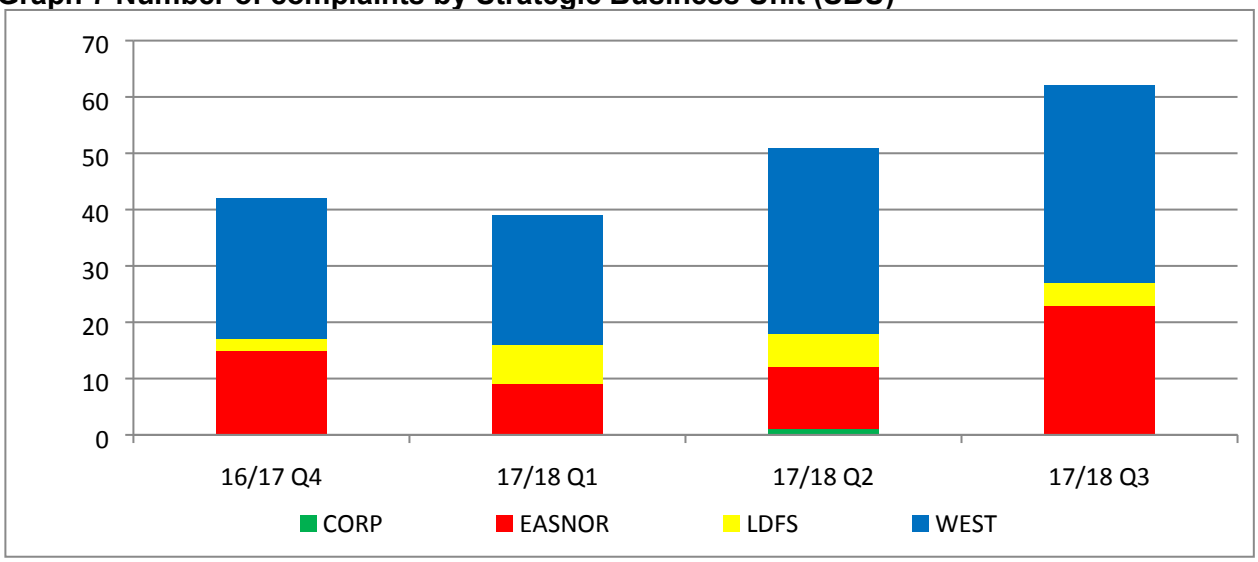
The Trust received 62 complaints in Q3 compared to 49 in Q2, a 27% increase. E&N Herts SBU saw the biggest increase across the trust and of these a number related to E&SE community services. The reasons and themes within these complaints is subject to a review by the business unit.

Acknowledgement within 3 days, as required by the Regulations, was 94% in Q3 compared to 98% for Q2. The Trust ambition is for 100% of all complaints to be acknowledged within 3 days throughout the year. The first response rate figures will be available after 5 February 2018.

Table 8: Complaints and acknowledgement and response rates for 2016/17

	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Total 2017/18
Complaints received	42	39	49	62	**194**
% of complaints acknowledged within 3 working days	98%	100%	98%	94%	**97%**
% of complaints with a first response within 25 working days (90% target)	89%	83%	86%	Data Not available at time of report	**TBC%**

Graph 7 Number of complaints by Strategic Business Unit (SBU)



East & North SBU received 23 complaints in Q3 compared to 11 in Q2. 14 of the complaints related to services provided across the range of Older Persons, CAMHS and Adult community services. One complaint was graded moderate* (see appendix for more information)

LD & Forensic SBU received 4 complaints during the quarter compared to 6 complaints received in Q2. 1 was about Hertfordshire LD Forensic Services, 1 about Hertfordshire Community Assessment and Treatment Service and 2 about Essex IAPT Services.

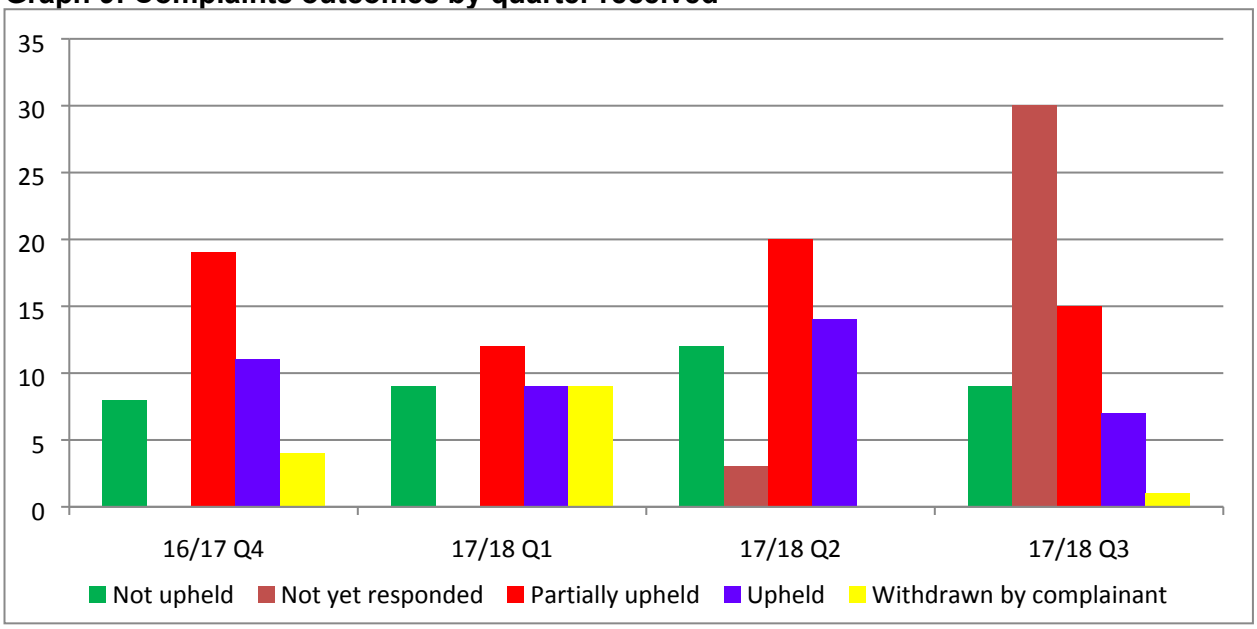
West SBU received 35 complaints this quarter compared to 32 complaints in Q2. 12 of the complaints were about inpatient services with 6 about Swift ward, 3 about Albany Lodge, 2 about Aston ward and one about Robin ward. There were 2 complaints about RAID, 1 complaint about CATT and 1 about ADTU. There were 16 complaints about adult community services with 9 complaints about South West Community Services and 7 about North West Community Services. There was 1 complaint about the Adult Community Eating Disorder Service and 2 complaints about Hertfordshire Wellbeing Services. Complaints are discussed at the relevant Quality and Risk and Practice Governance meetings where they are reviewed to identify trends and to determine what specific actions may be required. Three complaints were graded as moderate* (see appendix for more detail)

Corporate
There were no complaints about corporate services in Q3.

Main themes
The primary issue for 31 complaints was clinical practice (16 about care, 4 about assessment and treatment, 4 about diagnosis, 3 about care planning, 2 about failure to act, and 1 each about administration of drugs and failure to follow procedures).
There were 16 complaints about systems and procedures (6 about access to treatment, 3 about breaches of confidentiality, 2 about discharge and 1 each Mental Health Act detention, record keeping, non-referral and continuity of care).

Outcomes
Graph 9 shows the outcome of complaints for Q2 compared to the previous 3 quarters. The majority of complaints are fully or partly upheld. 11 complaints are awaiting a final response.

Graph 9: Complaints outcomes by quarter received



8.1 Learning from Feedback through PALS, Complaints and HYS
The following learning has taken place, or is planned to take place, in relation to complaints received this quarter.

Most of the complaints that were upheld or partially upheld related to individual service users and individual members of staff, with no clear pattern related to a particular service.

Volunteers in Community Hubs
As part of our commitment to improving the responsiveness of our services, we are introducing volunteers to all of our hubs to support with meeting and greeting of services uses, as well as helping to gather feedback from service users and carers. This has been piloted in St Albans and shown a significant increase in the quality of feedback. We will be introducing volunteers to our largest hubs by end of January 2018 (Saffron, Colne, Rosanne, Waverley, and St Paul's). Other hubs will follow in the coming months.

Reception and front of house staff
Over the last year we have been working with staff, service users and carers to identify how we can enhance the experience of working and visiting the community hubs.

Short term:

- Inconsistency of reading matter within the reception areas: A magazine subscription scheme has been introduced which delivers a variety of magazines to appeal to a wide range of tastes.
- Reception ambiance: At the suggestion of service user and carer groups, fish tanks have been installed in the bigger hubs to create a calmer and more relaxed environment. These have generated significant positive feedback.
- Call handling: As a pilot we have introduced a dedicated telephonist to pick up all the calls for one of the busiest adult teams in order to provide a consistent and more positive experience for callers. This will be reviewed in the spring.

Medium term

- Receptionist uniforms: A suggestion by some front of house staff. Uniforms that properly reflect this important role are being introduced with a positive response from both staff and visitors.
- Refurbishment of Saffron Ground reception: Following comments about the poor seating arrangements and general ambiance of the area, a better layout has been designed. Work should begin in the spring.

Long term

- WiFi in reception areas: At the request of service users we are working with the combined IT team to implement WiFi access, with the hope that there will be progress by the spring.
- Information in the television loops in reception: Request for information to be relevant to the local area as well as useful information about wellbeing. Slots should be paced so they can be read and be varied enough to engage and interest whilst waiting for appointments. This will be looked at further in 2018.

Service user property on wards

Following a number of complaints about property going missing on the ward, a number of changes have been made to the way property is recorded. On Swift ward property is being photographed as well as being recorded on the property / valuables lists to enable better identification of items should they go missing. Staff on all wards have been reminded to ensure that property is properly recorded both into and out of the wards to ensure that it is tracked appropriately. This is especially important when a service user moves between wards. Service users are encouraged to bring as few valuables, such as jewellery, electronic goods, expensive clothing, as possible.

A barcoding system for service user property is also going through procurement to further strengthen the logging and identification of service user property.

7. Ombudsmen requests

9.1 Files requested

The Trust received no for complaints files from the Parliamentary and Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO) or the Ombudsmen's Joint Working Team (JWT).

9.2 PHSO/LGO decisions returned

The Trust received 2 Ombudsmen's decisions in Q3, 1 from the Ombudsmen's Joint Working Team (JWT) and 1 from the PHSO.

Table 10: summary of decisions returned by the Ombudsmen

Service	Background and detail of learning	Ombudsman decision
CAMHS community Services C2863	The mother of a service user complained about the level of care and support provided. The Trust responded to the ongoing complaints but was unable to resolve them to the complainant's satisfaction. The Ombudsmen's Joint Working Team (JWT) decided to investigate the complaints which were about 5 different organisations in the hope that this would bring closure to all involved.	**Not upheld** No further action for the Trust
Adult Community Services C2754	The mother of a service user complained about the care and treatment she and her daughter had received from the Trust during the service user's admission to a specialist out of county unit. She complained of poor communication, that her request for a change of coordinator for her daughter was not addressed and the Trust failed to offer her a carer's assessment	**Not upheld** No further action for the Trust because whilst it was clear that the Trust's action had caused the family distress, the ombudsman was satisfied that following the complaint the Trust took appropriate action to put things right.
MHSOP Community Services C2734	Joint complaint with County Council The relative of a service user complained that there was a failure to safeguard the service user from financial abuse by a support worker, there was poor communication with the relative. That the Trust / Council were aware of the financial abuse but took no action to prevent it, the Trust alleged that the complainant had given a clue to the service user's PIN, thus enabling the abuse but this did not happen until after the thefts had taken place. The complaint was not investigated appropriately and there were lengthy delays. The Trust's independent investigation was flawed and inaccurate. Appropriate remedial actions were not taken to prevent similar problems happening to other service users.	**Partially upheld** The Joint Working Team (JWT) acknowledged that the Trust had identified several significant failings and was broadly satisfied that the actions taken by the Trust and the Council to remedy matters are appropriate and proportionate. Two further areas of fault were identified and the following recommendations made: The Trust to apologise for incorrectly implying that the support worker was able to steal from the service user as a result of the complainant sharing a hint about the service user's PIN number. The Trust to write to the complainant to explain how it will audit line management and supervision structures to ensure they remain robust Apologise for failing to involve the complainant in the decision making around the service user's finances in August 2010. Arrange a reflective practice event to discuss the report finding and share learning. Explain any actions taken to ensure staff compliance with local and national safeguarding guidance. These recommendations were completed on 29 December 2017. With final feedback to the complainant around the reflective learning event outstanding.

8. Complaints Training

At the end of Quarter 3 93% of staff had completed their mandatory complaints E-learning. This is the same as for Q2. During the quarter a half day training session on investigating and responding to complaints was provided to 6 members of staff.

Benchmarking

The Trust seeks feedback from complainants using an electronic survey within the HYS feedback umbrella. Where we have an email address we send the invitation and link by email, otherwise we send an invitation by post with the link. We also inform complainants that we can send them a questionnaire by post if they prefer.

In Quarter 3 no questionnaires were returned

The Trust continues to work with the Patient's Association to review its procedures and determine what changes we need to make in order to improve service user/carer experience of the complaints process with training due to take place in Q4.

Appendix 1

Overview of complaints received
During quarter 2 a total of 62 complaints were received, 60 of which were about Hertfordshire services.

6 complaints were graded as moderate risk with more detail provided in the table below.

Adult community services
30 complaints: 22 were about the Support and Treatment Teams (12 for West and 10 about East & North SBUs). 2 were graded as moderate.

The primary issue for 12 complaints was clinical practice, with 5 about systems and procedures, 4 about staff attitude and 1 about poor communication. 2 complaints were upheld, 6 partially upheld, 2 not upheld, 1 was withdrawn by the complainant and 11 are under investigation

4 were about Targeted Treatment Teams (3 about West and 1 about East & North SBU).

The primary issue for 3 complaints was clinical practice, with 1 about systems and procedures. 2 complaints were not upheld, and 2 are under investigation.

4 complaints were about Initial Assessment Teams (1 about West SBU and 3 about East & North SBU. The primary subject for 3 was clinical practice and the fourth was systems and procedures. 2 were partially upheld, 1 was not upheld and 1 is under investigation

Adult Community Eating Disorder Service
2 complaints:
- The parents of a service user complained that she was not being admitted for treatment. **Not upheld**
- A service user's mother complained about the attitude of two members of staff. **Not upheld**

Acute Adult Inpatient Services
12 complaints with 3 about Albany Lodge, 2 about Aston ward, 1 about Robin ward, 6 about Swift ward.
- Albany Lodge 1 – complaint about missing belongings. **Under investigation**
- Albany Lodge 2 – complaint about the way the service user was discharged from the ward and their subsequent care. **Under investigation**
- Albany Lodge 3 – Complaint about the care and treatment on the ward. **Under investigation**
- Aston ward 1 – A service user complained about staff attitude and care. **Under investigation**
- Aston ward 2 – A service user's mother complained about care on the ward. **Under investigation**
- Robin ward 1 – A service user's relative raised concerns about her care and access to physical health services. **Not upheld**
- Swift ward 1 – a service user complained about being detained under the Mental Health Act. **Under investigation**
- Swift ward 2 – A service user's relative complained about a service user's care on Swift and Aston wards and in the community. **Under investigation**
- Swift ward 3 – a service user's relatives complained about poor discharge planning and lack of appropriate support on discharge. **Upheld**
- Swift ward 4 – a service user's belongings were mislaid. **Upheld**
- Swift ward 5 – a service user's mother complained that he was discharged prematurely. Graded Moderate (see below). **Under investigation**
- Swift ward 6 – A service user's father complained about her overall care and discharge. Closed for consent. **Under investigation**

Crisis Services
There were 4 complaints about Crisis Services, 2 about RAID, 1 about CATT and 1 about ADTU

- ADTU – Breach of confidentiality. Complaint suspended as service user very unwell. **Not yet responded**
- CATT – A service user's partner complained about the lack of support from CATT. **Upheld**
- RAID 1 – A service user's son complained about diagnosis, care and lack of communication. **Partially upheld**
- RAID 2 – A service user's mother complained about the way a consultant spoke to the service user and stopped her involvement in a therapy group she was attending. **Under investigation**

Single Point of Access (SPA)/Mental Health Helpline
No complaints during Q3

Wellbeing
2 complaints.
- 1 - Poor communication while staff member was off. **Upheld**
- 2 – Parent of service user with special needs complained about lack of access to treatment. **Upheld**

Older Peoples Services
1 complaint about Older people's community services following death of service user – Mortality Group review undertaken Primary subject: Clinical Practice. **Partially upheld** due to poor communication with family members. Meeting being arranged with complainant.

CAMHS
Eight complaints
- CAMHS S 1 – a service user's parent complained about the attitude of the clinician towards the service user. **Under investigation**
- CAMHS S 2 - Joint complaint about three organisations. Primary subject for HPFT was Clinical practice. **Not upheld**
- CAMHS East 1 – A service user's mother complained that the service user is not getting the help or diagnosis she needs. **Under investigation**
- CAMHS East 2 – Mother of service user unhappy that she had been discharged and referred to another service. **Not upheld**
- CAMHS North – The parents of a young person complained about poor communication between professionals from different organisations. **Not upheld**
- CAMHS North West - Continuity of care. **Partially upheld**
- CAMHS CATT - Communication breakdown with relatives
- Forest House – A service user complained about a staff member's attitude **Not upheld**

Learning Disability and Forensic Services
1 complaint about medium secure services – The primary subject was clinical practice. **Under investigation and graded as moderate** (see below)
1 complaint about the Community Assessment and Treatment Service. The primary subject was about clinical practice. **Partially upheld**
2 complaints about Essex IAPT services. Primary subjects in each case were access to treatment. **Both partially upheld**

Moderate graded complaints

Table 10: Summary of High and Moderate* Risk complaints for Q2 2017/18

Service	Description	Outcome
Moderate		
Adult Community Services C3176	A service user's ex-partner complained that Complaint about Sus death having been left by staff attending his property after finding out he had taken an overdose	**Under investigation** Serious incident investigation owned by Ambulance Service – HPFT has been involved in the investigation. Mortality Governance Group review undertaken
Adult Community Services C3191	A service user's mother complained about the care and support being provided to her son who has autism.	**Under investigation** Safeguarding involved
Acute Inpatient Services C3179	A service user's mother complained that her son was discharged despite her explaining to the consultant that her son called her to say he intended to take his life when he is discharged and that he will be homeless. Mother was very concerned as her son was missing.	**Not yet responded** Under investigation (service user is currently under the care of Kent MH services)
Acute Inpatient Services C3147	A service user's mother complained about her daughter's care / failed suicide attempt / 1:1 nursing care whilst at L&D Hospital and service user's bed on Aston Ward being given to another patient.	**Not yet responded** Under investigation
Medium Secure Services C3184	A service user's mother complained about the service user's welfare, in particular that he was being threatened and beaten up by other service users on the unit.	**Under investigation** Safeguarding involved
Older People's Community Services C3161	A service user's son raised concerns about his mother's care. She did not take her medication, was not able to prepare food for herself, was unable to use toilet facilities unassisted and was unable to look after herself or her home properly. It was recommended that she be taken into care but a consultant decided this was not necessary as she appeared to be taking her medication and allowing carer to attend to her needs.	**This incident was subject to a desk top review by the Mortality Governance Group.** **Complaint partially upheld** Multi-agency involvement and decision making was appropriate. However, it was felt that if communication with the family had been better they would have understood the rationale behind the decision not to admit at that time. Service user death has been attributed to a stroke.

*On receipt, complaints are risk assessed against a 5x5 matrix, as low, medium and high risk. The rating is reviewed and adjusted, if necessary, once the investigation is complete. High and moderate risk complaints are itemised in this report

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board Meeting

Meeting Date:	25.01.18	**Agenda Item: 09 (ii)**
Subject:	A Review of Progress Against National Community Survey	**For Publication: No**
Author:	James Holland, I&E Team Manager	**Approved by:**
Presented by:	Jess Lievesley, Exec Director of Service Delivery & SU Experience.	

Purpose of the report:

The report provides an update on progress to address issues highlighted through results of the national community mental health survey as well as planned actions for the future.

Action required:

To Receive this report

Summary and recommendations:

- Consider contents
- Agree how results (when available) from future work should be used
- Consider comments re: impact of improving support for carers
- Clarifying timeline for future updates

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

Great Care, Great Outcomes

- We will improve the safety of our services so that people feel safe and are protected from avoidable harm
- We will improve the wellbeing and physical health of service users through better health monitoring and support to address health risk factors

Great Organisation

- We will support and empower staff to improve, innovate and become more productive in delivering great care

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

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

The project is designed to improve equity for people re: standards of service provision. Future work (Viewpoint & carers in Herts) is being co-produced as is Peer Experience Listening.

A Review of Progress against National Community Survey

1. Background

1.1 The 2017 Community Mental Health Survey Results for HPFT (released publically 15th November 2017) showed a number of areas for development. These results were previously presented to the board as well as to our Council of Governors. The results noted that 29 out of 32 scored questions showed a downward trend and the overall assessment from the CQC for the Trust was that our performance was "about the same". Notwithstanding, our commitment to improving the quality of the service and care we provide as part of our Good to Great Strategy dictates that we will look to build on these results and continually work to improve the experience of our service users and carers.

1.2 For reference the primary themes that emerged from the review were grouped around:

1.2.1 The quality of annual reviews
1.2.2 Feeling listened to and able to contribute
1.2.3 Knowing who to contact in a crisis

1.3 In response to these findings and wider feedback from commissioners and stakeholders, work is underway to look at how we can more proactively address the themes that emerged from the survey; accordingly this paper provides an update on progress and action that is planned over the coming months.

2. Work to date

2.1 Care review literature

2.1.1 Following the receipt of embargoed results in August 2017, the Trust began to look at what changes could be made in the short and long term to improve experiences for people across all community services.

2.1.2 One of the areas requiring specific focus from the Community Mental Health Survey was the proportion of people feeling they had received an annual care review (61% - a drop of 10% from the previous year).

2.1.3 Of particular importance is how this figure differed from HPFTs own data on the number of people who had received a CPA review in the past 12 months (c94%). This suggested there may be some disconnect in how well people understand when they have been invited for a care review.

2.1.4 As an initial piece of work, a new leaflet was produced for community services to ensure they are preparing people for their care review, including links to physical health and involvement of carers, friends and families (appendix). This was implemented across adult community from 1st October and is currently being

launched across older people's community services.

2.2 Welcome packs

2.2.1 Supported by the work we are doing in partnership with John Lewis trained colleagues, we have commissioned work to develop a new welcome pack for adult community and CAMHS services. The purpose is to provide consistent information at an individual's first point of contact with our services to ensure people are clear on how the service works, what they can expect and to reduce the anxiety associated with accessing specialist mental health services. This will be introduced in January 2018.

2.3 Review of Having Your Say Community Survey

2.3.1 On 1st July 2017, the Trust successfully launched the new HPFT Inpatient Survey, a co-produced review of this survey which ensures we receive feedback from service users at various points during their inpatient stay, rather than only being asked on discharge (in line with Friends and Family Test requirements).

2.3.2 There is currently a procedure in place to carry out the same process for the Trust community survey which will launch from 1st April 2018. As part of this process we will be discussing areas of priority for the Trust over the coming years so that feedback is relevant and reliable.

2.3.3 Additionally, following on from the feedback received from service users and carers about the positive and helpful addition of having trained volunteers in our St Albans community Hub, we have trained up additional volunteer colleagues to be present in all our Major Hubs by January 2018.

3. Co-Producing our response with Stakeholders

3.1 Reviewing service user and carer experience

3.1.1 To ensure that we have increased oversight on the work we are doing to improve the experience of service users and carers accessing our community services, we have commissioned the charities Viewpoint and Carers in Herts to carry out some direct work with service users and carers respectively on their experiences and the measures we are taking to improve.

3.1.2 These will be supported by a substantial piece of Peer Experience Listening (PEL) running in parallel providing semi-structured interviews for services users who have used community services more than once since 1st April 2016 asking about similar topics so this work can inform the work of Viewpoint. The current plan is to choose a random sample of 900 service users (in line with national community survey sample requirements).

3.1.3 The outcome should be a clear set of recommendations as well as an overview of what great looks like for people with respect to community services.

4. Conclusion

4.1 Whilst the numbers of respondents to the CQC adult community survey were low at c230 in absolute terms as a %, they represented about 24% of respondents and as such is broadly comparable with other trusts. However the national mental health community survey has highlighted that there are areas where we can strengthen what and how we are delivering our community services across HPFT.

4.2 As a Trust we are absolutely committed to improving the experience of those individuals who access care via our community teams. Working in partnership with service user and carer organisations as well as our internal quality and experience teams, we believe we the measure we are putting in place will positively impact on the way care is delivered in ways that improve the overall experience of the service user or the person they care for.

Appendix A – Community Action Plan 2018

Areas of Focus	Action	Success Measure	Lead	Timescale	RAG
1. A need to ensure that both the quality of care reviews is robust and that service users are clear when they are attending a care review.	New care review literature produced with input from service users and carers.	All services using new literature in preparing people for their care review meeting.	Community team managers.	November 2017	
2. Addition of volunteers to hubs to improve quality of feedback and demonstration of Trust values.	Volunteers recruited, checked and installed in all main hubs. (Rosanne, Colne, Waverley, Saffron)	Volunteers allocated to all main hubs.	Volunteer Coordinator Team Leaders	End of January 2018	
		Increase in feedback from service users and carers shows a measurable increase.	Team Managers	March 2018	
	Volunteers recruited and installed into all remaining hubs.	Volunteers in place across all hubs.	Volunteer Coordinator Team Leaders	March 2018	
3. Service users receive an appropriate welcome to help understand what service is on offer and to manage expectations.	Welcome pack is co-produced for, initially, use across Adult community & CAMHS community.	Welcome pack being used by SPA for all those send through to initial assessment.	SPA Team Manager	February 2018	
		Evaluation shows improvement in satisfaction and DNAs from introduction of welcome pack.	PG Leads	May 2018	

Areas of Focus	Action	Success Measure	Lead	Timescale	RAG
4. Review/scrutiny of service user and carer experience of Adult Community and SMHTOP through partnership work with external organisations. *Three areas of focus are:* • *Quality of care reviews* • *Awareness and understanding of out of hours services/support* • *Feeling that the service understands the impact of mental illness on whole life.*	Viewpoint commissioned to collect feedback from service users on a quadrant basis with a view to providing a final report to HPFT on what works well and what needs improvement for people.	Findings are able to be reported on a quadrant basis so as to localise feedback from service users, as well as providing an overall picture. Feedback includes both what works well and what needs improvement.	Viewpoint CEO I&E Team Manager	February 2018	
	Carers in Herts commissioned to collect feedback from carers on a quadrant basis with a view to providing a final report to HPFT on what works well and what needs improvement for people.	Findings are able to be reported on a quadrant basis so as to localise feedback from carers, as well as providing an overall picture. Feedback includes both what works well and what needs improvement.	Carers in Herts Involvement Manager I&E Team Manager	February 2018	
	HPFT Peer Experience Listening project focused on interviewing random sample of service users (based on random sample of 850).	At least 50 interviews conducted by peer experience listener and results used to inform above work as part of an iterative process.	Peer Experience Listening Coordinator	End of January 2018	
	Online Carer Assessment Survey available to carers until end of January providing opportunity to feedback on quality of support provided by HPFT.	Clearly defined actions arising from survey results that can be used along with other findings above to take action.	I&E Team Manager	End of January 2018	

Areas of Focus	Action	Success Measure	Lead	Timescale	RAG
5. Review of HYS Community Survey	HPFT Community Survey reviewed using same methodology as for Inpatient Survey Review.	Draft questions co-produced for review by QRMC.	Service Experience Lead.	January 2018	
		Final survey questions agreed and new questionnaires designed.	Service Experience Lead Comms & Marketing Manager	February 2018	
		New survey in use by all community services (MH & LD) from 1st April with a focus on asking at discharge.	Service Experience Lead Team Managers	April 2018	

Useful contacts

Herts Help (Community Support and Advocacy Services): 0300 123 4044
www.hertsdirect.org/hertshelp

Viewpoint (local service user involvement charity): 01707 328014
www.hertsviewpoint.co.uk

Mind in Mid Herts (local charity supporting people's mental health): 01727 865070
www.mindinmidherts.org.uk

Hertfordshire Mind Network (local charity supporting people's mental health): 02037 273600
www.hertsmindnetwork.org

Guideposts Trust (local charity supporting people's mental health): 01923 223554

Job Centre Plus (for advice and support on employment): 0345 604 3719
www.jobcentreplus.gov.uk

Money Advice Unit (Advice on finance and benefits): 0300 123 4040

Carers in Hertfordshire (local charity supporting unpaid carers): 01992 586969
www.carersinherts.org.uk

New Leaf Wellbeing College
(Free educational courses about wellbeing):
www.newleafcollege.co.uk

HPFT Patient Advice & Liaison Service (PALS):
01707 253916

Cover Artwork:
Detail from ***Roots of Resilience*** by Katie Chadwick

This piece is part of Hertfordshire Partnership University NHS Foundation Trust (HPFT) Art Collection
www.hpft.nhs.uk/art-project

You might want to use this space to make notes about what you would like to talk about:

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If you require this information in a different language or format please contact the Trust on 01707 253903 or speak with the service providing you with support.

Hertfordshire Partnership University NHS Foundation Trust works toward eliminating all forms of discrimination and promoting equality of opportunity for all.

We are a smoke free Trust therefore smoking is not permitted anywhere on our premises.

September 2017
www.hpft.nhs.uk

as One

Hertfordshire Partnership NHS
University NHS Foundation Trust

Preparing for your care review meeting

Information for service users

Our Values
Welcoming Kind Positive Respectful Professional

What is this leaflet about?

This leaflet provides you with information that will help you in preparing for your care review meeting and an opportunity to prepare some of the things you would like to discuss.

What is the review?

Your wellbeing plan (care plan) needs to work properly. The best way to make sure this happens is by reviewing this when it has been working for a little while.

When should it happen?

You should have an opportunity to review your wellbeing plan (care plan) with us at least every 12 months but you can ask for this at any time and we can discuss with you what is needed. We might also suggest this happens more regularly depending on the care and support you are receiving.

How will I know when it is happening?

We will write to you with as much notice as possible before we need to meet you to arrange a convenient time.

What will happen at the meeting?

Your care coordinator, doctor or other staff member supporting you will ask you how well things are going, if anything needs to change and if there is anything you don't like. This will help you to decide together what needs to be in your wellbeing plan (care plan) for the future.

What about my physical health?

It is really important that we all look after our physical health as evidence shows this has a positive impact on our mental health and wellbeing.

Depending on the services you receive, we may ask you to attend a physical health check before we meet so that we can discuss the results of this at your review meeting and any further support you might need.

Even if we don't ask you to go for a physical health check we will want to discuss your physical health and how this affects your overall wellbeing.

What sorts of things should I think about before the meeting?

It might be useful to think about the following things to discuss with us:

- How you feel your treatment and care is working for you.
- How your mental health is impacting on other areas of your life.
- How you would like people who are supporting you to be involved (such as family members, carers etc)
- What your goals are for your own ongoing recovery.
- Whether you feel your personal budget/direct payment is helping you achieve your goals and improve your wellbeing.

Who should be at your meeting?

If there is someone supporting you, that you would like to attend your meeting (such as a family member or carer) please let us know so that we can invite them and also ensure we provide them with any support they need. It may also be Important to have any other people who are helping you you such as a support worker, GP etc.

What can someone supporting me expect from a review meeting?

If there is someone who is providing you with support, it will often help them to be part of the conversation.

This is your choice but we do encourage this as it can help us to ensure everyone involved in supporting you has access to the right information to help with your ongoing recovery including information about support available for carers, friends and families.

What should be the outcome of the meeting?

The meeting will make sure everything in your wellbeing plan (care plan) is achievable, that everyone understands it and everyone knows what they need to do to make it work.

Contact details

If you need to contact someone about your care please contact the team. We recommend writing these details below:

The person responsible for your care is

Name: .....

Team: .....

Contact Details: .....

If you need support out of hours or in a crisis, and are unable to contact the team, please call the mental health helpline on 01438 843322

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS

Meeting Date:	**January 2018**	**Agenda Item:**
Subject:	**Learning from Deaths dashboard**	**For Publication: Yes**
Author:	**Catherine Pelley, Deputy Director Safer Care and Standards**	**Approved by: Dr Asif Zia, Executive Director Quality and Medical Leadership**
Presented by:	**Dr Asif Zia, Executive Director Quality and Medical Leadership**	

Purpose of the report:

This report provides the Board with an update on the development of the dashboard required as part of the Learning from Deaths national guidance published in March 2017.

The report provides information on the number of deaths reviewed during Q1 to Q3. Following the development of the Trust Learning from Deaths policy at the end of Q2 further detail is available on the deaths reviewed in Q3.

The report provides an update on the implementation of the national guidance and the ongoing work required to develop a way of determining avoidability in mental health deaths.

Action required:

To note progress on the development of the dashboard and currently available data.

To note the outcome of the review of deaths which occurred in the Trusts in-patient settings during Q3.

Summary and recommendations:

Following the Francis enquiry into events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This was reinforced by the recent findings of the Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

In March 2017 the National Quality Board issued the guidance on the actions all NHS Trusts should undertake to learn from a review of the care provided to patients who die stating it should be integral to a provider's clinical governance and quality improvement work.

Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. Commissioners are accountable for quality assuring the robustness of providers' systems so that providers

develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

The national guidance was written for all providers types. There has been little specific guidance for Mental Health and Learning Disability Trusts. The national support for implementation of reviews has to date focussed on Acute Trusts. The Trust has joined a network of Mental Health Trusts across the country to work on the implementation of the guidance over 2017/18. The network is supported by Mazars.

The update on the development of the dashboard is set out below.

National Guidance	**Position at end of December 2017**
The board should ensure that their organisation: • ensures that **mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board** in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised. From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards).	The Trust has started to collect data on deaths and develop a dashboard to enable this to meet the requirement to publish data and learning points from the Q3 onwards. A dashboard is attached for information. This dashboard sets out the range of data the Trust plans to publish as the implementation of the guidance is embedded in the Trust. The dashboard is based on a national format which has been amended to reflect the definitions within the Trust Learning from Deaths Policy. From October 1st the Trust has begun using the mortality screening tool for Learning Disability deaths. This process will help further develop the tool to ensure it is sensitive to the needs of a Mental Health and Learning Disability Trust. All deaths of a service user with a Learning Disability are being referred to the LeDeR programme. The Trust has yet to receive any outcomes from reviews of these deaths. The dashboard will be updated as data is provided by each Local Authority lead for the LeDeR programme. The Royal College of Psychiatrists is expected to publish further information on the Structured Judgement Tool. As part of the development of the policy and dashboard the Trust has identified a need to have wider representation on the Mortality Governance Group and that is currently being taken forward. Learning already identified by the group includes;

	• The need to ensure SPA collects information on cause of death when notified of a death. This reduces the need for the Trust to try and ascertain if further investigation is needed. • Information on the physical health needs of Learning Disability service users has been shared across the group. As each Trust in England is implementing the national guidance in a different way it is not possible to compare data from other Trusts at this point in time.

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

The report related to the following strategic objectives:
1. Deliver safe and effective services

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

Work is ongoing to determine the resource implications of this work

Equality & Diversity /Service User & Carer Involvement implications:

The Trust needs to ensure that it meets the needs of the bereaved as part of the implementation of the guidance.

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

The CQC will consider how the Trust has implemented the Learning from Deaths guidance as part of their inspection programme.

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

Death Review Group October 17

Learning from Deaths – development of dashboard

1. Purpose of the report

This report provides the Board with an update on the development of the dashboard required as part of the Learning from Deaths national guidance published in March 2017.

The report provides information on the number of deaths reviewed during Q1 to Q3. Following the development of the Trust Learning from Deaths policy at the end of Q2 further detail is available on the deaths reviewed in Q3.

The report provides an update on the implementation of the national guidance and the ongoing work required to develop a way of determining avoidability in mental health deaths.

2. Background and context

The effective review of mortality is an important element of the Trust's approach to learning and ensuring the quality of services is continually improved. "National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care" (National Quality Board March 2017) set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. Its aim was to help initiate a standardised approach that would evolve as national and local learning in respect of mortality review approaches increases.

A report was presented to the Trust Board in September 2017 detailing the Trust's approach to mortality review in line with national guidance. This is set out in the Trust's Learning from Deaths Policy which was approved for implementation from 30th September 2017.

3. Dashboard content

The national guidance also set out data collection and reporting requirements for mortality. There is a requirement for Trusts, from 1 April 2017, to collect and present at a public Board meeting on a quarterly basis data and learning points from deaths. The minimum requirement stated in the guidance is as follows:

a. Total number of inpatient deaths
b. Number that the Trust has subjected to care record review
c. Of these deaths subjected to review, an estimate of how many deaths were judged "more likely" than not to have been due to "problems in care"

In order to make the data more meaningful and informative the Trust has exceeded the minimum requirements in terms of the deaths reported by including data on all deaths including those in community services. The report includes details on all deaths notified to the Trust. This includes deaths which have occurred in other settings including care home and acute hospitals.

The Trust has established a process for collating mortality information. This includes capture of information from electronic clinical records and the Trust's incident reporting system (Datix).

The data on the dashboard covers all deaths reported on Datix from April 1st to December 31st 2017. The dashboard provides details on the numbers of deaths recorded each quarter and year to date. Included is the numbers of Learning Disability Deaths and those reported to the national mortality review programme. Currently the Trust has not received any learning from the national review programme. Future dashboards will include this detail.

Since April 2017 the Mortality Governance Group have reviewed all deaths which have been reported in the Trust. During Q1 and Q2 the Trust was developing its approach to Learning from Deaths and published its policy at the end of September 2017. The process of review is evolving and will eventually lead to all reported deaths being screened using the Mortality Screening Tool.

The dashboard includes the number of deaths reviewed following a complaint, the number referred to CQC and number of detained service user deaths. The CQC requires providers to report all detained deaths as part of routine provider reporting. The Trust also shares the outcome of the Mortality Governance Group with CQC every month as well.

The dashboard includes information on cases known to the Coroner. This includes deaths in the community and other care settings which have been referred to the Coroner. Not all of these deaths will require an inquest but have been reported due the cause of death not being known at the time of death. The Safer Care team ensure all in-patient deaths are reported to the Coroner if required.

Screening is being undertaken on all Learning Disability deaths and case note reviews on all deaths subject to a complaint. As the policy is implemented in 2018 more cases will be subject to a case note review. A number of deaths are subject to a Serious Incident investigation and this is included within the Patient Safety reporting to Board.

Since April 2017 all deaths have been considered by the Mortality Governance Group to assess if further work is required to identify learning. This is an evolving piece of work and the Trust expects more deaths to be reviewed in detail as the process to implement the screening tool and Structured Judgement Review is implemented.

4. **Measuring avoidability**

The national guidance has identified the need for Trusts to identify deaths where there are causes for concern. There is currently no nationally agreed methodology for mental health and learning disability services to use to determine avoidability. The Royal College of Psychiatrists is currently working on developing a tool to support providers. The Trust has used the implementation of the screening tool in Learning Disability Services to test out if the Royal College of Physicians methodology which was developed for acute Trusts could be used. Clinicians are not able to match the definitions with the circumstances for the cases reviewed to date.

The reviews of deaths being undertaken do consider if there are causes for concern. Deaths that are reported as a Serious Incident will be reported on as part of the Patient Safety report presented to Board.

5. Categorisation of deaths

As part of the review of deaths at Southern Health, Mazars set out a number of categories they used to review the deaths in the Trust. Following this many trusts have adapted this approach to help determine the level of review required and provide a better understanding of the learning from the review of deaths. The Trust has adopted this approach in the policy and this is included in the dashboard. The reviews are based on case records and datix reporting. The Mortality Governance Group considers the information available to them and agreed the category for reporting on the dashboard.

Category	Definition	Application in Trust
Unexpected unnatural death (UU)	An unexpected death from unnatural causes e.g. suicide, homicide, abuse, neglect.	The majority of these deaths would be considered as suspected suicide. The circumstances of the death enable the Mortality Governance Group to categorise the death ahead of Coroner inquest.
Unexpected natural death (UN1)	from a natural cause e.g. a sudden cardiac arrest	This would be a sudden death where there was no concern about the health of the service user at the time.
Unexpected natural death – (UN2)	From a natural cause but didn't need to be e.g. alcohol dependence and where there were may have been care concerns.	This would include service users who have a physical health need that is being treated but they deteriorate. Examples include a service user with an infection being treated in another care provider.
Expected unnatural death – (EU)	Expected but not from the cause expected or timescale. e.g. some people who misuse drugs, are dependent on alcohol or with an existing disorder.	The trust has yet to identify a death that meets this category. This may be because we don't provide drug and alcohol services.
Expected natural death – (EN1)	Expected to occur in an expected time frame e.g. people with terminal illness or within palliative care services.	This would include the service users who are on an end of life care pathway at the time of death
Expected natural death – (EN2)	Was not expected to happen in the timeframe. e.g. someone with cancer or liver cirrhosis who dies earlier than expected.	This would include service users whose physical health was of concern but they were not expected to die. It is predominantly service users cared for in community settings

6. Review of deaths reported in Q3

During Q3 there were 87 deaths reported on Datix. Each one has been reviewed by the Mortality Governance Group. Of the 87 deaths 15 were service users who were identified as having a Learning Disability. All of these deaths have been reported to the Learning Disability national mortality review programme. All of these deaths have had a review

undertaken internally as set out in the Trust policy. Of the 15 deaths no concerns were identified regarding the care provided by the Trust. Of the 15 deaths 1 case was referred to safeguarding as well as the LeDeR programme. This related to the care provided in the care home where the service user was resident.

The review of deaths identified the following:

- In 60% of reported deaths the service user was male
- 62% of deaths occurred in service users who were aged over 65
- 1 of the deaths which was reported in Q3 was a service user aged under 18. The service user was a suspected suicide in the community and is being investigated as a Serious Incident.
- 90% of deaths reported occurred in community settings or other establishments such as care homes and acute hospitals.

In Q3 11 service users were reported as having died in the Trusts in-patient settings. Further review was undertaken and of the 11 deaths 2 occurred in an acute hospital following appropriate escalation and transfer from our older peoples wards.

Of the remaining 9 deaths, all occurred in our older peoples wards. 78% of the service users had an agreed end of life care plan in place at the time of death. 100% of the service users died of physical health causes. Bereavement information and support is offered to all families in these circumstances. In a number of cases the family have made positive comments about the care provided by the Trust. No concerns have been identified to indicate that any of the deaths were caused by problems with care provided by the Trust.

During Q3 the Trust received 3 complaints relating to service users who have died. 1 of these cases was investigated as a Serious Incident and is still subject to a Coroner's inquest. The complaint came from a close relative but not the next of kin. The SI investigator contacted the next of kin who confirmed they were not concerned about the care provided by the Trust but agreed we could respond to the complainant. This response has been provided and sets out the learning from the investigation. Until the inquest has been concluded it is not yet possible to confirm if the death was related to problems in care. However the investigation has not identified any such concerns.

1 of the complaints received related to care provided across primary care, acute care and the Trust. This was overseen by the commissioners and we await a copy of the final response sent to the family. This case is also subject to a Coroner's inquest. A case note review was undertaken and found evidence of some very good quality care with staff providing responsive and user-focused care. There was evidence of regular communication across the boundaries between internal and external (to the Trust) teams and in the management of risk.

The review found evidence of thorough physical health screening on admission and during the time the service user was an in-patient in the Trust.

The third case reviewed related to a service user who died in the community and was in receipt of services from the Trust, social services and community services. The case note review undertaken by a Consultant Psychiatrist identified that the care provided was good and the death was considered definitely unavoidable due to the very complex physical health needs of the service user.

Each SBU is taking forward the outcomes of each case note review.

All deaths in Q3 have been reviewed and categorised. 18% of deaths remain uncategorised due to insufficient information about the cause of death. Once this is available the data will be updated. All other deaths have been categorised and this is included in the dashboard, 80% of death categorised are considered to have a natural cause.

The Trust reported 2 deaths of detained service users to the CQC during Q3. These were both deaths in older people's services and include a service user on section 17 leave in an acute hospital bed.

7. Data limitations

National guidance indicates that it would be inappropriate to draw comparisons or use any published data for benchmarking between organisations. This is because organisations have locally determined their approach to mortality review, including the scope of deaths to be included in mortality review and reporting processes. The data is therefore not comparable across organisations. The Trust's focus will be on using mortality data internally to monitor quality of services and, in accordance with the overarching aim of the national guidance, to derive learning from the review of deaths that will ultimately serve to enable the Trust to improve the quality of the services it provides.

The position in terms of the mortality data reported in quarterly reports will continually change as further information on deaths is received by the Trust and reviews are completed. As such, the information presented is only reflective of the position at a particular point in time and will be subject to change as future presentations of the same period are made to the Board.

Until approval of the Learning from Deaths Policy for implementation from 1st October 2017, there was no approved methodology in place within the Trust to assign a grading for the extent to which deaths were judged to be due to "problems in care". As such, this information is not available to report for deaths occurring in Q1 or Q2. All deaths have been reviewed by the mortality governance group.

8. Reporting deaths to the Learning Disability national mortality review programme

The national mortality review programme (LeDeR) for deaths of patients with a learning disability has now been rolled out across all areas where the Trust provides services. The work is led locally by Local Authorities and each one is at a slightly different stage of implementation. The Mortality Governance Group reviews all deaths and ensures that they have been reported to the LeDeR programme. This is included in the dashboard. The Trust has yet to receive any learning from reviews undertaken using this methodology. All Learning Disability Deaths are subject to mortality screening as set out in the Trust policy.

9. Duty of Candour

The Trust has a Duty of Candour policy which sets out the definition, duties and responsibilities of senior staff post incident, identifying those incidents where Duty of Candour applies. For each death which is considered to be unexpected and unnatural the Duty of Candour would apply. Following the reporting of a death, the Trust write a Duty of Candour letter to the family to give them information about the internal investigation process and how they can contribute to it. Once completed, a copy of the full report is always shared with the family and the Coroner. Trust commissioners monitor compliance with the Duty of Candour principles when reviewing and quality assuring serious incident reports. The commissioners have not raised any concerns about how the Trust implements the Duty.

The Trust attempts to make contact with all families following the reporting of a death to offer condolences. This is appreciated by many families and there are many examples of positive feedback on the care provided which is included in the Datix record. The Trust has developed a bespoke bereavement booklet services can use to support families at this time. The Help is at Hand booklet is provided to families in all cases of suspected suicide.

10. Mortality Governance Group

The Trust Mortality Governance Group meets every month and reviews all the deaths reported since the last meeting. The group has a standing agenda which includes

- Review of all deaths including review of cases screened
- Update on previous cases
- Inquest review and oversight
- LeDeR update
- Dashboard update
- Complaints requiring case note review

A recent review of the Terms of Reference has identified the need to enhance the membership to include a physical health lead, wider SBU representation and public health input. This is being taken forward by the Chair of the group. The CCG are part of the group following the review. The Chair is considering how the group can provide information to the service user and carer councils in the Trust.

11. Identified learning

The Mortality Governance Group identified the need to ensure a clear link with the physical health group and strategy. The Physical Health group have been asked to identify a representative join the group.

The work of the group in 2017 has identified the need to ensure a wider representation across the Trust as well as external partners. The CCG have joined the group and public health have been asked to identify a representative.

12. Conclusion

Mortality review processes and associated data and information are in their formative stages both nationally and within the Trust. As such, it is anticipated that the Trust will continue to evolve these processes in accordance with local and national learning.

Data and information relating to deaths in scope for mortality review will continue be reported to the Trust Board on a quarterly basis. It will be possible to increase the level of analysis of data over time as it will be possible to start to identify possible trends / issues emerging from the data.

In accordance with the National Guidance, the Trust also intends to publish information within the Quality Account 2017/18 which will be published at the end of June 2018.

HPFT Learning from Deaths dashboard 2017/18

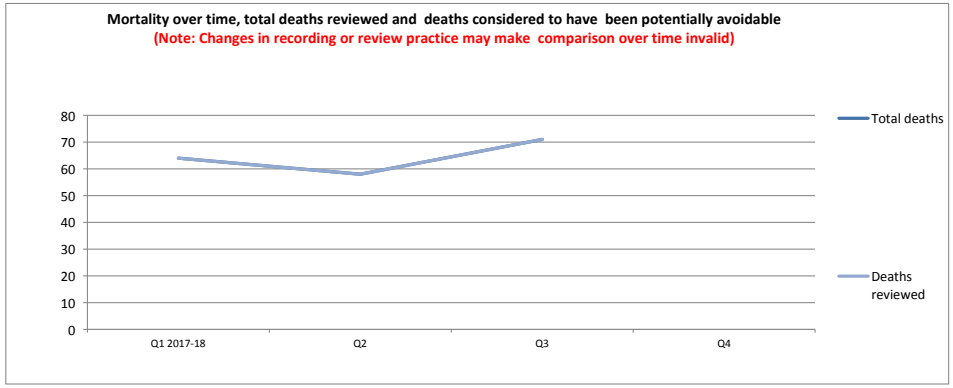
Description:
The dashboard is a tool to aid the systematic recording of deaths and learning from care provided by HPFT.

Summary of total number of deaths and total number of cases reviewed

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		In-patient Deaths reviewed	
December	Last Month	This Month	Last Month	This Quarter total	MHSOP deaths Q3
24	26	24	26	9	9
This Quarter (Q3)	Last Quarter	This Quarter (QTD)	Last Quarter	EOL plan in place	Physical health cause
72	58	72	N/A	7	9
This Year (YTD)	Last Year	This Year (YTD)	Last Year		
193	0	193	n/a		

Time Series: Start date 2017-18 Q1 End date 2017-18 Q4

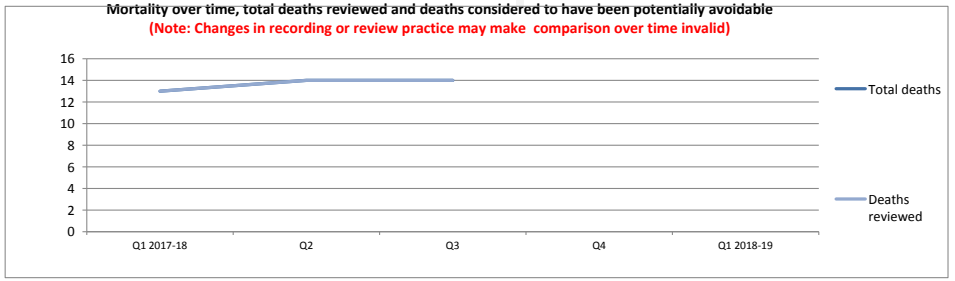


Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Number of cases with review outcome completed	
December	Last Month	This Month	Last Month	This Month	Last Month
8	3	8	3	0	0
This Quarter (Q3)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
15	14	15	14	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
41	N/A	41	N/A	0	N/A

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD MEETING

Meeting Date:	25th January 2018	**Agenda Item: 11**
Subject:	Workforce & OD Key Performance Indicators – Q3 Results	**For Publication: Yes**
Author:	Mariejke Maciejewski – Deputy Director of Workforce and OD	**Approved by: Jinjer Kandola**
Presented by:	Jinjer Kandola – Director of Workforce & Organisational Development	

Purpose of the report:

To update the Trust Board on the Q3 performance against the key workforce metrics and organisational development activity agreed in the Annual Plan.

Action required:

To note the report and recommend any additional measures required.

Summary and recommendations to the Board:

The key performance indicator for the vacancy rate has improved in Q3 from 14.30% to 13.43%. The turnover rate currently stands at 13.27% showing a slight increase this quarter from 13.14% in Q2. The sickness absence rate has increased to 4.72% from the previous quarters 4.27%, however this takes in the winter months with an expectation of an increase sickness due to the winter period. The PDP rate has decreased to 87% from Q2 when it had reached its highest point of 89% this year with significant improvements being made in the SBUs. Trajectories continue to be in place to improve the PDP rates by the end of Q4 and SBUs continue to share best practice. Mandatory training rates have fallen to 81% in quarter 3. This was predicted during the last quarter as we move to the new competency framework by the end of March 2018. A significant amount of work has been undertaken to review statutory and mandatory training including the use of more e learning packages, using 'Go To' meetings and producing a statutory and mandatory training matrix for staff. A task and finish group to achieve compliance by the end of March has been established.

Recruitment and retention remains a key focus for the Trust. An annual recruitment activity plan for the next financial year is being produced as well as undertaking activity to aid retention of staff. The Trust has continued to be involved in work on recruitment and retention on a national basis with NHS Employers and NHS Improvement during the quarter.

Delivery against the activity in the OD Strategy has continued in Q3. A significant amount of engagement activity continued in Q3 including the Big Listen, Local Listens, Senior Leaders Forums, the annual staff awards and a number of health and wellbeing initiatives. Q3 saw the continuation of the flu campaign which is encouraging all staff to have the flu vaccine. The national staff survey took place during Q3 with 46% of all staff responding to the survey. Feedback from the Q3 pulse survey saw an improvement or maintenance in the friends and family test scores, with 67% of staff recommending the Trust as a place to receive care, and 67% saying they would recommend the Trust as a place to work.

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

Summary of Financial, IT, Staffing & Legal Implications:

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 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

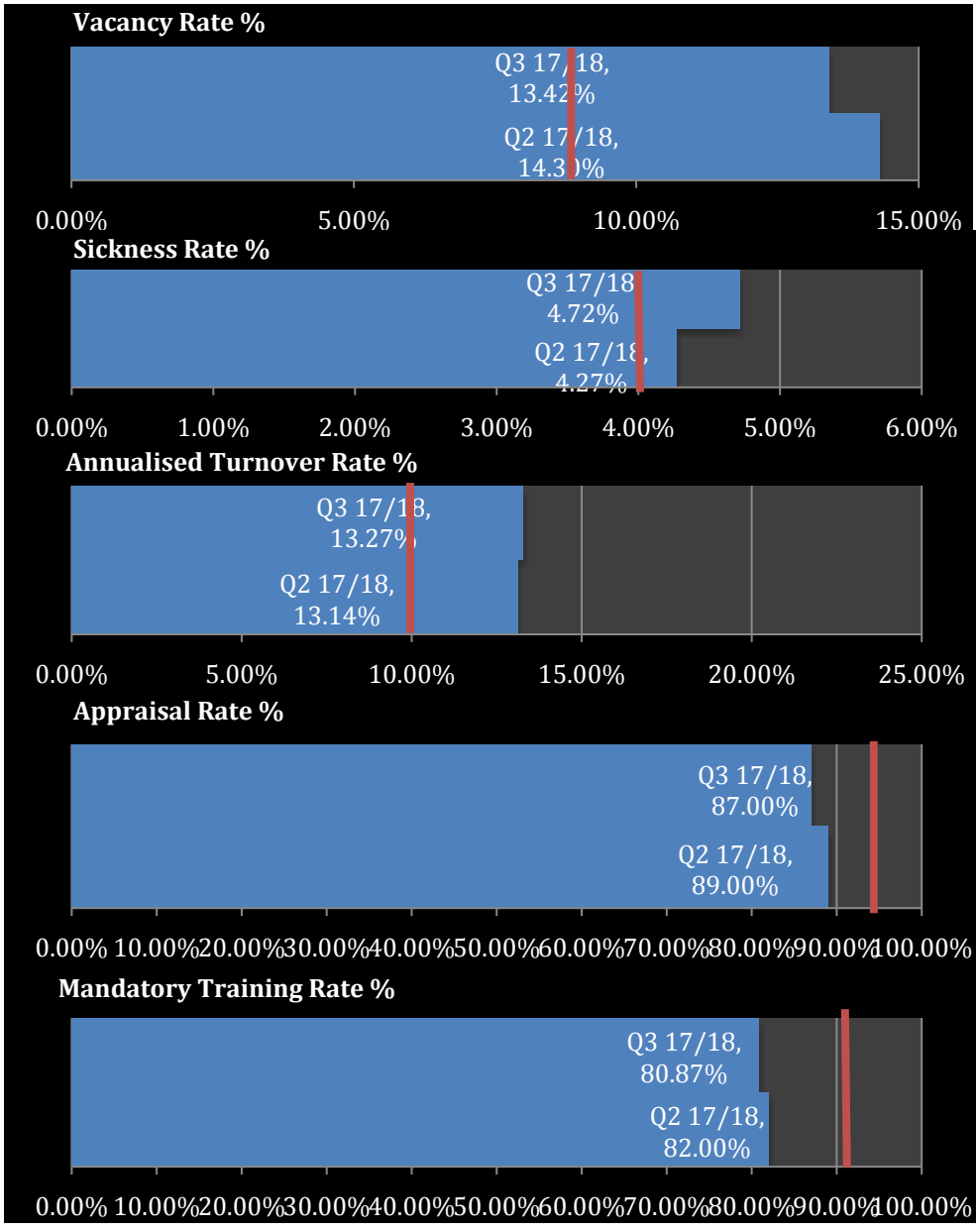
Workforce and Organisational Development Report
Quarter Three: October – December 2017

1.0 Introduction

The purpose of this report is to appraise the Trust Board on the Q3 performance of the key workforce metrics and organisational development activity as agreed 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. Detailed below is the Q3 summary position.

2.0 Executive Summary

KPI Summary Position



The key performance indicator for the vacancy rate has improved in Q3 from 14.30% to 13.43%. The turnover rate currently stands at 13.27% showing a slight increase this quarter from 13.14% in Q2. The sickness absence rate has increased to 4.72% from the previous quarters 4.27%, however this takes in the winter months with an expectation of an increase sickness due to the winter period. The PDP rate has decreased to 87% from Q2 when it had reached its highest point of 89% this year with significant improvements being made in the SBUs. Trajectories continue to be in place to improve the PDP rates by the end of Q4 and SBUs continue to share best practice. Mandatory training rates have fallen to 81% in quarter 3. This was predicted during the last quarter as we move to the new competency framework by the end of March 2018. A significant amount of work has been undertaken to review statutory and mandatory training including the use of more e-learning packages, using 'Go To' meetings and producing a statutory and mandatory training matrix for staff. A task and finish group to monitor progress against trajectory by the end of March has been established.

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3.0 Key Workforce Metrics

3.1 Establishment Data

The establishment data as at 30 December 2017 is as follows:

Funded Establishment =	**3337.30**
Staff in post =	**2889.27**
Vacant posts =	**448.03**
% Vacancy rate =	**13.42**
% Turnover rate =	**13.27**
% Stability rate =	**89.38**

3.2 Turnover Index

The turnover rate has increased slightly from 13.14 % in the last quarter to 13.27%. Work continues to be undertaken to address turnover and all SBU's have localised retention plans . The Trust has also submitted its retention improvement plan to NHS Improvement during Q3 and as a Trust we will be working through four key areas of focus with a view to reducing turnover to 11% over the next 12 months. Work is also being undertaken with STP colleagues to look at new initiatives with regards to recruitment, attraction and retention.

3.2.1 Analysing the leavers data

There were 100 leavers during Q3 compared to 130 in Q2 . This is the third quarter where nursing & midwifery staff had more leavers (23) than starters (20) starters.

Analysis of the reasons for leaving in Q3 showed that the top highest reasons given were relocation, worklife balance and retirement. This is the first quarter which has seen promotion pushed to the fourth position.This indicates that we need to focus our efforts on workforce planning, flexible working, and career and succession planning. Initiatives such as the internal recruitment process, to make it easier for staff to move internally within the Trust and streamlining the retire and return processes should support this.

Further tables and graphs showing the turnover information can be found in Appendix 1, section 3 – Turnover.

3.3 Stability Index

This data shows the number of staff with more than one year's experience at two points in time, usually a year apart. These results are compared to give a reflection of the increase or decrease in experience in the organisation. A target of 75% - 85% represents a good balance of new ideas and organistional memory. The stability index at the end of Q3 has remained fairly static at 89.38% which is outside the target but higher than recommended which continues to be positive and shows that experience is being retained in the organisation.

3.4 Key Recruitment Activity

Recruitment activity has continued during Q3. There are a total of 138.6 wte posts at offer and starting stage of which 31.4 wte are due to start during Q4.

The current time to hire is 57.5 days (11.5 weeks) which is reducing. The time to hire is measured from advert to the unconditional offer and excludes notice periods. These parameters are aligned to the Midlands and East Recruitment Streamlining Sector. The Recruitment SLA has been agreed at the recruitment and retention group with input from the MDs and has been communicated to recruiting managers. The recruitment team continues to work with recruiting managers across the Trust to support them to meet the new target in the coming months.

During Q3 representatives from the Trust have continued to participate in the NHS Employers Widening Participation Scheme with a view to improving attraction and retention which has been supported by the sharing of good practice and information across Trusts.

The Recruitment and Retention Group membership has been reviewed and changed since November to include HR business partners, service line leads, professional leads, and heads of nursing. The change in membership for the group has come about as it was felt that the focus of the group is to reach the operational managers and be able to inform discussions regarding recruitment and retention in a more pragmatic way.

Each SBU has reviewed their local recruitment and retention plan for their areas. The local SBU recruitment and retention plans include succession planning, putting in place career pathways in order to encourage retention, and reviewing current job descriptions in order to create some new ways of working.

Social media advertising continues to form part of our strategy and more work is being undertaken in this area so we are maximising the potential to attract candidates.

Recruitment and retention payments continue to be in place in hard to recruit areas with a review to be undertaken to evaluate their success and whether they should continue moving forward.

The Trust attended Bucks University in November which generated 48 expressions of interest to work at HPFT. All the potential candidates have been followed up via email in order to support and encourage them to apply and gain employment within the Trust. The annual recruitment activity plan has been reviewed adding forth coming events and recruitment days to the end of 2018.

The Trust held a student event in December with thirty seven students in attendance. All students have been asked to submit their preference for the areas that they wish to work . Four students from the February 2015 cohort are about to commence employment with the Trust with another eight students in the pipeline.

The Trust welcomed it's first overseas candidate from the Phillippines in November 2017 who will be undertaking the OSCE test in February 2018. One other candidate is awaiting a decision to proceed with their application from the NMC.The number of applicants remaining in the overseas process is 6 from the original 50 offers made.

The Trusts recruitment processes received partial assurance from auditors in September and recommendations from the audit report are being put in place to ensure that the Trust's recruitment process is adhered to by all involved.

3.5 Junior Doctor Recruitment

Health Education East of England has not been successful with the recruitment of junior doctors into Psychiatry over the past few years. This is now having an impact on the available medical workforce to deliver efficient patient care across services. As a result it was anticipated that there would be between 21 and 26 vacancies in the February 2018 intake. Substantial efforts have been made which has resulted in only 5 vacancies remaining with further interviews scheduled for mid-January, with a predicted overall vacancy rate of 3 posts. The task and finish group established to steer the action plans identified to mitigate and manage potential risks to patient care

as a result to the reduction in junior doctor numbers continues and reports through Workforce Board, WODG and TMG to give assurance to the board on the steps being taken to minimise risks to patient service delivery.

The East of England Deanery are interviewing for the August 2018 rotation, between 29th January and 2nd February. Offers will be made to Junior Doctors during March 2018, and at this point the Trust will be in a better position to understand the exact number of vacancies for the August intake. In the interim the task and finish group will continue to meet and plan ahead to highlight and mitigate risk and continue to give assurance to the Board, on plans as it looks likely that there is potential to have approximately 20 vacancies at higher trainee level.

3.6 Number of starters

There was a total of 104 new starters and 100 leavers in this quarter which resulted in a net gain of 4 staff.

The breakdown of new starters by staff group is shown in **appendix 1, section 3, Graph 5 – starters and leavers by staff group.**

3.7 Vacancy Trend

The number of vacancies has reduced from 466.85 wte in Q2 to 448.03 wte in Q3 and the vacancy rate has decreased from 14.30% in Q2 to 13.42% in Q3. This is despite the fact that 43 wte additional posts have been added to the establishment this quarter which makes a total increase in establishment of 125.06 wte in this financial year. The increase this quarter is mainly due to the successful bid of Tier 4 CAMHS services. The vacancy rate would have been 9.7% if there were no additional posts added to the establishment during the financial year.

Whilst the vacancy rate is 13.42% it should be noted that 78.5% of our staff deployed are substantive, 17% are bank workers who work for us on a regular basis directly engaged on HPFT's bank. Only 4.3% of our workforce are agency staff.

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

3.8 Temporary Staffing

During Q3 bank and agency fill rates increased slightly to 92.13 %. The bank and agency fill rate is reported as follows; Nursing 91.61%, Admin 94.99%, Social workers 95.05 % and OT/AHP 90.64%.

There was a decrease of 2014 shifts requested to be filled in Q3 in comparison to Q2. 71% of temporary staffing shifts requested are filled by bank staff and 21% of the shifts are filled by agency staff.

The % FTE of the workforce covered by bank in Q3 was 16.99% and 4.30% for agency.

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

3.9 Sickness Absence

The sickness absence rate for the Trust has increased from 4.27% in Q2 to 4.72% in Q3. There has been an increase in the sickness absence rates for all SBUs with the exception of Corporate. Sickness boards have been established so that there continues to be a focus on reducing the number of long term sickness absence cases and managing short term sickness absence cases for staff who have high bradford scores. Corporate continues to remain below the Trust target of 4% with a sickness absence rate of 2.77%. East and North SBU sickness absence rate increased to 4.9 % in Q3 but a number of long term sickness absence cases are now coming to conclusion. In LD&F the sickness absence rate for Q3 has increased to 5.06% with some outlying areas including Broadlands Clinic, NE Community Services East LD team, and Lexden AT&T inpatient unit. The West SBU has a sickness absence rate of 4.92% and is focusing on the resolution of long term cases and the 'top 20' short term cases.

The top reasons given for absence in the Trust are as follows:

1. Cold, Cough, Flu
2. Other known causes – not classified elsewhere
3. Gastrointestinal problems
4. Unknown causes
5. Anxiety/stress/depression/other psychiatric illnesses

The estimated costs to the Trust of sickness absence for Q3 has been calculated in excess of £1 million which is an increase of £132k in comparison to Q2. A breakdown of the sickness absence costs by SBU can be found **in appendix 1, section 4.**

There are currently 72 short term sickness absence cases and 54 long term sickness absence cases being formally managed through the employee relations team as at the end of December 2017. The number of short term sickness absence cases that are being formally managed has remained constant since the last quarter. The number of long term sickness cases being managed has reduced by nine cases at the end of Q3. The HR Business Partners have been tasked with how we support those areas with high sickness absence rates through either additional support from occupational health or the use of health and wellbeing initiatives.

3.10 PDP Rates

The PDP rates have reduced since Q2 from 89 % to 87 %. The PDP rates for each SBU are as follows:

SBU	Q4%	Q1%	Q2	Q3
LD&F	93%	90%	94%	94 %
East and North	85%	86%	92%	91 %
West	93%	86%	89%	86 %
Corporate	90%	79%	72%	65 %
Trust	**90%**	**86%**	**89%**	**87 %**

At the end of December the East and North SBU PDPs were at 91% a slight drop from the previous quarter. A concentrated effort was made with a target of 95% set by the end of September by the MD. In order to keep this compliance rate up a focus at team performance meetings and core management meetings will continue with encouragement for all to get dates booked in to keep momentum sustained.

The West SBU PDP rate dropped at the end of Q3 to 86%, which was disappointing after the rate had increased to 92% in November. The main concerns at the end of Q3 were the rates in Community Services (78%) and the Wellbeing Service (81%). The SBU's Managing Director has written to managers in those Service Lines to request that all outstanding PDPs are completed by the end of January 2018.

The LD&F SBU PDP rate has continued at 94% and above during Q3. At the end of Q3 all of the Service Lines, with the exception of Mental Health Rehabilitation Services (87%), were at 90% or above, with Hertfordshire Forensics (98%) and Essex IAPTs (96%), above the Trust target of 95%. Hertfordshire Forensics continue their strong record, with monthly rates above 95% since March. Remedial plans, with oversight via team reviews, are in place for the other Service Lines to achieve an increase in their rates in Quarter 4.

Corporate – there will be increased focus in the Corporate areas as the PDP rates are significantly lower than both the clinical SBUs and the Trust target.

3.8 Mandatory Training Rates

The Core Skills Statutory and Mandatory training rates in Quarter 3 has ended as follows:

Statutory and Mandatory Training = 81%
Essential Training = 85%

This is below the Trust target of 92%. Statutory and mandatory training has seen a decrease of 1% in the last Quarter. It should be noted that the compliance rates currently being reported are based on the old statutory and mandatory training compliance. The Trust is currently in a transition period of transferring all staff onto new training competencies to align with the core skills training framework. As staff become compliant in the new statutory and mandatory training levels the old competency levels will decrease.

Quarter 3 Compliance by SBU based on the old competencies:

	31-Oct-17		30-Nov-17		31-Dec-17	
Business Streams	**Mandatory**	**Essential**	**Mandatory**	**Essential**	**Mandatory**	**Essential**
Corporate Services	83%	83%	83%	84%	81%	83%
SBU Learning Disability & Forensic	82%	89%	83%	89%	83%	89%
SBU MH East & North Herts	82%	83%	82%	84%	82%	83%
SBU MH West Herts	79%	84%	79%	84%	78%	83%
Overall	81%	85%	81%	86%	81%	85%

The table below shows the statutory and mandatory training compliance rates for each training competency based on both the old and new competencies. It should be noted that we do not have staff practicing without training but there is currently a period of transition whilst we move onto the new competencies.

Training Course	Old Competencies % Compliance	New Competencies % Compliance
Infection Prevention and Control - Level 1	68%	47%
Infection Prevention and Control - Level 2		49%
Safeguarding Adults - Level 1	75%	48%
Safeguarding Adults - Level 2		27%
Safeguarding Children - Level 1	76%	50%
Safeguarding Children - Level 2		29%
Safeguarding Children - Level 3		19%
Preventing Radicalisation - Levels 3, 4 & 5 (Prevent Awareness)		38%
BLS	79%	68%
ILS	86%	71%
PBLS	88%	88%
Equality, Diversity and Human Rights	94%	94%
Fire Safety 1 Year	72%	72%
Fire Safety 2 Year	83%	83%
Health and Safety	91%	92%
Information Governance	83%	84%
Moving and Handling Level 1	81%	81%
Moving and Handling Level 2	72%	72%
Grand Total	**81%**	**61%**

A significant amount of work has been undertaken with regards to improving the statutory and mandatory training rates so that we are aligned to the core skills training framework. Recovery plans in safeguarding, WRAP, moving and handling, resuscitation, and infection prevention and control are being closely monitored and trajectories to achieve compliance against the new competencies, by the end of March 2018, are in place. A review of statutory and mandatory training has resulted in the following changes:

- E learning packages being purchased for safeguarding and WRAP training
- A review of face to face training for safeguarding
- Trialling the use of 'Go to Meetings' for face to face training,
- A review of the level of competencies that staff need to have for moving and handling
- Producing a detailed statutory and mandatory training matrix so that all staff are aware of what training they need to complete and at what level for their job role.

A weekly statutory and mandatory task and finish group has been established with a target to reach 92% compliance in statutory and mandatory training by the end of March 2018. Progress against the targets and trajectories is being closely monitored

and where progress is not being achieved or behind trajectory the subject matter experts and the learning and development team are being asked to take the appropriate action.
Planning and commissioning for training for the financial year 2018 – 2019 has continued in Quarter 3 in readiness to finalise in Quarter 4.

In a response to feedback from staff regarding the current learning management system procurement processes are also in progress to purchase a new Learning Management System. The new system will automate a lot of the manual process that are currently in place and will be more user friendly for staff to use and access. The current timeline for this procurement is as follows:

Procurement Activity	Date
Bids to be received	2nd January 2018
Individual Scoring Process	2nd – 10th January 2018
Evaluation Panel	11th January 2018
Presentations from shortlisted bidders	24th January 2018
Implementation	Early in the New Financial Year

4.0 Organisational Development Activity

The OD team works closely with the Workforce Team to deliver the Workforce & OD Strategy. The high level deliverables in the Organisational Development activity plan are outlined below with associated activity detailed for Q3.

4.1 Developing a Culture of Innovation and Continuous Improvement

The Continuous Improvement Workforce Development proposal has been endorsed by the Executive Team. The proposal will be taken to the Finance and Investment Committee in January to secure the required investment so that the tender process can commence.

4.2 Delivering Effective Leadership Capacity and Capability

The Senior Leaders Forum this quarter focused on the embargoed staff survey results, and the annual plan as well as a session on the well led review.

Leadership Development activity this quarter has included the following:

- Senior Leaders Forum
- One active cohort of Managing Service Excellence with 18 participants
- One active cohort (two completed cohorts) of the Mary Seacole Local Programme, which is a joint initiative with the NHS Leadership Academy and STP colleagues, with 7 HPFT employees participating
- Development and rollout of a 4 day Senior Leadership Programme for CAHMS Senior Leadership Team
- MBTI Sessions for LD&F Senior Leadership Team
- The continuation of cohort 9 of the Leadership Academy, 15 Emerging Leaders and 10 Leaders
- A programme of masterclasses for Senior Leaders has been developed
- Team leaders away days have also taken place

As part of the collective leadership work a coaching for leader's development programme, which will support a change in culture around appreciative enquiry, empowerment, and supporting the workforce has been approved and a tender process will take place during Q4 to secure a provider who will design, develop and evaluate a coaching programme for our tier 2 and tier 3 leaders.

4.3 Maintaining and Growing Staff Engagement

The Annual Staff Awards and Development Awards took place during Q3. There were over 250 nominations for the staff awards. The awards were held at Tewinbury Farm to enable more staff to attend. The day acknowledged all the hard work that takes place throughout the Trust by our staff and was a reminder of all the inspirational work that our staff do on a daily basis to deliver excellent, high quality care to service users.

Two Inspire Award presentations have taken place with 35 nominations in total and 11 winners.

The national annual staff survey was conducted in Quarter 3. It was the first time we did a full census and 1396 staff responded out of 3020 eligible staff - 46.9%. The final results will be issued in mid-February and the final outcomes will be published at the beginning of March.

During the quarter a communications plan was delivered, including a staff stories campaign aimed at highlighting many of the opportunities and benefits provided by the Trust including health and wellbeing, career development and innovation support. Part of the Health and Wellbeing CQUIN this year will be measured by the outcome of the staff survey.

The new pulse survey was utilised for the third quarter. Quarter Three saw a decline in the number of respondents however this may be due to the pulse survey opening the day after the National NHS Staff Survey closed. There was an improvement in the staff friends and family questions. This quarter 67% of staff said they would recommend the Trust as a place to work compared to 62% last quarter. 67% of staff recommended the Trust as a place to receive care which was the same as last quarter and staff saying they are mindful about living the Trust Values always or often, remained the same at 92%.

The new pulse survey questions are divided into five sections which align with the elements in the OD Strategy (Culture, Customer Experience, Staff Experience and Capability, Leadership and Organisational Effectiveness & Design).

The findings from the survey, both qualitative and quantitative suggest that staff have high levels of confidence in their skills and abilities. This is reflected in that 94% of respondents said they had the skills and knowledge to do their job effectively an increase of 4% on quarter two.

There continues to be a positive improvement in staff who believe the Trust takes positive action on their wellbeing with results increasing by 4% to 81% for quarter three. Additionally 88% of staff said that they did not experience bullying and harassment at work, a positive improvement of 11% on quarter two and 92% did not experience violence which is another positive increase of 4% on the previous quarter.

One of the largest thematic areas of concern last quarter was workload management but there have been some improvements this quarter. 28% of staff said they did not work additional unpaid hours, an increase of 4% and 56% felt their workload was manageable compared to 46% in Quarter Two. There was a decrease of 2% in staff who said that Trust processes help them to be effective (Q2 34%) and an increase of 7% to 57% of staff who say they are able to make improvements easily at work.

In the qualitative responses staff reflected that improved IT and data systems and more access to developmental training and CPD would enable staff to progress and be more effective.

Some of the staff who had experienced Bullying and Harassment felt that the Trust had not supported them and were not effective in tackling it with the team or individual. The Workforce and OD team will work in partnership with staffside to address some of the feedback received. The OD activity plan is being reviewed to ensure these areas are addressed.

4.4 Improving Staff Health and Wellbeing

Health and Wellbeing activities have continued throughout the quarter. Since the beginning of the year, 54% of the workforce have engaged with a Health Hub activity.

The table below shows the Health Hub Activities that have taken place during Q3:

Health Hub Activity	Number of Staff who Participated
Swim the Channel Challenge	43
10 minute workplace massages	240
Registered Users on Health Manager	390
Active users of Health Manager to support personal wellbeing	237
4 Schwartz Rounds	60
Mindfulness Course held in Lexden	
Working Together as One Magazine produced and distributed	Sent to all staff
70 flu clinics held	Vaccinated 51.5% of frontline staff
Attendance at Corporate Induction to advise new starters on wellbeing and benefits	
Development of Staff Health and Wellbeing booklet	

The health and wellbeing plan for 2018 has been received by the WODG and activities approved. It was agreed that activities will be targeted to departments using both soft and hard metrics.

5.0 Learning, Education and Development

5.1 Provision of Education and Delivery of the Learning and Development Agreements

5.1.1 Apprenticeship Levy

In May 2017 the Trust signed up to the Apprenticeship Levy and from this point the levy money will be taken from the Trust which will be drawn down through training our learners on an Apprenticeship Standard with an approved provider. We currently have 24 apprentices in the system and new Apprenticeship Standard for Adult Care Worker will start another cohort during Q4. Procurement has been completed for the Medical Administration Apprenticeship and staff working in this area have been contacted and advised that they can complete this programme. To increase the number of apprenticeships moving forward we are proposing that the majority of Band 2 Health Care Assistants are employed on an apprenticeship as well as exploring which posts in the organisation would benefit from the offer of a higher degree apprenticeship programme.

5.2.1 Access to learning

During Q3 there has been a total of 3484 attendances on a range of classroom based training sessions. A further 1061 e-learning packages have been completed by staff and a total of 216 classes were commissioned. The Learning and Development Service are currently piloting a new process to reduce the number of Did Not Attends (DNAs). The reporting of DNA's has highlighted a number of issues that the learning and development team are trying to resolve so that we get a more accurate position and can put the appropriate processes in place to reduce DNA's.

5.2.2 Streamlining Project

From the 1 April 2017 HPFT have aligned to the core skills statutory and mandatory streamlining project (CSTF). All learning outcomes, objectives, assessments and lesson plans have been configured with the East of England streamlining project. Therefore HPFT are delivering the correct learning content to the correct target audiences. A review of the recovery plans during Q3 found that they were not delivering the outcomes expected within the required timescales. As a result a further review has taken place which is outlined in section 3.8 above.

Following feedback from staff work is also underway to procure a new learning management system which will improve the efficiency and effectiveness in the way that the Trust delivers training. Tenders have been received from three companies and the shortlisting process is underway with a view to selecting a preferred supplier by the end of January 2018 with a view to implementing the new system due Q1 of 2018/19.

5.2.3 LQAF

The library quality assurance framework (LQAF) was submitted to Health Education England during Q3. The Trust is awaiting the outcome of the assessment which will become available during Q4.

6.0 Recommendation

The Board is asked to note the Q3 position and the level of activity that is being undertaken to support delivery of the Workforce and Organisational Development metrics as well as the actions being identified to improve the position moving forward.

Mariejke Maciejewski
Deputy Director of Workforce and OD
January 2018

Dec 2017 - Based on Q3 2017/2018

HPFT Workforce Information Report Summary

WORKFORCE INFORMATION REPORT SUMMARY

Workforce Report Dec 2017 (Based on data for Q3 (2017/2018)

Section 1: KPI summary position

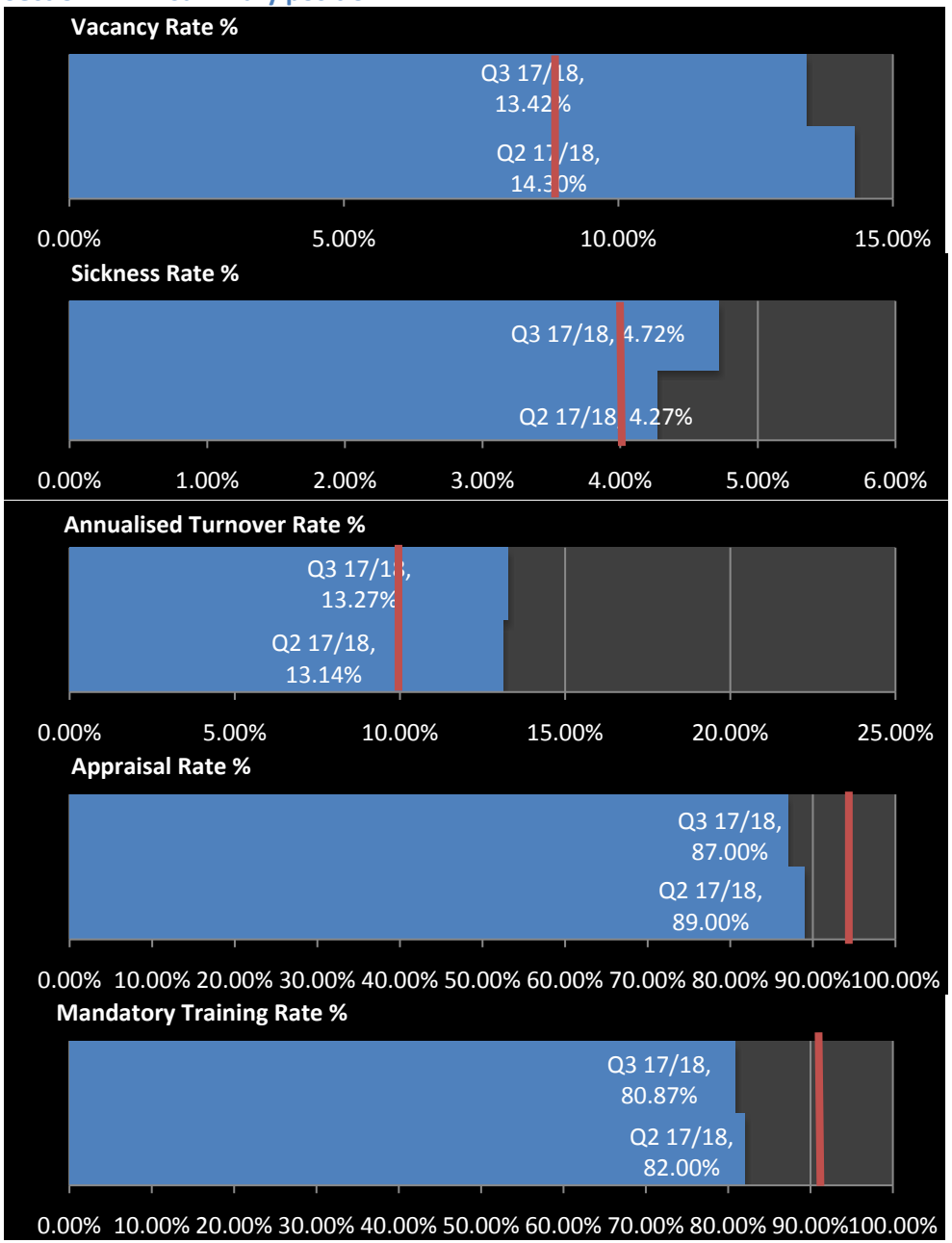
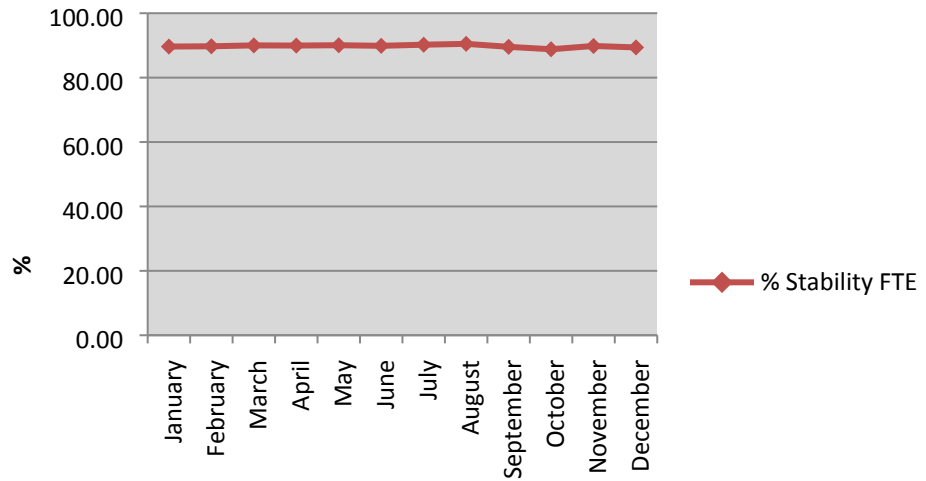


Table 1: Establishment Data

Funded Establishment =	3337.30
Staff in post =	2889.27
Vacant posts =	448.03
% Vacancy rate =	13.42
% Turnover rate =	13.27
% Stability rate =	89.38

Graph 1 : % Stability



WORKFORCE INFORMATION REPORT SUMMARY

Section 2: Recruitment

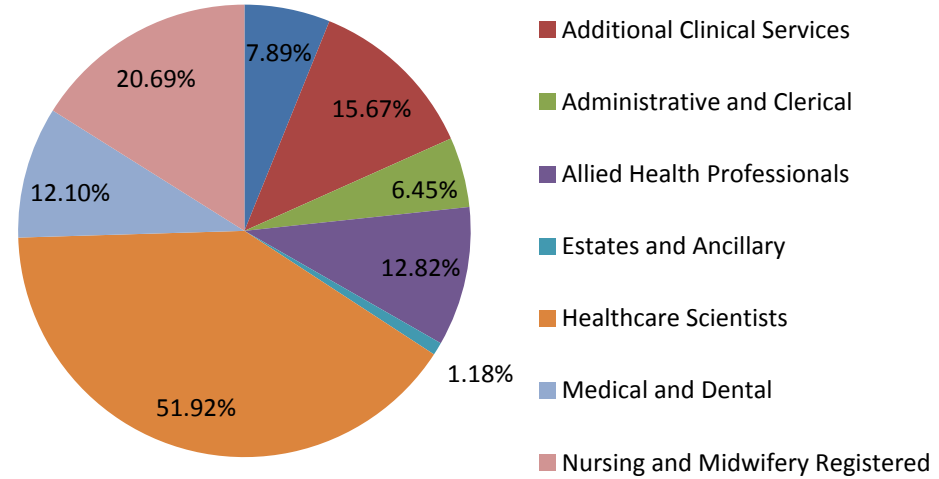
Table 2: Recruitment Summary by SBU

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Authorisation	6	3	18.5	10.55	38.05

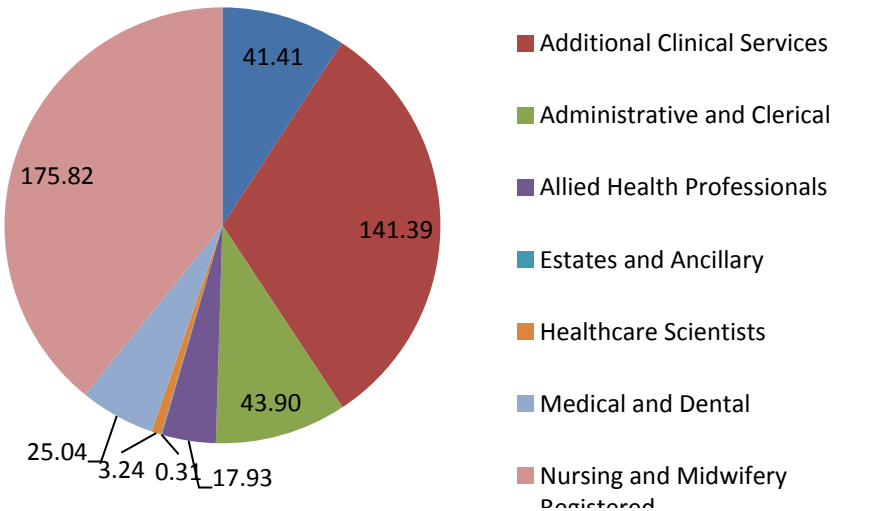
Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Longlisting	3	21.6	23.16	10.75	58.51
Shortlisting	1.6	6.4	14	9	31
Interview	2	15.8	20.5	13	51.3

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Offer	8.8	47.8	47	35	138.6
Starting	1	7	10	13.4	31.4

Graph 2: Vacancies (%) by Staff Group



Graph 3: Vacancies (fte) by Staff Group



WORKFORCE INFORMATION REPORT SUMMARY

Section 3: Turnover

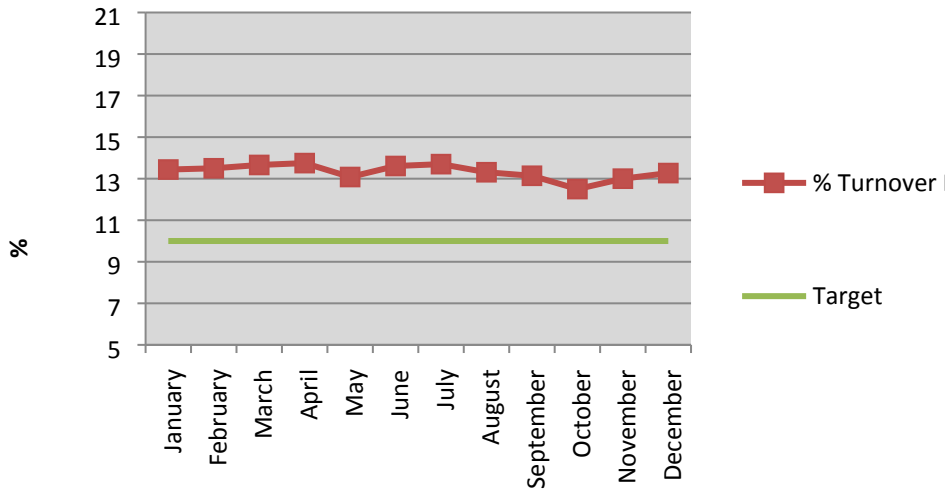
Table 3: Q3 2017-2018 Leavers by Leaving Reason

Leaving Reason	Total
Voluntary Resignation - Relocation	18
Voluntary Resignation - Work Life Balance	15
Retirement Age	13
Voluntary Resignation - Other/Not Known	9
Voluntary Resignation - Promotion	9
Voluntary Resignation - Better Reward Package	5
Dismissal - Capability	5
Voluntary Resignation - Lack of Opportunities	4
End of Fixed Term Contract	4
Voluntary Early Retirement - no Actuarial Reduction	4
Redundancy - Compulsory	3
Voluntary Resignation - Child Dependants	2
Voluntary Resignation - To undertake further education or training	2
End of Fixed Term Contract - External Rotation	1
Retirement - Ill Health	1
Voluntary Early Retirement - with Actuarial Reduction	1
End of Fixed Term Contract - Other	1
Voluntary Resignation - Incompatible Working Relationships	1
Voluntary Resignation - Health	1
Voluntary Resignation - Adult Dependants	1
Grand Total	**100**

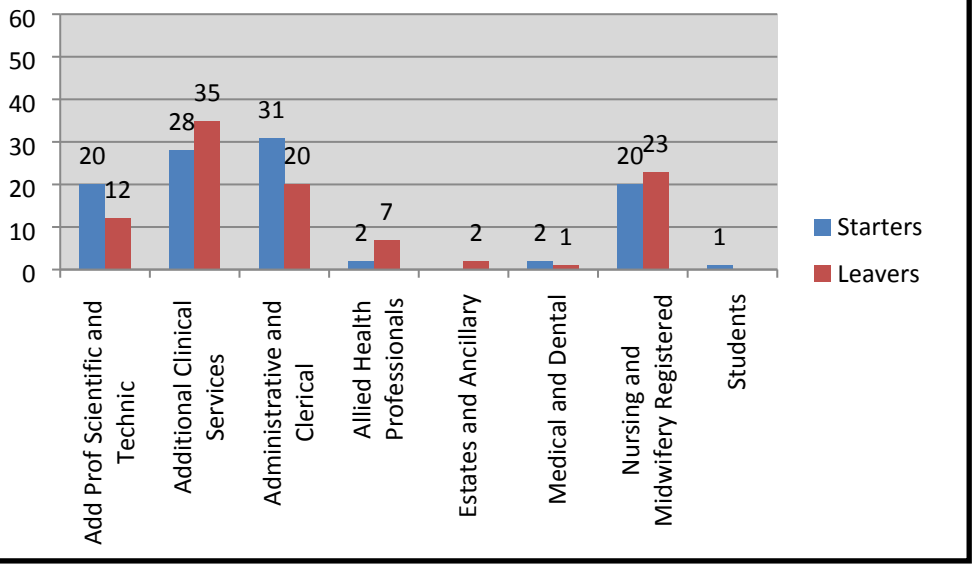
Table 4: Retirement Profile

	Age		
Retirement profile	**55-59**	**60-64**	**65+**
367 Corporate	46	22	14
367 SBU Learning Disability & Forensic	117	40	16
367 SBU MH East & North Herts	113	80	35
367 SBU MH West Herts	95	73	21
Grand Total	**371**	**215**	**86**

Graph 4 : % Turnover



Graph 5: Starters & Leavers by Staff Group Q3



Section 4: Sickness Absence

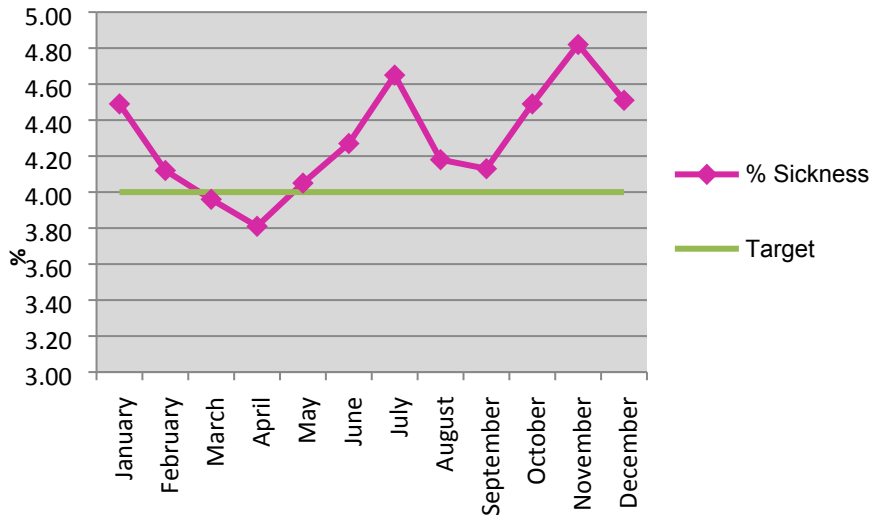
Table 5: Q3 2017-2018 Top 10 Reasons for Sickness Absence

Sickness Absence Reason	No Of Episodes
S13 Cold, Cough, Flu - Influenza	430
S98 Other known causes - not elsewhere classified	184
S25 Gastrointestinal problems	182
S99 Unknown causes / Not specified	162
S10 Anxiety/stress/depression/other psychiatric illnesses	115
S16 Headache / migraine	80
S11 Back Problems	70
S12 Other musculoskeletal problems	67
S15 Chest & respiratory problems	54
S28 Injury, fracture	44

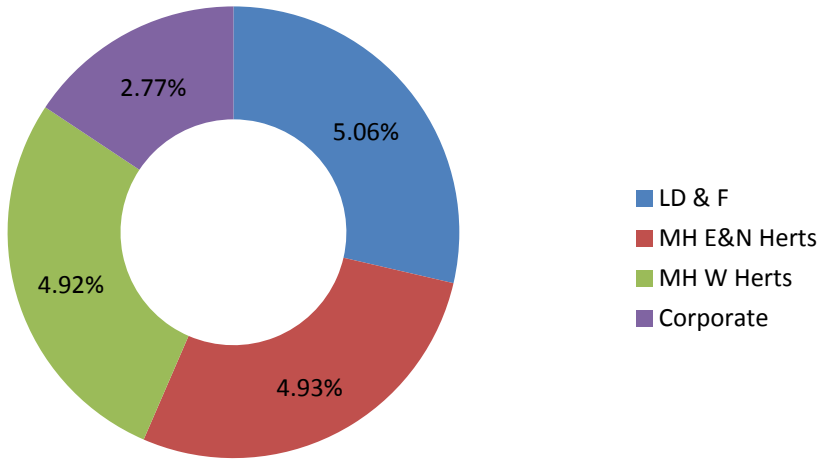
Table 6: Sickness Cost

SBU	Estimated Cost of sickness Q3
Corporate	£80,339
LD & F	£326,368
MH E&N Herts	£299,540
MH W Herts	£305,943
Trust	**£1,012,191**

Graph 6: % Sickness Absence by Month



Graph 7: Q3 % Sickness Absence by SBU



WORKFORCE INFORMATION REPORT SUMMARY

Section 5: Temporary Staffing

Table 7: Q3 2017-2018 Bank, Agency & Substantive Spend

2017- 2018				
Total spend	**Q3**		**YTD**	
	£	**%**	**£**	**%**
Agency	2,040,432	5.56%	6,257,980	5.74%
Bank	3,966,432	10.80%	11,762,795	10.78%
Substantive	30,717,877	83.64%	91,056,265	83.48%
Total	**36,724,741**		**109,077,040**	

Graph 8: Bank & Agency Spend

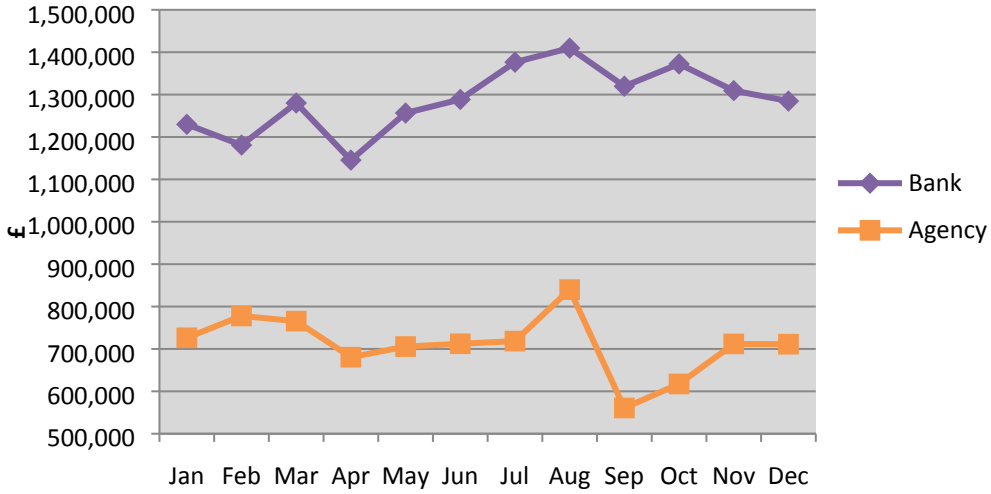
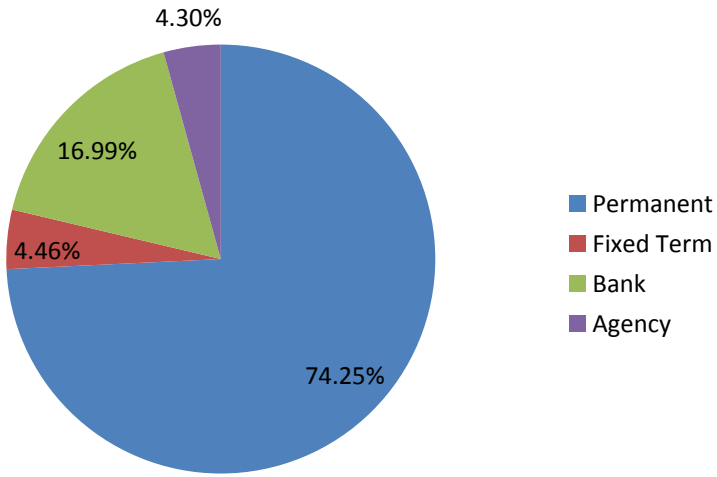


Table 8: Q3 2017-2018 Bank and Agency Usage

Staff	Number of Shifts requested minus the cancellations	Number of Bank Shifts Filled	Bank Fill Rate	Number of Agency Shifts Filled	Agency Fill Rate	Total Fill Rate
Nursing Qualified and Unqualified	24,373	17,377	71.30%	4,951	20.31%	**91.61%**
Admin	4,331	3,726	86.03%	388	8.96%	**94.99%**
Social Workers	788	465	59.01%	284	36.04%	**95.05%**
OT/AHP	1,293	913	70.61%	259	20.03%	**90.64%**
Total	**30,785**	**22,481**	**73.03%**	**5,882**	**19.11%**	**92.13%**

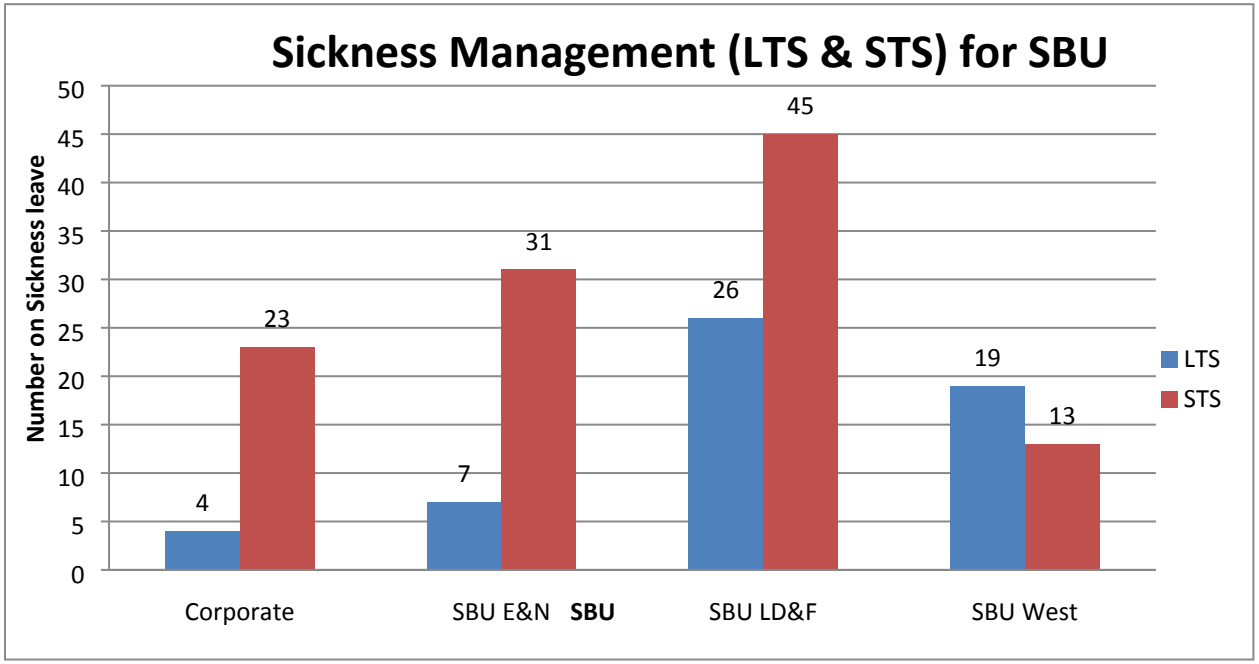
Graph 9: % FTE of Workforce by Assignment Category



Section 6: Employee Relations & Sickness Management

Table 9: Total Number of Live Employee Relations Cases in Progress by Staff Group

Live ER Cases	Add Prof Scientific and Technic	Additional Clinical Services	Admin and Clerical	Allied Health Professionals	Medical and Dental	Nursing and Midwifery Registered	Total
Number of Disciplinary Cases	2	9	3			7	**21**
Number of Grievances							**0**
Number of Capability cases	1						**1**
Number of Bullying & Harassment cases	1	1	1				**3**
Number of Whistleblowing cases							**0**
Total number of cases in progress	**4**	**10**	**4**	**0**	**0**	**7**	**25**
Number of Mediation sessions							**0**
Number of suspensions/restricted duties	2	2	1			3	**8**
Number of appeals			1			3	**4**



Section 7: Staff Development

Table 10: Appraisal Compliance

SBU	Number of completed appraisals	Number of Staff	PDP Rate %
367 Corporate	209	300	**65%**
367 SBU Learning Disability & Forensic	734	768	**94%**
367 SBU MH East & North Herts	687	742	**91%**
367 SBU MH West Herts	726	793	**86%**
Grand Total	**2356**	**2603**	**87%**

Graph 10: % PDP Compliance

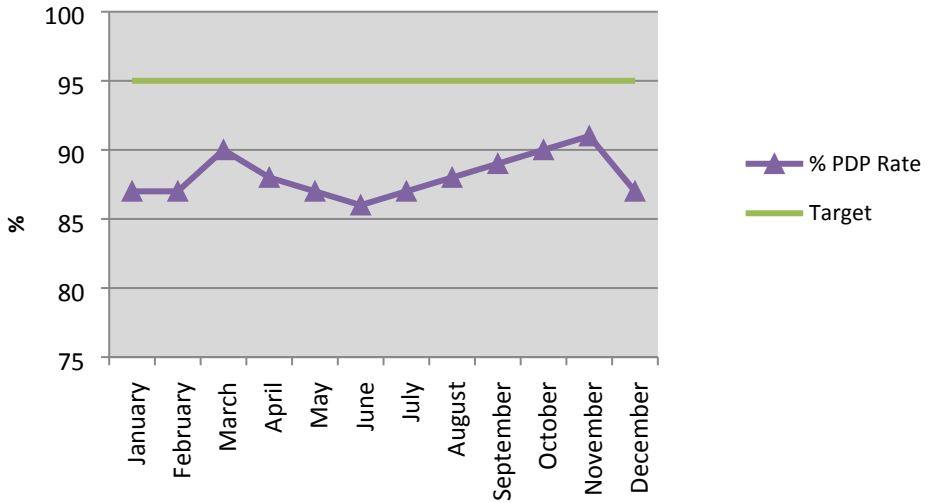
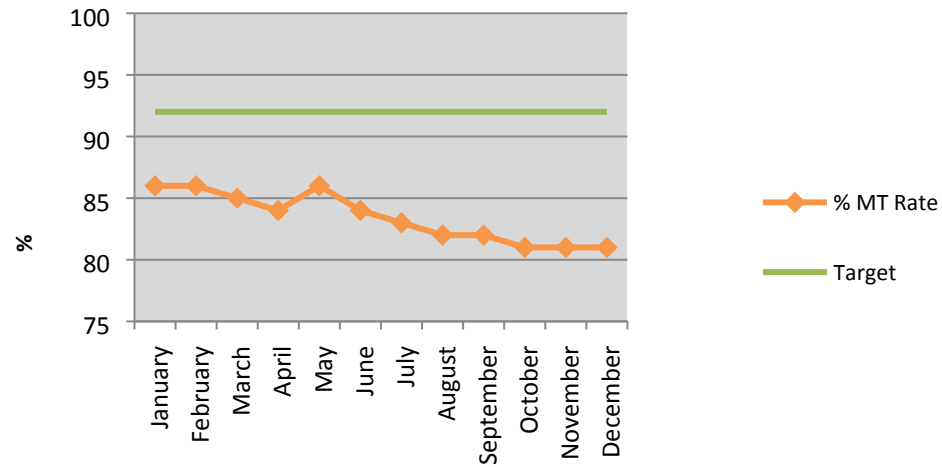


Table 11: Mandatory Training Compliance

SBU	Does not meet requirement	Due to expire	Meets Requirement	% Compliance
367 Corporate	326	69	1283	**81%**
367 SBU Learning Disability & Forensic	1148	320	5309	**83%**
367 SBU MH East & North Herts	1181	360	5008	**82%**
367 SBU MH West Herts	1612	407	5287	**78%**
Grand Total	**4267**	**1156**	**16887**	**81%**

Graph 11: % Mandatory Training Compliance



Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	25.01.18	**Agenda Item: 12**
Subject:	Finance Report for the period to 31st December 2017	**For Publication:** No
Author:	Sam Garrett, Head of Financial Planning & Reporting	**Approved by:** Paul Ronald, Deputy Director of Finance and Performance Improvement
Presented by:	Keith Loveman, Director of Finance	

Purpose of the report:

To inform the Board of the current financial position the key highlights and risks and the forecast of the likely financial position for the full year.

Action required:

To review the financial position set out in this report, consider whether any additional action is necessary, or any further information or clarification is required.

Summary and recommendations to the Board:

The overall Trust position reported in December is a surplus of £80k, which is better than the Plan of £14k by £66k (before STF). The overall Trust position year to date (before STF) is a surplus of £1.145m, which is ahead of the Plan of £563k by £581k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating, the UOR, reports as a 1, the highest rating. Key figures are summarised below:

UOR	1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000
Surplus (Deficit) excluding STF		14	80	563	1,145
Total Pay (including Agency)		12,516	12,283	112,458	109,592
Agency		710*	750	6,394*	6,615
Secondary Commissioning		2,165	2,685**	19,216	20,948**

*NHSI Ceiling (breaching HPFT recovery plan by £234k year to date)
** Secondary Commissioning spend is higher this month due to CAMHs Tier 4 NCM (see below)

There are four main variances within this position:

1. Pay overall is better than Plan by £233k in the month (1.9%), and £2.9m year to date (2.5%). Substantive pay decreased by c. £130k, however month 8 was particularly high and the upward trend remains. Both Bank and Agency pay also decreased, by £24k and £8k respectively. Agency despite reducing in September and October remains

adverse to the NHSI Plan and to the Recovery Plan, both in the month and year to date. Further details on pay are provided in Section 3 and Appendix 2a.

2. Income is better than Plan by £400k, increasing by £29k overall, however there was £360k of new income for CAMHs Tier 4 NCM (New Care Models) which went live on 4th December. Taking out the effect of this new income, income actually reduced in the month by £330k, however like Pay month 8 was particularly high, and there were no particularly large reductions, just a combination of small ones. This position assumes 100% CQUIN for all contracts except Hertfordshire at 90%; for Hertfordshire this figure presents some risk, but there is a recovery plan in place, and to date projections do reach 90%. Further details on income are provided in Section 7.

3. Secondary commissioning adverse to Plan by £520k, an increase of £274k from November, however as with income this includes new expenditure for CAMHs Tier 4 NCM, this was £326k, taking out this effect spend decreased by £52k. Observation costs in December were c. £63k; Rehab placements and Acute/PICU placements were stable; Older Peoples placements decreased having been high in November; and social care increased by c. £60k. Further details are provided in Section 4.

4. Other Direct Costs, Overheads and Financing were adverse to Plan by c. £47k, and decreased in the month by c. £210k, comprising a number of variances. The biggest movement in the month was Miscellaneous Other Operating Expenses, decreased by £184k, across a number of areas.

This position remains a favourable one, albeit with several risks, which will be monitored carefully in the final quarter of the year:

1. In recent months there have been general increases in spend which though not large in themselves cumulatively have started to become significant. This has not impacted upon the surplus in earlier months with additional (backdated) Hertfordshire income offsetting this.

2. Although pay remains underspent, and has reduced this month, a pronounced upward trend remains (see graph at 3a), with recruitment ongoing, so it will not remain underspent to this degree. The Pay underspend of £2.9m year to date, represents c. 100 posts, based on an average.

3. Additional spend is planned e.g. to drive performance improvement and data quality initiatives; spend on Information Technology to support staff.

This position is stated before income from the Sustainability and Transformation Fund (STF); £1.2m for the year to date.

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

Effective use of resources, in particular to meet the continuing financial requirements of the organisation.

Summary of Implications for:

Finance – achievement of the 2017/18 planned surplus and Use of Resources Rating.

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

1. Background to Financial Plan 2017/18

1.1 The Financial Plan reflects the early settlement of all key contracts. There is a net uplift of 0.1% comprising inflation of 2.1% and efficiencies of 2.0%. Additionally, there has been a £750k reduction in the Hertfordshire Social Care contract. Although there is an overall increase in income, this is in respect of new services, rather than growth for existing ones, with demography from only East and North Hertfordshire CCG of £659k; Herts Valleys have not provided demography in 2017/18. The Trust has to meet the growing pressures both in the level and nature of the demand for services, the challenges in recruiting and retaining staff, and the growing impact of wider systems issues. The national background to this year is one of continued and increasing concern across provider organisations and the system as a whole.

1.2 The CRES level assumed within the Plan is £5.7m, and the NHSI Agency Ceiling is £8.5m, which is c. £1.0m below last year's actual spend. The Plan is summarised in Fig. 1a below:

Fig. 1a Description	2016/17 Plan	2016/17 Actual	2017/18 Plan*
Income	211.4	218.1	221.7
Pay	-136.1	-138	-147.8
Other Direct Costs	-27.8	-31.1	-28.2
Overhead Costs	-36.9	-34.9	-35.6
EBITDA	**10.6**	**14.1**	**10.1**
EBITDA Margin	5.01%	6.44%	4.56%
Financing	-10.0	-9.9	-9.4
Impairment	0.0	-1.6	0.0
Surplus	**0.6**	**2.6**	**0.8**

* This is before any amounts due under the Sustainability and Transformation Fund

2. Performance Summary and Risk Rating

2.1 The overall Trust position reported for December is a surplus of £80k, which is ahead of the Plan of £14k by £66k; year to date the position is a surplus of £1.145m, which is ahead of the Plan of £563k by £581k. This position does not include income from the STF (Sustainability and Transformation Fund).

2.2 The four main variances within this position are:

2.2.1 Pay overall better than Plan by £233k

2.2.2 Income better than Plan by £400k

2.2.3 Secondary commissioning adverse to Plan by £520k.

2.2.4 Other Direct Costs, Overheads and Financing adverse to Plan by £47k

2.3 Performance against budgets for each section of HPFT is reported below:

E&N	West	LD&F	Support Services	Other	Total
(482)	8	759	237	623	1,145

"Other" relates to Central items which are not part of an SBU or Support Services, such as reserves, depreciation, and PDC. Further details on individual Strategic Business Unit performance is within Section 5.

2.4 The Trust's overall Use of Resources Framework Rating, the UOR, reports as a 1 in the month, the highest level. The detailed calculation of this is shown in Appendix F1, with the main in month movements highlighted in the summary below:

Metric	Rating	Reported Rating	Commentary
Capital Servicing Capacity	1.7 ⇨	1 ⇨	Rating stayed the same in month, no further loan repayments until month 12
Liquidity	1.1 ⇨	1 ⇨	Strong cash position of £55m supporting liquidity metric. Increase in cash due to delays in payments relating to transistion to ELFS shared service
I&E Margin	1.6 ⇨	1 ⇨	Rating stayed the same in month
I&E Variance	1.8 ⇨	1 ⇨	Rating stayed the same in month
Agency Spend	2.1 ⇨	2 ⇨	Agency spend fell slightly in month but continues to be behind NHSI cap.
UOR Overall		1 ⇨	

2.5 There are 2 main NHSI Agency Targets, the Expenditure Ceiling, and the Hourly Price Cap:

2.5.1 **Agency Expenditure Ceiling** – set at £8.5m for 2017/18, the same as for 2016/17. Spend for 2016/17 was £9.5m (before the reversal of £700k unutilised prior year accrual), so an overall reduction of £1.0m is required to keep within the ceiling. Spend for December was £750k (£757k in November) which is £40k above the ceiling (£220k above year to date). Further details are within Section 3.

2.5.2 **Agency Hourly Price Cap** – focuses on price cap and off-framework breaches. There were a total of 131 price cap breaches reported in the 4 weeks of December, averaging 33 per week (34 per week in November), all of which relate to Medical locum shifts; overall there has been an increase in breaches in recent months. The breaches are summarised below and detailed in Appendix F3.

3 Key Financial Risks

3.1 The Finance Department have assessed the current key financial risks for the Trust as follows:

3.1.1 The Trust's new CAMHs Tier 4 NCM service has been set up on the basis that new, specialist community teams will enable young people to stay out of expensive hospital placements. If young people continue to be placed at the same rates, and funding is also spent on the new teams, there could be a shortfall of income over expenditure. Initial signs are positive.

3.1.2 Work is ongoing in calculating the 2018/19 CRES, however currently there is a shortfall.

3.1.3 The Trust is currently engaged in a dispute with Interserve, the Hard and Soft Facilities Management provider, who have a contract of £5m. There is a risk that it will be necessary to pay a significantly higher contract value going forward.

4 Trading Position

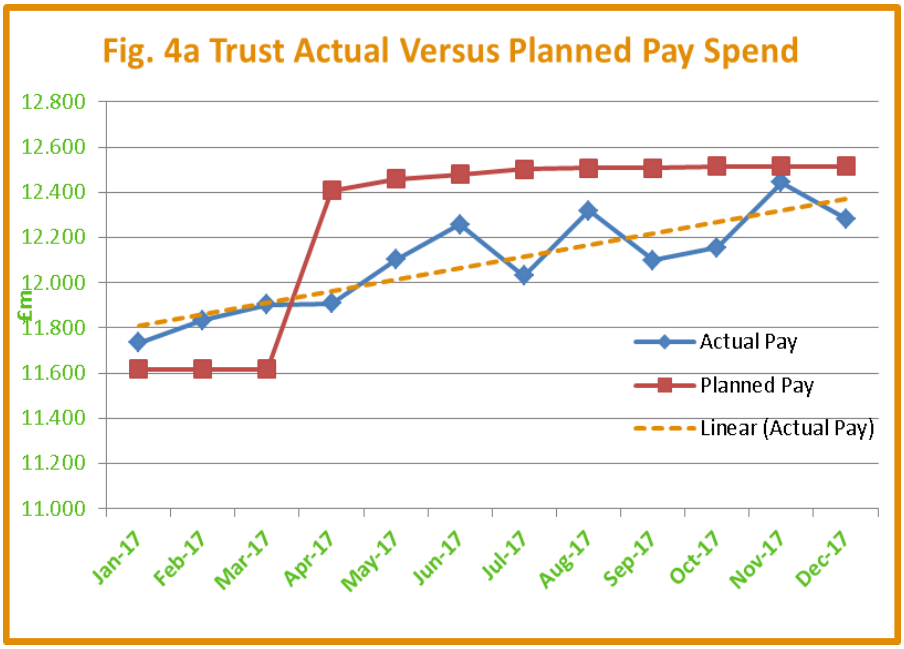


Fig. 4a shows the actual against planned pay spend over the last 12 months. Pay Costs totalled £12.3m in December, £233k better than Plan. The trend line shows that overall pay has increased steadily over the 12 months, despite small decreases some months.

4.1 Of the overall total spend in the month, £10.2m (83%) was on Substantive Staff, £750k (6%) on Agency, and £1.3m (11%) on Bank. Fig. 3b shows Agency spend for the last 12 months, alongside the NHSI Spend Ceiling and Agency Reduction Plan. The trend line illustrates that overall there has been a reduction in spend over the last 12 months, though not sufficiently yet to meet the year to date NHSI Ceiling or Internal Plan.

4.2 The most significant area of non-pay spend above Plan is Secondary Commissioning, which reports for the month at £2.7m against a Plan of £2.2m; however as stated above this was the first month of expenditure for the new CAMHs Tier 4 NCM contract. £326k was accrued for these new external placements, and without this expenditure would have been £2.4m, a reduction on Month 8. Health Placement Observation Costs have remained high at c. £63k in December, and have not reduced as expected due to several particularly expensive placements. Rehab placements and Acute/PICU placements were stable; Older Peoples placements decreased having been high in November; and social care increased by c. £60k.

5 Forward Look

5.1 At this point it is fully expected that the Trust's control total will be met at the end of the year. However it should be noted that there are some risks within this:

5.1.1 Pay remains underspent but has increased year to date with the trend is rising.

5.1.2 Secondary commissioning for long-term health placements, social care placements, and social care packages, have not achieved the savings planned for in year.

5.1.3 External PICU and Acute placements have also not yet fully achieved planned savings.

5.1.4 There is additional expenditure planned later in the year, for instance to drive performance improvement and data quality; develop Information Technology to support staff.

5.1.5 There is a contract dispute with the major facilities provider which could involve some additional unbudgeted cost

5.2 An End of Year forecast has been presented to the FIC setting out the range and expected position including the key areas of uncertainty and related actions.

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS

Meeting Date:	25 January 2018	**Agenda Item:**
Subject:	Annual Plan Report (Q3) 2017/18	**For Publication: Yes**
Author:	Karen Taylor, Executive Director Strategy & Integration	**Approved by:** Karen Taylor Executive Director Strategy & Integration
Presented by:	Karen Taylor, Executive Director, Strategy & Integration	

Purpose of the report:

Present the Trust's performance against the Annual Plan for the 3rd quarter of 2017/18.

Action required:

To receive the report, discussing the content and implications for Trust performance

Summary and recommendations:

The Annual Plan comprises of ten objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust needs to take and the milestones to be reached, by quarter, in order to deliver the Trust's agreed outcomes for the year. At the end of each quarter each objective receives two RAG ratings which indicate:

- An assessment of whether the Trust is on track to achieve the stated outcome(s) by the end of the year
- An assessment of whether the milestones/actions planned for that quarter were achieved.

At the end of Quarter 3 good progress has been made, with the assessment of the Annual Plan outcomes showing that seven (out of ten) objectives are RAG rated Green and are on track to fully deliver the planned end of year outcomes. Two objectives are rated Amber and one Red;

Objective 2 - Deliver better access to our services. The amber rating reflects that although access to adult community services has improved and commissioners have agreed the new DNA policy, the access target is not going to be achieved – a reflection of both the level of demand and the resources available for initial appointments.

Objective 8 – Innovate, improve and become more productive. There is considerable evidence of innovation and improvements being made throughout the Trust, however the Amber rating relates to being able to demonstrate the improved use of resources.

Objective 6 - Reduce vacancy levels and reliance on temporary staffing. The stretch target 10% vacancy and 10% turnover rates are unlikely to be achieved by the end of 2017/18. This is in part due to an increase in establishment of 80 WTE in year, but also due to the challenging recruitment environment. Work with NHSI has demonstrated the Trust has adopted all nationally cited best practice, although work continues on the development of new roles and a new marketing campaign.

The attached paper summarises progress against the Annual Plan. It provides a detailed commentary, by objective, against the milestones delivered during Quarter 3. It also provides a detailed commentary, by objective, against the required outcomes by objective and a projected end of year position (RAG).

The Board of Directors are asked to discuss and receive the Quarter 3 Trust Annual Plan report.

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

Summarises Progress against Annual Plan (all objectives)

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

Financial & staffing implications of the annual plan have previously been considered; actions to support delivery of the Trusts financial, staffing, IT plans are contained within the Annual Plan

Equality & Diversity and Public & Patient Involvement Implications:

None noted

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

Delivery of the Annual plan supports delivery of key targets and standards across the Trust

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

Executive Committee 10 January 2018

TRUST ANNUAL PLAN 2017/18 – QUARTER 3 REPORT

1. Summary

The Annual plan comprises of ten objectives across the four themes of the Trust's 'Good to Great' strategy. It describes the actions the Trust needs to take and the milestones to be reached, by quarter, to deliver the Trust's agreed outcomes for the year.

At the end of each quarter each objective receives two RAG ratings providing:

- An assessment of whether the Trust is on track to achieve the stated outcome(s) by the end of the year
- An assessment of whether the milestones/actions planned for that quarter were achieved.

2. Progress against Outcomes

At the end of Quarter 3 good progress has been made with seven (out of ten) objectives RAG rated Green and on track to deliver the planned end of year outcomes. Two objectives are rated Amber and one Red.

Table 1 End of Year RAG projection

Objective		End of Year Projection
1	We will improve the safety of our services so that more people feel safe and are protected from avoidable harm	
2	We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy	
3	We will improve the wellbeing and physical health of service users through better health monitoring and support to address health risk factors	
4	We will continue to create a more empowered and engaged workforce through developing a culture of collective leadership	
5	We will strengthen the capabilities and capacity required to deliver our plans by developing our leadership base	
6	We will reduce vacancy levels and reliance on temporary staffing by developing new roles and reducing staff turnover	
7	We will provide staff and teams with better access to the right information and tools to do their jobs effectively and efficiently	
8	We will support and empower staff to improve, innovate and become more productive in delivering great care	

9	We will deliver more joined up services across mental health, physical health and primary care	
10	We will be recognised as system leaders having successfully driven and delivered on key system priorities	

Appendix 1 provides a commentary against the end of year projection for each objective. The Amber or Red objectives are as follows:

- Objective 2 - Deliver better access to our services. The amber rating reflects that although access to adult community services has improved and commissioners have agreed the new DNA policy, the access target is not going to be achieved – a reflection of both the level of demand and the resources available for initial appointments.

- Objective 8 – Innovate, improve and become more productive. There is considerable evidence of innovation and improvements being made throughout the Trust, however the Amber rating relates to being able to demonstrate the improved use of resources.

- Objective 6 - Reduce vacancy levels and reliance on temporary staffing. The red rating is because the stretch target 10% vacancy and 10% turnover rates are unlikely to be achieved by the end of 2017/18. This is in part due to an increase in establishment of 80 WTE in year, but also due to the challenging recruitment environment. Work with NHSI has demonstrated the Trust has adopted all nationally cited best practice, although work continues on the development of new roles and a new marketing campaign.

3. Progress against Milestones

The assessment of progress against the quarterly annual plan milestones provides a greater level of detail about the considerable programme of work and activities taking place across the Trust. (Appendix 2). At the end of Quarter 2 four objectives were rated Green with full delivery of the milestones and five rated Amber. Only one objective has been RAG rated Red, and it should be highlighted this rating has occurred due to the decision made to delay the tender for the cultural change programme in Quarter 2 to allow the new Director of Innovation and Transformation time to bring their experience and expertise to develop the most appropriate programme for the Trust.

4. Conclusion

At the end of Quarter 3, good progress has been made against the Annual Plan, with the majority of outcomes on track to be delivered. Seven objectives are rated Green (70%) and overall 90% of objectives are RAG rated Green or Amber.

Appendix 1 – Annual Plan End of Year (EOY) Projection

	Objective	Exec. Dir. Lead	EOY Projection at			Year End Outcomes Commentary
			Q1	Q2	Q3	
1	We will improve the safety of our services so that more people feel safe and are protected from avoidable harm	JP				• Safety on our inpatient wards Single easy read survey, increased response (30 in Q1 to over 200 in Q3). 90% of service users in acute wards responding positively to the 'feeling safe' question in quarter 3 • Reducing Suicide rates on track (9 in quarter 3/ 21 year to date)
2	We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy	JL				• SPA – significant improvements with no 14 day breaches taking place during Q3 • CAMHS CHOICE access times have continued to perform strongly during the quarter. Partnership waits – average remain above 6 week target • Tier 4 CAMHS – being mobilised in quarter 4. • Psychosis pathway being developed by clinicians for completion as planned Q4 • Amber rating reflect improved position for Adult services but remain under 98% target. Partnership waits in CAMHS remain above 6 weeks.
3	We will improve the wellbeing and physical health of service users through better health monitoring and support to address health risk factors	JP/KT				• Improved physical health screening, interventions and advice being delivered e.g. community physical health clinics and inpatient admissions • Physical health Strategy year 1 action plan on track to be delivered • Service user feedback - 85% (437/512) service users responding to the 'having your say' community survey reported they felt their physical needs are being met • Prevention and wellbeing priorities – development as part of FEP pathway work
4	We will continue to create a more empowered and engaged workforce through developing a culture of collective leadership	JK				• Recognition & value of staff continued through Inspire Awards, Annual Awards, and through local recognition pilots (Albany Lodge, Robin & HR department) • Engagement activities including The Big & Local Listens, Good to Great Roadshows, health & wellbeing activities (e.g flu campaign and Schwarz rounds) • Managing Service Excellence, Leadership Academy & Mary Seacole Programme. • Staff feedback including 'pulse survey' suggest outcomes being delivered, waiting external validation from national staff survey
5	We will strengthen the capabilities and capacity required to deliver our plans by developing our leadership base	JK				• Leaders receiving improvement approach/tools training - through ad hoc sessions and training programmes, and through the leadership academy. • QI training sessions & Systems leadership provided to Senior Leaders • Innovation and continuous improvement programme for all staff will commence at the beginning of 2018/19

	Objective	Exec. Dir. Lead	EOY Projection at			Year End Outcomes Commentary
			Q1	Q2	Q3	
6	We will reduce vacancy levels and reliance on temporary staffing by developing new roles and reducing staff turnover	JK				• Vacancy rate as at the end of December 2017 was 13.42% (Target 10%) • Turnover rate was 13.27%. (Target 10%). • 80 WTE additional posts in 2017/18 has elevated the Trust's vacancy position, at the same time the recruitment market has remained difficult. • NHSI national recommended actions have been implemented. • Development of new roles is also building momentum - nursing associate programme, mental health accelerated nurse programme and apprentices in place
7	We will provide staff and teams with better access to the right information and tools to do their jobs effectively and efficiently	KL/ RA				• PARIS and business intelligence system (SPIKE) now being utilised across the Trust - positive & improved experience reported from staff across the Trust. • Accurate Information work stream is being built upon to accelerate the already effective work taking place. • Data quality officers are now assigned to specific service teams.
8	We will support and empower staff to improve, innovate and become more productive in delivering great care	KL/ JL/RA				• Growing number of quality improvement / innovation projects being delivered e.g. SPA, SW Community services, approach to CRES • Safe Care is now fully enabled across all inpatient settings and is allowing for the real time review and allocation of resources • Video calling/conferencing – various pilots are running throughout the organisation to support and encourage agile working • Amber projection for year reflects the use of core productivity metrics. Although involved in NHSI model hospital initiative - work streams for E Roster, Procurement, Back office review, Mental Health costing standards - these have not yet come to a conclusion and cannot yet demonstrate improved use of resources.
9	We will deliver more joined up services across mental health, physical health and primary care	KT				• Hemel Hub (between HCT & HPFT) is due to be completed during Quarter 4 • Stort Valley & Villages Integrated team (Older people) is in place • Primary Mental Health Care pilots are starting in quarter 4. • West Herts Integrated Diabetes service commenced Quarter 3 • Physical health strategy year 1 plan is on track to be implemented. • 85% service users in adult community have reported feeling their physical health needs are being met (Having your say)
10	We will be recognised as system leaders having successfully driven and delivered on key system priorities	KT				• MH&LD is one of the named priorities across the STP • HPFT Executive Team, together with senior clinicians and managers actively participate in the STP - providing leadership across broad range of STP programmes of work (e.g. workforce, Finance, Mental Health & LD, Place Based Care, AHP working group)

Appendix 2 – Annual Plan Quarter 3

Full Commentary against Milestones and Outcomes

Great Care, Great Outcomes

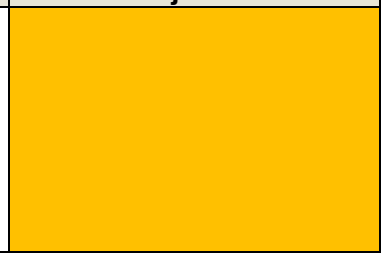
Priority 1 (Owner JP)	Q3 Key Actions / Milestones	Q3 Milestones Rating	Q4 Milestones Projected
We will improve the safety of our services so that more people feel safe and are protected from avoidable harm	First phase of plan delivered including pilot sites beginning new initiatives.		

Key areas of focus	Commentary:
• Reducing suicide rates - in particular through sign off and delivery against suicide prevention strategy • Improving safety on our inpatient wards – in particular through delivery on our MOSS strategy • Delivering consistently on the fundamentals of care across all of our services	**Reducing Suicide rates** - The Trust has joined the Zero Suicide Alliance and engaged in the planned launch event in Q3. In quarter 4 the team will work with the Alliance to formulate an action plan based on the learning across the Alliance. There were 9 suspected suicides recorded in Quarter 3. Year to date position is 21 suspected suicides. **Safety on our inpatient wards** • As previously reported there is now one single easy read survey utilised across all inpatient services from 1 July 2017. The survey is administered on discharge from the service to ask service users to reflect back on their care. Exceptions to this are for longer stay service users where this is asked at the care review. Response rates have increased from approximately 30 responses using the old survey, to 100 in Quarter 2 using the new survey to now 211 in this third quarter. • The new survey has seen 90% of service users in acute wards responding positively to the 'feeling safe' question in this quarter. • During Q2 our response to violence and aggression was considered and, as a consequence, we will be developing our training and offer to support our staff to be more responsive to the needs of different service users, including those where there is extreme violence. An external review has now been commissioned and will take place in Quarter 4.

Summary and Actions Being Taken	Key Outcomes at Year End	Year End Outcomes Projection
The new approach to assessing service user's experience of safety has continued to be effective, with not only an improved positive response, but also a greater number of service users providing feedback. Recent analysis of year on year suicide trends remains encouraging	• Reduction in suicides by 10% (Maximum 32 - 8 per quarter) • More service users on acute wards will report feeling safe (moving from baseline of 65% to 80% by end of Q4)	

Priority 2 (Owner JL)	Q3 Key Actions / Milestones	Q3 milestones Rating	Q4 milestones Projection
Priority 2 **We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy (QSDS)**	Full implementation of new Single Point of Access operating processes CAMHS DBT community team established (subject to commissioner approval)		

Key areas of focus:	Commentary:
• Delivering consistent timely access to services through design and implementation of a more robust access pathway • Deliver consistent access to all CAMHS services • Other Quality and Service Development Strategy priorities as confirmed during Q1	Within the quarter we have tested and safely implemented our new operating System within our single point of access. This has resulted in significant improvements in the effectiveness of this critical aspect of our service, with no 14 day breaches taking place during the quarter, improved referral management and timely and responsive triaging. CAMHS access times have continued to perform strongly during the quarter. Partnership waits have also improved. Full performance data for the quarter is not available until the 22 January. Due to delays with NHSE's provision of financial and activity data regarding CAMHS Tier 4 provision, our operational teams were not able to able to commence the work until October, therefore these implementation timelines have been moved back by two months. A plan and clear trajectory is in place. Adult services, whilst improving their position in quarter, remain under target. Measures are in place to further improve this position in Quarter 4, however current demand and capacity modelling suggests the 98% target set by commissioners is no longer mathematically achievable and discussions are taking place to address this for 2018/19. Great Care, Great Outcomes (QSDS) development of the Psychosis pathway is being developed by our clinicians for completion as planned in Quarter 4.

Summary:	Key Outcomes at Year End	Year End Outcomes Projection
Good progress has been made during the quarter, and access has improved across CAMHS and Adult services, and SPA is now functioning well. The Psychosis pathway will be delivered in Quarter 4 as planned. Amber position reflects the delays in commencing Tier 4 CAMHS due to ongoing work with NHSE; and also the adult access position.	• Timely access to adult community services • QSDS Outcomes to be agreed and pathway pilot to be completed • Timely access to CAMHS services – CHOICE & partnership • Reduced inpatient admissions for Young People	

Priority 3 (Owner: KT / JP)	Q3 Key Actions / Milestones	Q3 Milestones Rating	Q4 Milestones Projection
We will improve the wellbeing and physical health of service users through better health monitoring and support to address health risk factors	Delivery against prevention and wellbeing plan Development staff competency framework for physical health Information leaflets for service users developed		

Key areas of focus:	Commentary:
• Development of and delivery against prevention & wellbeing priority within the Quality and Service Development Strategy • Improved physical care of service users through delivery against our physical health strategy and action plan	There has been considerable work in the last quarter continuing the focus on physical health. • A physical health toolkit has been completed to support staff, and additional resources for staff in relation to physical health have been placed on the intranet and are being promoted. • An information leaflet for service users in relation to physical health has been developed and will be available mid Jan. An easy read version suitable for people with learning disabilities will next be adapted. • As part of the Quarter 3 CQUIN work the Trust participated in a National Clinical Audit, submitting to the Royal College of Physicians a total of 300 questionnaires. The audit included cardio metabolic screening and interventions for service users with Significant Mental Illness across both our inpatient and community settings. A similar audit is now in progress via the RCP auditing those on the First Episode Pathway. All results should be published by the RCP by April 2018. • The process of developing a staff competency framework for physical health is well underway, and a series of core competencies have been identified. It is anticipated that this will be completed in Quarter 4. The Prevention & Wellbeing priorities were presented to November's Quality & Risk Management Committee (QRMC). Detailed delivery plans are due for approval at the Quality Risk Management Committee in February 2018. This work has taken longer than originally envisaged due to the need to achieve wide engagement and align with the care pathway work. This will provide a strong foundation for delivery in 2018-19. Partnership projects with the University of Hertfordshire (healthy food on a budget and physical activity) have been delayed due to university staff shortages but are planned to progress in Quarter 4.

Summary	Key Outcomes at Year End	Year End Outcomes Projection
Good progress has been made with the scoping of the prevention and wellbeing priorities, with targets development for recovery, and within Learning Disability services. Further targets are being tested and developed as part of Psychosis Pathway, and this approach will ensure that prevention and wellbeing is embedded into the development of all future pathways. Strong progress made to deliver against the physical health year 1 action plan.	• Screening, assessment & interventions / advice being delivered to support improved physical health • Increased number of service users reporting their physical health needs being met • Specific prevention and wellbeing targets to be confirmed as part of plan developed in Q1.	

Great People

Priority 4 (Owner: JK)	Q3 Key Actions / Milestones	Q3 Milestones Rating	Q4 Milestones Projection
We will continue to create a more empowered and engaged workforce through developing a culture of collective leadership	Delivery of key programmes to support managers		

Key areas of focus	Commentary:
• Developing more empowered clinical leaders through delivering on our Collective Leadership agenda • Continued improved engagement of our workforce through a systematic approach to delivery against the Trust's engagement model	Collective Leadership The review of the current leadership offerings and redesign has commenced, together with a new Leadership Competency Framework. The Leadership Programmes will be reviewed once the leadership competencies have been approved and signed off so that they reflect the changes. The timescales continue to be behind plan at present but an action plan of key tasks to be completed has been produced which will enable delivery of the review and redesign of the leadership competencies by the end of Q4. A 'Coaching for Managers' Development programme is also out to tender. Clinical Leaders Programme for Key Staff Groups The Team Leaders Development Programme continued during Q3 with further sessions planned for Q4. Another Senior Leaders Forum took place in Q3 and during Q3 a new Senior Leadership Team (SLT) forum has been established which takes place on a monthly basis. An away day is planned for the SLT during Q4. Other Activities to Achieve Year End Outcomes A number of other engagement activities have taken place during Q3 which includes The Big Listen, Local Listens, Good to Great Roadshows, health and wellbeing activities including the flu campaign and Schwarz rounds. Managing Service Excellence, The Leadership Academy and the Mary Seacole Programmes continue to run.

Summary	Key Outcomes at Year End	Year End Outcomes Projection
A number of engagement activities have been delivered during Q3 to support the delivery of the end of year outcomes. The clinical leadership programmes have either been completed or are still in progress. The Q3 amber rating reflects that we are behind plan on the broader redesign of the Trust's leadership development offerings which will be achieved by the end of Q4 but we continue to offer leadership development to staff through our current range of programmes.	• Improved satisfaction with level of responsibility and involvement. • Increase support from immediate managers. • Increase in recognition & value of staff by managers and organisation.	

Priority 5 (Owner: JK)	Q3 Key Actions Planned / Milestones	Q3 Milestone Rating	Q4 Milestone Projection
We will strengthen the capabilities and capacity required to deliver our plans by developing our leadership base	Commence roll out to deliver sessions (cultural change programme)		
Key areas of focus:	**Commentary:**		
Developing our leadership base with a particular focus on: • System leadership • Continuous improvement and innovation mind set and approaches • Clinical leaders	During Quarter 3 leaders from adult community services (North West and East & South East quadrants) commenced a short 'Operations Development Programme' the aim of which is to impart operations management skills focussed on establishing a high performance and continuous improvement culture. The programme concludes in January 2018. The Q1 and Q2 milestones regarding the delivery of a cultural change programme remain outstanding and progress was further delayed during Q3. The tender document received Executive Team endorsement in mid-December with the direction that further approval for the required investment was received from Finance & Investment Committee prior to approaching the market (mid-January 2018). The revised timetable will seek the procurement of a suitable supplier towards the end of Q4 / beginning Q1 2018/19 with an implementation plan likely to commence towards the end of Q1 2018/19. In the meantime, alternative 'one off' training and development opportunities for individuals involved in key improvement activity is being considered on an ad hoc basis in order to provide the required capability and approach. Throughout quarter 3 there has also continued to be significant activity regarding the development of our clinical leaders (see priority 4 for more detail). Leading quality improvement continues to be a focus of the Leadership Academy programme content, with cohort 9 commencing in January 2018.		

Summary	Key Outcomes at Year End	Year End Outcomes Projection
There is Executive endorsement of the tender document and approach to the cultural change programme and we have recruited to a project officer role to provide capacity to the procurement. Due to the implementation delay, it will not be rolled out to staff this financial year. However leaders have been supported with developing their improvement thinking and skills in 'hands on' ways through the work of the continuous improvement team, through the Managing Service Excellence programme, and Team Leaders Development programme.	Leaders across the organisation have received training and support on improvement approaches and tools	

Priority 6 (Owner JK)	Q3 Key Actions Planned / Milestones	Q3 Milestones Rating	Q4 Milestones Projection
We will reduce vacancy levels and reliance on temporary staffing by developing new roles and reducing staff turnover	Delivery of the agreed recruitment & retention plan		

Key areas of focus	Commentary:
• Creation of new roles and use of apprenticeship model • Robust local recruitment and retention plans supporting greater flexible working	Development of Apprenticeships and New Roles: Progress is being made with regards to new roles with 10 staff continuing to be seconded onto the nursing associate programme with plans for a further two cohorts during 2018/19. In addition 10 candidates continue on the mental health accelerated nurse programme. During Q3 the STP have commenced a Physician Associates programme with the University of Hertfordshire. Placements with HPFT will take place in June 2018. We now need to start planning for when these staff complete their training programmes so that we have identified areas within the Trust in which we will utilise these roles so we gain maximum benefit. Progress with regards to different ways of working within the Trust has been slow but additional support is being sourced to assist with this piece of work. The Trust currently has 21 apprentices in place and more staff have been identified to start on the apprenticeship programme. Unfortunately, the procurement process for securing a training provider for apprenticeship programmes has been a more complex and difficult process than anticipated. The Trust is proposing recruiting the majority of Band 2 HCAs on an apprenticeship so that we can meet our levy moving forward. Local Recruitment and Retention Plans: Local recruitment and retention plans are in place for each SBU and these are in the process of being revised. Progress continues to be monitored through the recruitment and retention group. In addition the Trust has submitted its Retention Improvement Plan to NHSI during Q3 and progress against activity will be monitored through WODG and IGC. The current vacancy rate as at the end of December 2017 was 13.42% (reduced from 14.3% in September) and the turnover rate is 13.27%.

Summary	Key Outcomes at Year End	Year End Outcomes Projection
Detailed recruitment and retention plans are in place and the NHSI retention improvement plan has been submitted, with work taking place to implement the plan. New roles are being developed, however, the year-end stretch targets (10% vacancy rate and 10% turnover rate) are not on track to be delivered. A focus on retaining staff to reduce turnover rates as well as continued recruitment drives will take place in Quarter 4.	• Reduced staff turnover (10%) • Lower vacancy levels (10%)	

Great Organisation

Priority 7 (Owner RA /KL)	Q3 Key Actions / Milestones	Q3 Milestone Rating	Q4 Milestone Projection
We will provide staff and teams with better access to the right information and tools to do their jobs effectively and efficiently	**Q3** New EPR contract in place aligned to agreed strategic development programme		

Key areas of focus	Commentary
• Development of our EPR and business intelligence systems • Improved data quality and recording	<u>PARIS development</u> • PARIS development has continued throughout Q3, to include the release of a triage form to support our new Perinatal service and the Quick View service user data at a glance feature. Quick View has made finding and viewing key information much easier and faster than before and has been well received by our staff. • Well specified list of system requirements have been set out with EPR supplier (Civica) built around the experiences of TUVE who are seen as vanguard client of Civica, modified to meet HPFT requirements. The specification has been clinically led and involved extensive period of internal consultation. • Contract negotiation and commercial discussions with CIVICA on track to complete in Q4. <u>Business Intelligence System</u> • Development of BI system continues in accordance with approved business case. Design and build of new warehouse approaching completion and review of business rules for KPIs on track for completion in February. Development partner appointed and have commenced with work on web based front end reporting and external oversight/assurance being provided through experienced NHS BI partner. • On data quality, the Accurate Information work stream is being built upon to accelerate the very effective work already being achieved. Data quality officers are now assigned to specific service teams with targeted actions being assigned to each officer based upon the current data quality assessment tool provided through SPIKE. This enables the identification of outliers and the ability to track the required data quality improvements in almost real time.

Summary	Key Outcomes at Year End	Year End Outcomes Projection
PARIS development continues as per the agreed priorities and is now making a really positive impact to accessing information more effectively. The new CIVICA contract is on track for sign off in Q4. The development of SPIKE 2 is progressing successfully to the planned timeline of Q4 with the new reporting to be available for April data in May 2018. Data Quality initiatives have been developed and presented to the Audit Committee, with early wins identified and being implemented.	Improved experience of Paris and business intelligence systems Improved data quality evidenced through internal & external audit programmes	

Priority 8 - Owner RA/KL/ JL/JK	Q3 Key Actions / Milestones	Q3 Milestone Rating	Q4 Milestone Projection
We will support and empower staff to improve, innovate and become more productive in delivering great care	Agile working programme rolled out		

Key areas of focus	Commentary:
• Successfully embedding innovative and more productive ways of working e.g. agile working, back office, valuing service user time • Using technology more effectively to support new ways of working e.g. Hemel hub, agile working • Role out of Safe Care tool across services to better align staff to meet acuity levels across inpatient settings	Safe Care is now fully enabled across all inpatient settings and is allowing for the real time review and allocation of resources based on organisational need and clinical acuity. Digital Dictation & Voice Recognition – the BigHand system project will provide up to 500 staff with ability to use mobile phones for the recording of information and then provide a choice of options for transcribing this information into the clinical record. Video calling/conferencing – various pilots are running throughout the organisation to support and encourage agile working. These have been further refined by providing additional equipment such as large meeting room screens and higher quality cameras. Infrastructure – the roll out of Wi Fi access to all of our sites has now completed to both support the use of and further embedding of the SafeCare tool and access to all key Trust systems such as PARIS and TrustSpace. Back Office - The programme has not progressed to the original timetable due in part to the change in emphasis of the Alliance and exploration of the options available through the STP. The intention is now to commission an external review of the options for back office services, building on the work previously done. The transfer of finance to a shared service model has been completed from month 9 and the transition will embed in Quarter 4. The outcome of the consultation for a single Estates & Facilities function shared between HPFT and HCT was published in Quarter 3 and the structure will be recruited to during Quarter 4, including confirmation of posts to be filled by current staff. The core productivity metrics are being developed through the model hospital initiative being developed with NHSI and HPFT is involved in the pilot project. As part of this development HPFT are actively involved in the NHS *work streams; E Roster, Procurement, Back office review, Mental Health costing standards.*

Summary	Key Outcomes at Year End	Year End Outcomes Projection
Progress continues to be made but impact at a Trust wide level was not met in Q3. An approach that targets several key teams with the objective of getting them to a good practice standard of using the right tools and infrastructure to deliver an efficient service has now been adopted.	• Evidence of a growing number of quality improvement / innovation projects being delivered across the Trust • Measurable improvements in the Trust's use of resources	

Great Networks and Partnerships

Priority 9 - Owner: KT / JL	Q3 Key Actions / Milestones	Q3 Milestone Rating	Q4 Milestone Projection
We will deliver more joined up services across mental health, physical health and primary care	Integrated Diabetes service in place through RAID+ and wellbeing teams.		

Key areas of focus	Commentary:
• Successful delivery of key 'integration projects' through HPFT / HCT Alliance • Improved joint work with GPs and GP federations resulting in improved referral and discharge pathways	The Integrated Diabetes service is now operational in West Hertfordshire. The service is operated as part of our RAID and IAPT functions, with the additional RAID staff in place since the beginning of December, and reporting on access is due to begin by the end of January 2018. HPFT remains actively represented on both Operational and Steering groups. Both Access and Recovery rates are good for the IAPT element of the Integrated Service. It has been agreed with commissioners that the model should also be expanded into Respiratory Long Term Conditions. In Quarter 2, it was reported that the primary care models were underdeveloped. IT access issues had slowed progress during Quarter 3, but a solution has now been found to this and there is now a planned go-live date during January 2017 for two of the three pilot sites.

Summary	Key Outcomes at Year End	Year End Outcomes Projection
Milestones for Q3 have been delivered, and progress has been made towards commencing the primary mental health pilots.	• Delivery of Hemel, Stort Valley & Villages and CAMHS/Children's services projects • Increased rate of 'appropriate' referrals and improved flow • Improved service user and staff experience	

Priority 10 - Owner: KT	Q3 Key Actions / Milestones	Q3 Milestone Rating	Q4 Milestone Projection
We will be recognised as system leaders having successfully driven and delivered on key system priorities	STP Mental Health work stream successfully focussing and supporting delivery of MH 5YFV across the STP footprint.		

Key areas of focus	Commentary:
• HPFT/HCT Strategic Alliance recognised as driving and delivering on key system priorities • HPFT recognised for continued leadership of key system functions and programmes	HPFT Directors, our CEO and other senior clinicians and managers continue to play an active and full part across the STP, leading on a number of STP programmes of work, in addition to the MH&LD work stream. HPFT's Head of Allied Health Professionals has led work across the STP regarding the role of AHPs. This has led to improved networks and potential ideas for working differently in the future across mental and physical health. The STP Mental Health workstream has a clear programme of work. The STP has recently secured additional national funds as part of the recently released winter pressures funding; it has highlighted disparity in service provision across the STP for Core 24 and is reviewing best practice to address this. An STP wide focus on primary mental health has supported the set up of the three pilots in Hertfordshire. Funding has been secured for an STP wide Clinical Lead for Mental Health, further strengthening the voice for MH&LD across the system. Good recognition given from the MH & LD Regional Clinical Network about progress made to date. Out of area admissions are a target area for improvement in line with national agenda; together with ensuring funding commitments of FYFV delivered. Work continues to focus on the delivery of the Hemel Hub with Hertfordshire Community Trust, which is due for completion at the beginning of March 2018. The deployment of equipment to staff moving into Hemel Hub is underway which will enable staff to work in an agile way without relying on fixed desk computers and telephones. This work will complete in Q4 to allow staff to become familiar with the new equipment in readiness for the go live.

Summary	Key Outcomes at Year End	Year End Outcomes Projection
Continued leadership across the STP, including and going extensively beyond MH&LD, demonstrates the commitment by HPFT to the STP. MH&LD has been prioritised by the STP for focus and development. Although the Strategic Alliance has not materialised in the way first envisaged; specific projects have continued such as the Hemel Hub.	HPFT system leadership valued and sought by local partners Improving mental health and learning disability services is central to local health and social care economy plans	

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	25th January 2018	**Agenda Item: 15**
Subject:	Report from the Chair of the Audit Committee – meeting held 6th December 2018	**For Publication: Yes**
Author:	Catherine Dugmore	**Approved by:**
Presented by:	Catherine Dugmore Audit Committee Chair	

Purpose of the report:

To:

- Report key matters from Audit Committee to the Board

Action required:

To:

- Note the report
- Seek any additional information, clarification or assurance as appropriate
- Direct Audit Committee concerning any further action required

Summary and recommendations to the Board:

The Audit Committee met on 6 December and considered the following matters:

- Risk Topic – General Data Protection Regulations (GDPR)
- Internal Audit
- Counter Fraud
- External Audit Update
- Trust Risk Register
- Board Assurance Framework
- Evaluation of:
  - Audit Committee Effectiveness
  - External Audit Effectiveness
- Use of Waivers Q2
- Audit Committee Business Programme 2017/18
- Six monthly reports and minutes from Finance & Investment Committee and Integrated Governance Committee

The meeting was followed by a private meeting between Non-Executive Directors and the auditors.

Hertfordshire

Risk Topic – General Data Protection Regulations (GDPR)

The Committee regularly reviews specific risk areas in detail with a focus on the actions being taken by the Trust to manage/mitigate risk and to improve processes and systems in this respect. In May 2018, a new Data Protection framework in the form of the Data Protection Bill 2018 and the General Data Protection Regulations (GDPR) will replace the Data Protection Act 1998. Although in general the principles of data protection remain similar, there is greater focus on evidence-based compliance with specified requirements for transparency, more extensive rights for individuals and considerably harsher penalties for non-compliance. The key to compliance is identifying the information we hold and understanding how the information flows both internal and external to the organisation. The Audit Committee received a very comprehensive presentation from Nikki Whiter, Head of Information Governance and discussed the issues faced by the Trust and the actions to address these. Given the short deadline for GDPR compliance, the committee requested a further update at the March meeting.

Internal Audit

RSM presented the progress report on the audits within the 2017/18 plan and gave a good overview. These covered Recruitment, Patient Safety: Responding to Medical Emergencies (Resuscitation) and Safeguarding – Delegated Responsibilities. Partial assurance had been received for the three audits and the Audit Committee spent significant time considering the detail. Clear action plans were discussed in relation to addressing the findings from each audit and the Committee requested that:-

- An update on recruitment issues is brought to the next meeting
- RSM were requested to perform an unannounced follow up audit on medical equipment and report back to the next meeting; and
- A re-audit is to be undertaken as part of the 2018/19 plan, following completion of the action plan and embedding of the new procedures.

Counter Fraud

RSM highlighted progress against the completed work plan activities for Counter Fraud, noting the improvement made to the format of the Trust Induction. This now includes a 30-minute session on Counter Fraud and Bribery, which will ensure that all staff receive this important information. Audit Committee noted the Counter Fraud Benchmarking Comparison report and that this did not highlight any significant outlier issues for the Trust.

Audit Committee discussed the content of the External Audit report. Three areas of risk have been identified as potentially significant and requiring audit focus;

- The approach to Property Valuations
- The accounting treatment of Capital Expenditure
- The potential for Management Over-ride of Controls

Trust Risk Register

The Trust Risk Register was reviewed having recently been presented to IGC. Audit Committee discussed management oversight and noted that a robust discussion took place at the Executive Team meeting. The overall reflection is that the document does reflect the key risks but that the discussions need to be kept live.

Board Assurance Framework

RSM have provided some informal comment on the updated Board Assurance Framework (BAF) noting the improvements to the document in relation to the Trust's revised strategic objectives, and suggesting some areas of further improvement to work on to ensure it becomes a fully effective tool. Audit Committee noted the comments and the clear narrative regarding the current development of the BAF, recognising the challenges being faced and suggested that a Board Workshop would be helpful.

Evaluation of:

a) **Audit Committee Effectiveness**
b) **External Audit Effectiveness**

Due to software issues, the exercise will run again.

Use of Waivers Q2

Audit Committee noted the report.

Audit Committee Business Programme 2017/18

The annual business programme was reviewed.

Six monthly reports and Committee minutes

Audit Committee noted the six-monthly reports from Finance and Investment Committee and Integrated Governance Committee, and the approved minutes.

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

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

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

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	25.01.18	**Agenda Item: 16**
Subject:	Board Assurance Framework (BAF)	**For Publication:**
Author:	Jonathan Elwood, Company Secretary	**Approved by:** Jonathan Elwood, Company Secretary
Presented by:	Jonathan Elwood, Company Secretary	

Purpose of the report:

For discussion of the latest iteration of the BAF and to provide timescales for introduction of the revised Trust Risk Strategy and underlying Policies.

Action required:

Please receive the BAF and proposed revision of the risk process and associated documentation.

Summary and recommendations to the Audit Committee:

The BAF has undergone a series of updates to ensure that as a method of setting out the most important risks facing the organisation, it identifies the control framework used to manage them, shows any gaps in control and details the assurances that the Trust uses to satisfy itself that the controls are working as intended.

Each Risk, Control and Assurance line has been reviewed by the Lead Director and peer reviewed in an Executive session to ensure that the information provided in the BAF is sufficient to provide the Board with the necessary assurance.

The Trust is now reviewing the overarching Risk Strategy and Policy Documents to ensure we maintain a comprehensive, pro-active and dynamic risk management framework.

Recommendation:
Board are asked to receive the BAF and note the work in relation to reviewing and renewing the Risk Management documents

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

Summary of Implications for:

1 Finance-
2 IT-
3 Staffing-Yes, continued development of staff and engagement
4 NHS Constitution-Yes, covers the entire spectrum of the Trust's operations
5 Carbon Footprint
6 Legal – Yes as non-compliance with statutory regulations can negatively impact on the BAF

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

NO

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

Yes

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

Seen by the IGC January 2018

The Trust has a wide-ranging and pro-active approach to risk management. This is supported by an overarching Risk Strategy and a comprehensive set of policies and operational documents which sit beneath this.

The Board Assurance Framework (BAF) sits alongside the Trust Risk Register and is the principle method of setting out the most important risks facing the organisation. It sets out the control framework used to manage them, any gaps in control and how the organisation satisfies itself that the controls are working as intended. The BAF is intended to provide Trust Board with a clear and comprehensive understanding of the most important risks faced by the organisation and sets out how those risks are managed, how assurance on the operation of those controls is obtained, and enables timely consideration of assurance outcomes.

This latest version of the BAF has been reviewed by the relevant Lead Director and peer reviewed at an Executive group meeting to ensure that the controls listed are sufficient for each risk and that the assurances listed against each control do provide the necessary re-assurance stated.

The controls and assurances listed will be reviewed as part of the normal risk management process and assurance sources will continue to be reviewed at Board and its sub-committees and minuted accordingly.

The main structure of the BAF will be reviewed again as part of the overall process of renewing the overarching Trust strategy. This will enable any new or revised Trust objectives to be captured within the BAF at an early stage with any newly identified risks and refreshed controls put in place.

The overarching Risk Strategy and its and its underlying policies are due for review and renewal. The Strategy is currently being re-written and will be completed alongside the main Trust Strategy to ensure that it fits with the Trusts vision, values and incorporates the latest objectives. The policies and operational documents will be reviewed in light of the updated Risk Strategy. The intention is to create a comprehensive risk framework which will support the following aims:

- Board members will be able to focus on what drives success as well as failure.
- The BAF and risk registers will be regularly reviewed, and inform the Board's cycle of business. Risk control is viewed as vital for success and focused on the most important issues.
- The BAF will have a balance of internal and external sources of assurance.
- Gaps in control and assurance are alerted to the Board and discussed and analysed and the results are used to: (i) underpin decision making; and (ii) drive the agenda for the Board and Board committees.
- Risk registers will be reviewed at a frequency relative to the risk and minuted discussion will show evidence of challenge and accountability.
- Risk registers will reflect a balance of quality, performance, financial, external and strategic risks.
- The relationship between risk, cause and impact will be clearly understood, and there will be a clear link between cause and mitigating actions evidenced in risk registers.
- Appropriate training will be at all levels of the Trust to ensure consistent use and understanding of the risk processes..
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- There will be correlation between performance and assurance reporting to the Board, and the presentation of risk described in risk registers.
- The annual Head of Internal Audit opinion will show full assurance on the adequacy and effectiveness of risk management, control and governance processes.

A Board workshop will be held in early 2018 to update Executive and Non-Executive Directors on renewed risk processes to establish best practice and to confirm the Trust risk appetite.

IGC are asked to receive the BAF and note the work in relation to reviewing and renewing the Risk Management documents

Hertfordshire Partnership NHS
University NHS Foundation Trust

Board Assurance Framework (BAF)

17th January 2018

To be reviewed by:

- IGC January 2018
- Trust Board January 2018

Introduction

This Board Assurance Framework brings together the principal risks potentially threatening the Trust's Strategic Objectives and outlines specific control measures that the Trust has put in place to manage the identified risks and the independent assurances relied upon by the Board to demonstrate that these are operating effectively.

Explanation of Assurance types and levels

Assurance Type **-** The identified source of assurance that the Trusts receives can be broken down into a three line model (1st, 2nd and 3rd line assurances)**. The assurance type column RAG rating records the highest level available for each control**

1st Line	2nd Line	3rd Line
Assurance from the service that performs the day to day activity E.g. Reports from the department that performs the day to day activity, Departmental Meetings, Departmental Performance Information	Assurance provided from within the Trust - Internal assurance E.g. Management Dashboards, Monthly monitoring	Assurance provided from outside the Trust - Independent assurance E.g. Internal Audit, External Audit, Peer Review, External Inspection, Independent Benchmarking

Assurance Level - For each source of assurance that is identified you can rate what it tells you about the effectiveness of the controls

High	Medium	Low
One or more of the listed assurance sources identify that effective controls are in place and the Trust Board 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	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
What the Trust aims to deliver on the next phase of the Good to Great journey	**Principal risks are** those that threaten the achievement of the Trusts strategic objectives. There is a risk that…	The Trust should ensure that **key controls are** in place which is designed to manage the principal risks.	What sources of assurance are there? **[It is essential that minutes of Board and Sub-committees that review assurances, contain a clear reference to the quality and level of assurance received.]**	It is essential that Board and Board sub committees receive regular reports about the assurances on the management of their principal risks and are proactive in addressing issues that arise.	The assurances that the Trust receives can be broken down into a three line model	Each source of assurance that is identified you can rate what it tells you about the effectiveness of the controls	The date of the assurance	There is a lack of assurance about the effectiveness of one or more of the key controls. This may be as a result of lack of relevant reviews, concerns about scope, depth of reviews that take place or the length of time since the last review.	The Executive Director Responsible for managing the Risk [& the Principle Board Sub-Committee]
Good to Great Strategy (Great Care, Great Outcomes) [Positive Experience, Effective, Safe]									
1. The safety of our services will improve so that more people feel safe and are protected from avoidable harm	**Service users are not able to progress positively through our services, feel safe and be protected from avoidable harm** - **Service users on acute wards do not report feeling safe** - **Failure to reduce the number of**	Suicide Prevention Strategy	Suicide Prevention Reports included in Patient Safety Reports	Executive Committee IGC Trust Board	2nd Line	High	29.11.17		Director of Quality & Safety [IGC]
		Review of all Serious Incidents [Details sent to CQC for review]	Serious Incident Briefing Report. Weekly	Executive Committee CCGs IGC Trust Board	3rd Line	High	Weekly Quarterly 13.12.17		
		Performance Monitoring Processes	SBU Quality Report Quality Dashboard Performance Review	QRMC Executive Committee	2nd Line	High	09.10.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
	suicides		Process Practice Governance Audit Operational Services Update Quarterly Performance Report Safe and Effective / Friends and Family Test	IGC Trust Board			14.12.17 29.11.17		
		Safer Care and Standards Processes	CQC MHA Inspections	Mental Health Act Quality Managers Meeting. IGC	3rd Line	High	Bi - Annually		
			Quarterly & Annual Patient Safety Reports	QRMC Executive Committee IGC Trust Board CCG QRM	2nd Line	High	27.09.17 13.09.17 23.05.17 14.12.17 29.11.17		
			Externally Commissioned Quality Visits Latest completed December 2017, 2 currently in progress	SBU Quality and Risk Committee QRMC [If issues raised then - Executive Committee IGC]	2nd Line	High	27.09.17		
			HPFT Quality Visits Quality Visit Report – Part of Performance Report	Executive Committee IGC Trust Board	2nd Line	High	29.11.17		
			Integrated Health and Care Commissioning Team (IHCCT) Quality Assurance Visit Programme	CCG Quality Review Meetings IGC	3rd Line	High	24.07.17 13.09.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
		Quality Account Processes	Quality Account 16 - 17 (Externally Audited) Published alongside annual report Included in Q1 Performance Report annually	Executive Committee IGC Trust Board External Audit	3rd Line	High	18.04.17 24.05.17 24.05.17		
		CQUIN Processes	CQUIN Reports – Part of quarterly Performance Report CQUIN results for Q1 were all delivered to commissioner satisfaction	Executive Committee IGC Trust Board CCGQRM	2st Line	High	09.10.17 29.11.17 25.09.17		
		Safer Care and Standards Processes	Freedom to Speak up – 6 monthly review	Speak Up IGC Annual Report 2016 - 2017	2nd Line	High	08.06.17		
			Concerns raised with the Trust via the CQC (CQC Concerns) - 6 Monthly review	IGC (Part of the Speak Up IGC Annual Report 2016 – 2017) Trust Board	2nd Line	High	08.06.17 29.11.17		
			Externally Commissioned McCallion Report on SI processes	Executive Committee IGC Trust Board CCG QRM	3rd Line	High	08.06.17 24.07.17		
			Internal Audit Reviews Risk Management Processes	Audit Committee	3rd Line	Medium	21.09.17		
			Health, Safety and Security Report (Annual Report)	HSSC QRMC IGC	2nd Line	High	09.10.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
			Emergency Planning and Business Continuity EPRR Core Standards compliance – CCG & NHSE approval Emergency preparedness, Resilience and Response Annual Report	Executive Committee IGC Trust Board	2nd Line	High	09.10.17 27.09.17		
		MOSS Strategy	Annual Report	HSCC QRMC IGC	2nd Line	High	14.07.17 09.10.17		
	The fundamentals of care are not delivered consistently across all our services	National Quality Board (NQB) Staffing Report	Quarterly Safe Staffing Levels report	QRMC Executive Committee IGC Trust Board	2nd Line	High	08.06.17 25.09.17		Director of Quality and Medical Leadership [IGC]
		HR Processes	Trust performance KPI report on Workforce Workforce and OD Report Pulse Survey Report (Q) – Part of the Workforce & Organisational Development Report Good to Great Road Shows, Big Listen and Local Listen.	Executive Committee WODG IGC Trust Board	2nd Line	High	08.06.17 09.10.17 29.11.17		
		External Systems for Staff Feedback	National Staff Survey 2016 Report on Key Findings	Executive Committee WODG IGC Trust Board	2nd Line	High	08.06.17		
		Annual Programme of Clinical Audit (Practice Audit and Clinical Effectiveness)	Annual Audit Programme	Executive Committee IGC	3rd Line	High	08.06.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
				Trust Board CCG QRM			24.07.17		
		Medicines Management (Safe and Secure handling of medicines)	Pharmacy and Medicines Optimisation Annual Report Safe and Secure Handling of Medicines Audits Quarterly	Executive Committee IGC Trust Board CRLLG	2nd Line	High	13.07.17 06.09.17 27.07.17		
		NICE Guidance Policy	NICE Progress Reports	QRMC Executive Committee IGC	2nd Line	Medium	25.09.17 09.10.17		
2. The Quality and Service Development Strategy will deliver a better experience of services and improved outcomes	**Service users unable to access the right services in a timely way** - **Service users will not experience timely access to adult community services** - **Service users will not experience timely access to CAMH services – CHOICE and partnership** - **Inpatient admissions for young people are not reduced**	Performance Monitoring Processes	Trust Performance KPI report – Access Times. Re-admission rates. Performance Review Process Live Data Performance Dashboards Performance Audit Internal & External Audit	Executive Committee TMG Trust Board SBU Core Management PRM Contract review meetings Internal & External Audit	2nd Line	High	27.09.17		Director of Service Delivery and Customer Experience [IGC]
		Performance Monitoring Processes PRM	Trust Performance KPI report – recovery & outcome metrics Performance Review Process Live Data Performance Dashboards Performance Audit Internal & External Audit	Executive Committee TMG Trust Board SBU Core Management PRM Contract review meetings Internal & External Audit	2nd Line	High	29.11.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
		Quality Impact Assessments Procedure for CRES	Individual Quality Impact Assessments	IGC QRMC CRES PAB and Trust Executive Committee	2nd Line	High	13.05.17 25.09.17		
		Service User Feedback	Community Mental Health Survey Compliments, Complaints and HYS feedback Peer listening reports and feedback	QRMC Executive Committee IGC Trust Board	2nd Line	High	13.01.17 26.01.17 08.06.17		
		Carers Pathway Development	Carer Pathway report	QRMC	2nd Line	High	20.06.17		
3. Better health monitoring and support to address health risk factors is delivered and the wellbeing and physical health of service users will improve	- **Service users will not report physical health care needs being met**	Physical Health Strategy Action Plan	CQUIN achieved and agreed with commissioners quarterly SBU Physical Health Leads	TMG ORMC Trust Board Physical Health Committee	2st Line	High	29.11.17 25.09.17		Director of Service Delivery and Customer Experience [IGC]
		Physical Health data collection PARIS –	Quarterly Performance Reports Development of bespoke reporting PACE Reporting	Physical Health Care Committee TMG	1st Line	Medium	October 17		
		Physical Health Strategy – measures against outcomes –	Annual Report Community Health Services Survey POM UK Audits	Physical Health Care Committee Executive Committee IGC	1st Line	Medium	July 17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
			PACE Audits Service User Feedback	Trust Board					
Good to Great Strategy – Great People [People have right skills and values, Leaders who involve and empower, a workplace where people grow, thrive and succeed.]									
4. A culture of collective leadership is developed and a more empowered and engaged workforce is created	**Staff do not report feeling engaged and motivated and do not recommend the Trust as a place to work** - **Staff do not report improved satisfaction with level of responsibility and involvement** - **Staff do not report increased support from immediate managers** - **Staff do not report an increase in recognition and value by managers and the organisation**	Multi Professional Quality Improvement Performance Framework (QIPF)	QIPF Quality Performance and Review Update Paper (Action Plan)	IGC	2nd Line	High	08.06.17		Director of Workforce and OD [IGC]
		Workforce Health and Wellbeing Strategy Action Plan	Workforce and Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	29.11.17		
		Health and Wellbeing CQUIN Action Plan	Quarterly Report	Executive Committee WODG IGC Trust Board	2nd Line	High	29.11.17		
		Systems for Staff Feedback As defined in the Engagement & OD Strategies	Pulse Survey Report– Part of the Workforce & Organisational Development Report Good to Great Road Shows, Big Listen and Local Listen.	Executive Committee WODG IGC Trust Board	2nd Line	High	29.11.17		
		External Systems for Staff Feedback	National Staff Survey 2016 Report on Key Findings	Executive Committee WODG IGC Trust Board	2nd Line	High	08.06.17		
		Harassment and Bullying Plan	Workforce and OD Report	Executive Committee WODG IGC Trust Board	2nd Line	High	29.11.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
		Appraisal / PDP Reward and Recognition Processes	Statutory & Mandatory Training Report Monthly Inspire and annual awards Quarterly Workforce and Organisational Development KPI Report (to services monthly)	Executive Committee WODG IGC Trust Board	2nd Line	High	13.07.17 29.11.17		
		Mandatory Training Programme							
5. Our leadership base is developed and the capabilities and capacity required to deliver our plans is strengthened	**Leaders across the organisation do not receive appropriate training and support on improvement approaches and tools** - **Failure of staff to develop strong core competencies**	Organisational Development Plan	Workforce and Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	29.11.17		Director of Workforce and OD [IGC]
		Continual Professional Development (CPD)	CPD report for the non-medical 2017/2018 commissioning year	WODG IGC	2nd Line	High			
		Staff Feedback systems	Pulse Survey Report– Part of the Workforce & Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	29.11.17		
			National Staff Survey 2016 Report on Key Findings	Executive Committee WODG IGC Trust Board	2nd Line	High	08.06.17		
	Strong clinical leadership of key service changes is not evident	Clinical Leadership Structures in place	Quality Impact Assessments	MSC IGC Trust Board					Director of Quality and Medical Leadership [IGC]
		External review of Trust Governance arrangements every three years	Independent Well Led Review Update	Executive Committee IGC Trust Board	2nd Line	High	08.06.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
		Academic links in place with University of Hertfordshire Clinicians Leading Innovations Group		University of Hertfordshire strategic Management Group	2nd Line	Medium	10.11.17		
		Systems for Staff Feedback As defined in the Engagement strategy & the OD Strategy.	Pulse Survey Report – Part of the Workforce & Organisational Development Report	Trust Board	2nd Line	High	29.11.17		
		External Systems for Staff Feedback	National Staff Survey 2016 Report on Key Findings	IGC	2nd Line	High	08.06.17		
6. New roles are developed, staff turnover reduces and there is a reduction in reliance on temporary staffing	**New roles are not created which support the clinical model.**	Recruitment and Retention Strategy and Policy	Quarterly Recruitment and Retention Report	Executive Committee WODG IGC Trust Board	2nd Line	High	13.07.17		Director of Workforce and OD [IGC]
	Turnover and vacancy rates are not reduced	Recruitment and Retention Strategy and Policy. Ongoing Development of Workforce plans.	Quarterly Workforce and Organisational Development Report (to services Monthly)	Executive Committee WODG IGC Trust Board	2nd Line	High	29.11.17		
		Agency Reduction Action Plan	CRES Programme Assurance Board reports	Executive Committee FIC Trust Board	2nd Line	High	14.07.17		
	Recruitment and retention plans are not robust and do not support increased flexible working	Recruitment and Retention Strategy and Policy	Recruitment and Retention Group Reports	WODG Executive Committee IGC Trust Board	2nd Line	High	09.10.17 29.11.17		
Good to Great Strategy (Great Organisation) [Always getting fundamentals right, Always learning, innovating and improving.]									
7. Staff and teams	**Staff will not have an**	Digital Strategy Action Plan	National Staff Survey	Executive	3rd Line	High	08.06.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
will have better access to the right information and tools to do their jobs effectively and efficiently	**improved experience of our EPR and Business Intelligence systems**		2016 Report on Key Findings	Committee WODG IGC Trust Board					Director of Innovation and Transformation [IGC]
			Pulse Survey Report– Part of the Workforce & Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	29.11.17		
			PARIS/BI Development Group – progress reports IM&T Strategy External review	IM&T Strategy Board Executive Committee IGC	2nd Line	High	09.10.17		
		Strategic Investment Programme	Report from Finance & Investment	Trust Board	2nd Line	High	29.11.17		
	The quality and recording of data does not improve	Clinical Recording Assessment Framework	Progress reports against project plan	IM&T Strategy Board	1st Line	High	27.11.17		
		Monitor, validate and audit data quality against standards	Accurate Information Group	IM&T Strategy Board MSC Executive Committee	1st Line	Medium	Sept 2017		
		Performance Monitoring Processes	Quality Dashboard Performance Review Process Operational Services Report Quarterly Performance Report Trust Performance KPI report	Executive Committee IGC Trust Board	2nd Line	High	29.11.17		
	Failure to maintain a sustainable financial position that supports investment and the	Annual Operational & Financial Plan Strategic Investment Programme	Financial summary report monitoring performance against plan including Overall NHSI Use of	Executive Committee Trust Board FIC	2nd Line	High	13.12.17		Director of Finance

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
	continuity of services		Resources Risk Rating Progress report on delivery of Strategic Investment Programme	Audit Committee Modernising our Estate Board Executive Committee FIC			10.10.17		[FIC or Audit]
		External Audit	Annual Governance Statement Annual Financial Statements	Trust Board Audit Committee	3rd Line	High	27.05.17 27.05.17		
		Cash Releasing Efficiency Programme	Part of Financial Summary Report CRES Programme Assurance Board	Executive Team FIC Trust Board Trust Management Group	2nd Line	High	13.12.17		
		Hertfordshire and West Essex Sustainability and Transformation Plan (STP) Trust Contracts	Update reports CEO Brief STP Report Contract Update Report	Trust Board FIC	2nd Line	High	13.12.17 10.10.17		
8. Staff will be supported and empowered to improve, innovate and become more productive in delivering great care	**Innovative productive ways of working are not embedded**	Organisational Development Plan – High Level Deliverables	Workforce and Organisational Development Report	Executive Committee WODG IGC	2nd Line	High	29.11.17		Director of Innovation and Transformation [FIC or IGC]
		Single Oversight Framework Requirements	Use of Resources Metrics	Executive Committee FIC Trust Board	2nd Line	High	14.07.17 29.11.17		

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
	Technology to support new ways of working is not used effectively	Productivity Monitoring Processes	Financial summary report Annual Accounts Finance Reports CRES Programme Assurance Board Trust Performance KPI report	Executive Committee FIC Trust Board	2nd Line	High	27.09.17 14.07.17 29.11.17		
	The Safe Care tool is not successfully rolled out across services such that resource utilisation is not enhanced	National Quality Board (NQB) Processes	Safe Staffing Levels report Quarterly & Annual Reports	QRMC Executive Committee IGC Trust Board	2nd Line	High	08.06.17 25.09.17		
		Productivity Monitoring Processes	Financial summary report Annual Accounts Finance Reports CRES Programme Assurance Board Trust Performance KPI report	Executive Committee FIC Trust Board	2nd Line	Medium	14.07.17		
		Single Oversight Framework Requirements	Use of Resources Metrics	Executive Committee FIC Trust Board	2nd Line	Medium	14.07.17 29.11.17		
Good to Great Strategy (Great Networks & Partnerships) [Leading networks to deliver great joined-up care, Building great relationships and partnerships to meet whole persons needs]									
9. We will deliver more joined up services across mental health, physical health and primary care.	**Failure to work in partnership to deliver support and treatment that is joined up across mental health, physical health and social care services** - **Key integration**	Carers Pathway	Carer Pathway update	QRMC	2nd Line	High	13.01.17 20.06.17		Director of Strategy and Integration [FIC or IGC]
		5 Year FV Delivery Plan	STP Participation Provider Collaborative Individual Strategy Groups Integrated Care development Group	Executive Committee FIC Trust Board					

Strategic Objective	Principal Risk	Risk Controls	Assurance Source	Reported to	Assurance Type	Assurance Level	Assurance Date	Gaps in Assurance / Actions	Executive Lead
	projects will not be delivered - **Failure to work jointly with GPs and GP Federations** - **Service users and staff unable to report improved experience of referral and discharge pathways**								
		Performance Monitoring Processes	Performance Report	FIC Trust Board			14.07.17 29.11.17		
		Staff Feedback	Pulse Survey Report – Part of the Workforce & Organisational Development Report	Executive Committee WODG IGC Trust Board	2nd Line	High	29.11.17		
		Service User Feedback	Having Your Say	IGC QRMC Trust Board			08.06.17 25.09.17 29.11.17		
		Physical Health Strategy Action Plan	Physical Health Committee	QRMC	2nd Line	High?	25.09.17		
		Continuously engage with commissioners, DH, NHSI, review / reflect on intelligence amending plans in year as necessary	Clinical Commissioning Group	CCG QRM	3rd Line	High	25.09.17		
		Engagement Policy	Service User Council/Carer Council	Involvement & Experience Group	2nd Line	High	Nov 2017		
10. We will be recognised as system leaders having successfully driven and delivered on key system priorities.	**Improving MH & LD services fails to become central to local health and social care economy plans**	STP Leadership of MH and LD streams Locality Board membership	STP progress reports Reports to Integrated Care Development Group, Trust Management Group	Trust Strategy Group Executive Committee Trust Board	2nd Line	Medium	Weekly		Director of Strategy and Integration
	HPFT/HCT Strategic Alliance fails to drive and deliver key system priorities	Commercial Strategy action plan Strong relationships with all Key Stakeholders to drive and deliver key priorities	Relationship progress reports	Trust Strategy Group Executive Committee Trust Board	2nd Line	Medium	29.11.17		
		CCG Commissioning Intentions. Annual Plan	Quarterly reports	Executive Committee Trust Board	2nd Line	Medium	Annual 29.11.17		

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	25.01.2018	**Agenda Item:** tbc
Subject:	Trust Risk Register January 2018	**For Publication: Yes**
Author:	Nick Egginton, Compliance & Risk Manager	**Approved by:** Dr Jane Padmore, Executive Director of Quality and Safety
Presented by:	Dr Jane Padmore, Executive Director of Quality and Safety	

Purpose of the report:

The current Trust Risk Register (TRR)

Action required:

For information

Summary and recommendations:

1. Introduction / Background

The Trust Risk Register (TRR) outlines the high level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them. This reiteration of the Trust Risk Register was last presented at the Integrated Governance Committee on 18.01.2018 and contains those risks scoring 12 or above. These plus the 3 scoring below 12 were presented for discussion. Further work to refine the narrative update against each risk will take place over the next two weeks.

2. Escalated Risks to Trust Risk Register

None

3. Risks downgraded from Trust Risk Register or to be considered for downgrading

None

4. Risk scores increased

None

5. Risk scores decreased or to be considered for decreasing

None

6. Updates

Risk ID 861 The Trust fails to deliver safe services at the Broadland Clinic

The Trust continues to formally update the Broadland Clinic CQC action plan and shares this weekly with the CQC, a verbal update was provided at the recent CQC engagement meeting which was held on Monday 8th January 2018. Actions are on target to be completed by the end of January 2018 with the exception of a few actions which exceed the timeframe due to the estates work is out to tender. The CQC are aware of these actions with extended timeframes. The IGC received a report on 18th January 2018 giving an update on progress against the action plan.

7. Risks under consideration
Following the very recent well publicised issues in relation to Carillion, the position of the Trust's TFM provider and associated risks, Interserve, is under consideration.

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

Risks linked to Board Assurance Framework

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

There are no budgetary or financial implications in the TRR 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:

CQC Regulation 17 Good Governance
CQC Key Line of Enquiry; Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?

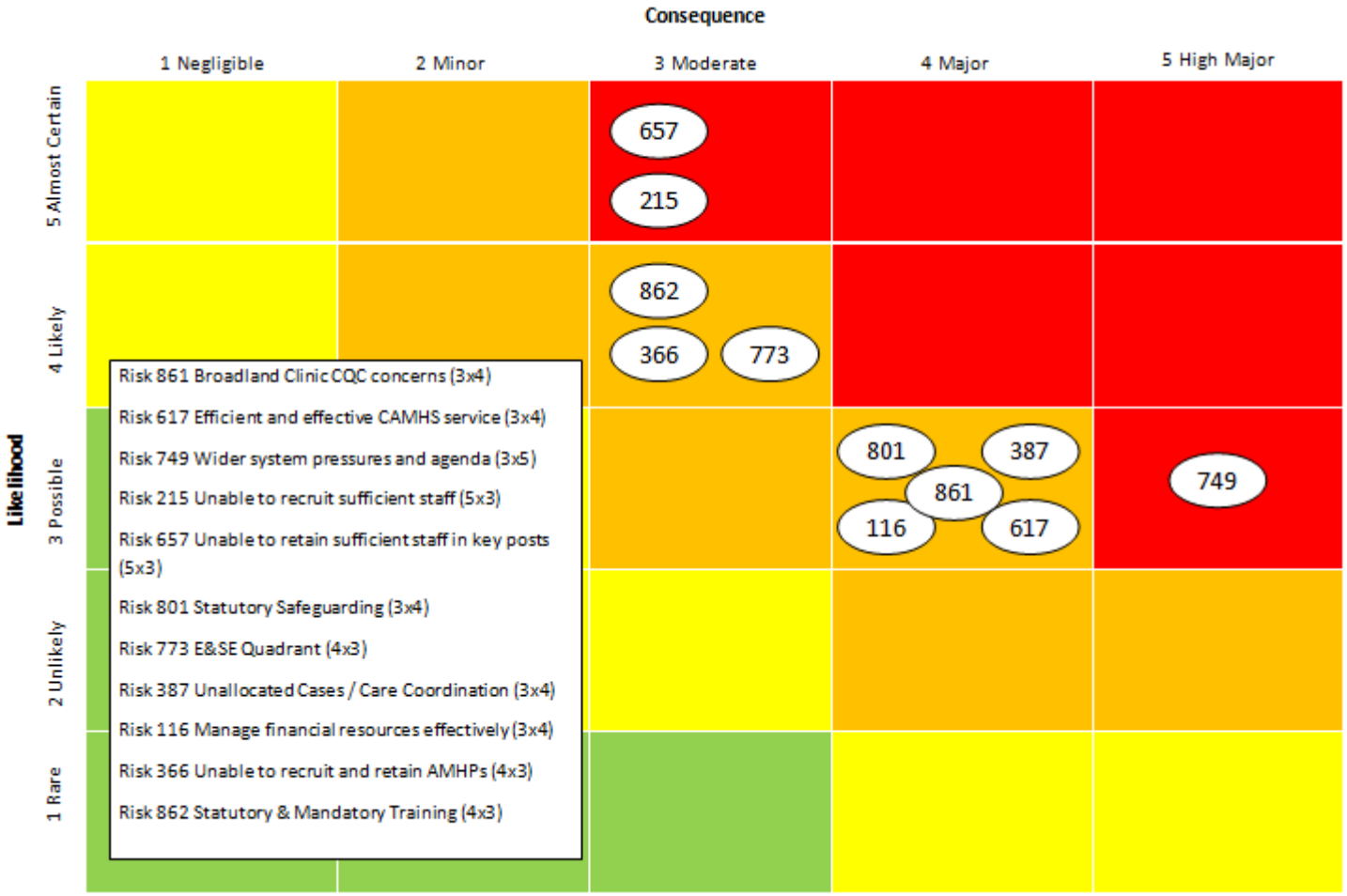
Seen by the following committee(s) on date:
Finance & Investment/Integrated Governance/Executive/Remuneration/Board/Audit

Exec 10.01.2018
IGC 18.01.2018
Trust Board 25.01.2018

Appendix 1 Trust Risk Register by Exec Lead and linked to Trust Strategic Objectives

	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Executive Lead
1	749	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT	20	15	10	Mental health and learning disability will be given the same emphasis as physical health in local care planning and delivery	Karen Taylor
2	215	The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	15	15	6	We will be seen as an employer of choice where people grow, thrive and succeed	Jinjer Kandola
3	657	The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	15	15	6	Our staff will report feeling engaged and motivated, and recommend the Trust as a place to work	Jinjer Kandola
4	861	The Trust fails to deliver safe services at the Broadland Clinic	20	12	8	Staff will report that they are able to deliver safe and effective services	Jane Padmore
5	617	Failure to provide an efficient and effective community CAMHS service which impacts on the clinical care provided to young people	16	12	6	Staff will report that they are able to deliver safe and effective services	Jess Lievesley
6	801	The Trust's statutory safeguarding delegated responsibilities not consistently and effectively undertaken placing service users at risk	16	12	6	Staff will report that they are able to deliver safe and effective services	Jane Padmore
7	773	Failure to respond effectively to increasing demand resulting in a risk to safety, quality and effectiveness	12	12	6	Staff will report that they are able to deliver safe and effective services	Jess Lievesley
8	387	Management of demand and capacity for those individuals pending care coordination allocation	16	12	6	Staff will report that they are able to deliver safe and effective services	Jess Lievesley
9	116	The Trust may not have sufficient resources to ensure short term and long term financial stability	16	12	6	We will make effective use of people's time and the money we have to deliver on the outcomes that matter to those we serve	Keith Loveman
10	366	To ensure sufficient AMHP coverage is in place to meet county requirements	12	12	6	Our staff will report feeling engaged and motivated, and recommend the Trust as a place to work	Jess Lievesley
11	862	Statutory and Mandatory Training Compliance	12	12	6	Staff will report that they are able to deliver safe and effective services	Jinjer Kandola

Appendix 2 Trust Risk Register Matrix



Trust Risk Register
January 2018

To be reviewed by:

Executive Team
10.01.2018

Integrated Governance Committee:
18.01.2018

Trust Board: 25.01.2018

Audit Committee:

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

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
749	02/02/2017	The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT	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	20	Regular review of position by the Executive, Strategy Committee and Board Active monitoring and intervention by Council of Governors Strong leadership roles for key staff within local STP On-going regular dialogue with commissioners 5 Work streams with STP including Mental Health which HPFT chairs Member of the West Herts Provider Collaborative – all providers in Herts Valleys working together on key pathways/development of new models in West Herts	15	10	De-emphasis within commissioning intentions Parity of esteem agenda not honoured within contract negotiations or lack of commitment. Mental Health is represented on every locality delivery group along with commissioners; the early warning would be if Mental health is not making it onto the agenda for these meetings. Due to financial pressures the Trust does not see a demography increase and / or usual commitments aren't delivered by CCG's by Dec 2017.	The local STP includes a commitment to delivering on parity of esteem, as well as implementation of the 5YFV mental health implementation plan and transforming care agenda for people with a learning disability The most recent contract negotiations with our main commissioners has concluded with East & North CCG fully honouring its parity of esteem funding commitment , but Herts Valley CCG financial position remains challenging with the CCG revisiting its commitments within all providers across the local health economy (including RAID and FEP services). It is anticipated that this situation remains the same as we enter contract discussions for 2018-19. Mental health and learning disability issues continue to have a strong profile nationally as well as locally through the work of HPFT leaders and partners within the STP and the Alliance with HCT. STP wide Mental Health & LD working group established to provide greater emphasis and oversight of MH investment and developments across STP. Chaired by Dir. Strategy HPFT, with representation Medical director & Dir. Delivery Meetings planned with all GP Localities and Federations started during August and September with CEO/ Director of Strategy, will continue during the remainder of the year.	Karen Taylor (Director of Strategy & Integration)	22/02/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
			from mental health and learning disability services								

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
215	16/10/2014	The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	Risk to Patient Safety, Quality, Staff Morale and Financial Risk. Recruitment There is a risk that the organisation is not able to recruit and select the best staff and that timely recruitment to vacancies does not occur leading to increased operational pressures and a reduction in quality of care	15	SBU review regular data – HR Performance Dashboards / HPFT Workforce Information Report Summary HR systems maintained to enable accurate establishment and vacancy information to be accessed at all times Recruitment and Retention Group	15	6	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	Recruitment hotspots remain in band 5 and 6 nursing posts. Recruitment to nursing positions in specialist areas such as CAMHS services continue to be very challenging due to the shortfall of skilled staff nationally and the competitiveness in the market. Establishment over the past 12 months has increased due to First Episode Psychosis service, increasing IAPT and Acute Inpatient establishments and more recently Perinatal community services. The Trust continues to benchmark its data against local trusts. The Recruitment and Retention Group continues to meet on a monthly basis to address the issues arising from their respective areas in relation to generating ideas to deal with hot spots areas and hard to fill posts. Each SBU has developed a local recruitment and retention plan for their areas which is currently being reviewed. The local SBU recruitment and retention plans include succession planning, putting in place career pathways in order to encourage retention, and reviewing current job descriptions in order to create some new ways of working. Work continues to encourage agency workers to work for the Trust in a substantive post or on the bank. The vacancy rate has reduced by 0.68% from 14.30% to 13.62% in October. The Recruitment Day on the 23 September 2017 generated a good response from qualified and unqualified applicants. There were 39 potential candidates on the day resulting in 36 conditional offers being made on the day. The Trust attended the Health Sector Jobs Fair in Birmingham on Saturday the 30th September 2017. Operational managers and members of the recruitment and medical staffing team generated 51 expressions of interest to work at HPFT. All the potential candidates have been followed up individually and via email in order to support and encourage them to apply and gain employment within the Trust including the learning disability student nurses who have been contacted to arrange interviews to take place in Birmingham at the end of November.	Jinjer Kandola (Director of Workforce & Organisational Development, Deputy CE)	14/02/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
									The Trust has received funding from Health Education England for the MSC Nurse Training for Mental Health. 4 internal staff have been seconded to undertake this nurse training with a further 6 students from the University of Hertfordshire who will undertake their placement with a view of securing employment with the Trust at the end of their two year MSC nurse training programme. The programme commenced on the 18 September 2017. The annual recruitment activity plan has been reviewed adding forth coming events and recruitment days in November 2017, January 2018, March 2018, June 2018 and September 2018 . A task and finish group has been set up to focus on the junior doctor gap for 2018. This has recently been reduced from 24 to 14. Social media advertising is being trialled including advertising on various social media platforms, job boards and targeted advertising as well as regular posting on the Trust Facebook , twitter accounts, Linked in and the Trust Career site.		

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
657	30/06/2016	The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	Risk to Patient Safety, Quality, Staff Morale and Financial Risk Retention There is a risk that a higher number of existing staff choose to exit the organisation due to high workloads and a perceived lack of career pathways leading to increased and unplanned vacancies and a drain of knowledge and experience from the organisation.	15	SBU review data - HR performance dashboards / HPFT Workforce Information Report Summary HR systems maintained to enable accurate turnover vacancy information to be accessed at all times OD plan for Talent and succession planning Recruitment and Retention Group	15	6	Increased banks / agency costs High turnover / Reduced Stability Index Exit interview feedback Lack of quality PDPs, inconsistent and ad hoc supervision	There are currently 366 staff aged 55-59 who are eligible to retire on a full pension, the Trust is working to mitigate this risk with flexible retirement plans and new roles enabling staff to return to work to the Trust following retirement. High risk areas include LD Herts and Bucks, there is an equal spread across East and North SBU between 25-33 staff per service, in West SBU this is heavily weighted towards Acute 24/7 services. Next steps include: - Local ownership for Retention - Retention Workshops to be implemented / Review healthy turnover - Buddying of Team Leaders to share good practice - Support for Line Managers to deliver meaningful PDP's and talent management conversations - Introduction of Staff Ambassadors, videos and blogs - Undertake Stay Surveys - Two active cohorts of Managing Service Excellence - Three active Cohorts of the Mary Seacole Programme (joint initiative with NHS Leadership Academy, WHHT, E&N NHS Trust and HCT) The Trust continues to be involved in retention workshops with NHS Employers and has commenced on a piece of work regarding retention with NHS Improvement. In addition, the Trust also continues to be involved in a scheme of widening participation and strengthening domestic supply with NHS Employers. New Coaching Skills for Leaders Development Programme - Proposal that the trust invests in a programme of workforce development targeted at Tier 2 and Tier 3 leaders initially, but rolled out across all people managers over time. Delivery against the activity in the OD Strategy has continued in Q2. A significant amount of engagement activity continued in Q2 including the Big Listen, Local Listens, Senior Leaders Forums and a number of health and wellbeing initiatives. A significant amount of work is being undertaken to support long term sick employees back to work and to address short term sickness absence which is having a positive effect. There were 130 leavers during Q2 which is higher (by 41) than Q1. This is the second quarter where nursing & midwifery staff	Jinjer Kandola (Director of Workforce & Organisational Development, Deputy CE)	14/02/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
									had more leavers than starters. Analysis of the reasons for leaving in Q2 showed that the highest reasons given were relocation, work-life balance and promotion which are the same reasons as last quarter. This indicates that there is a need to focus efforts on flexible working, as well as career and succession planning. Some of these activities have been embedded into the SBU retention plans. The turnover rate has reduced slightly this quarter from 13.6 % in the last quarter to 13.14%. Work continues to be undertaken to address turnover and all SBU's have localised retention plans. The Trust is also working with NHSI with regards to retention. The trust met with NHSI on the 24th October to discuss recruitment and retention plan as part of the NHSI retention support programme. The R&R plan is to be finalised and submitted to NHSI.		

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
861	06/11/2017	The Trust fails to deliver safe services at the Broadland Clinic.	The risks are: - The seclusion environment will enable the safe provision of seclusion practice - The Restraint Practice will not be delivered in line with the policy and best practice - Risk Assessments are not updated regularly and using an appropriate tool, leading the risks not being managed effectively. - Ligature points management are not managed effectively and environmental risks are not managed in a way that keep service users and staff safe - Staffing are not receiving regular Supervision that supports safe practice	20	Care plans monitored weekly in relation to the management of violence and aggression Ongoing presence of Clinical Team Leaders and Charge Nurses in handovers with Modern Matron and Service Line Lead presence on a regular basis within handovers The Head of Nursing to spend the day at the Broadland Clinic on at least a monthly basis Enhanced review of all RIDDOR reportable incidents relating to violence and aggression Medication care plans in place for those on Clozapine Broadland Clinic closed to new admissions Refresher training in relation to undertaking seclusion following requirements of the MH Act. Review of safe staffing data to be undertaken	12	8	Increase in the following: - unfilled shifts for RN's, HCA's and other registered professional - safeguarding incidents - staff injuries/RIDDORS - number of incidents involving physical restraint by ward	The Trust was issued with a possible section 31 urgent enforcement letter of intent to which the Trust responded to with an action plan that addressed the issues raised in the letter. On the 1st November the CQC issued the Trust with a formal warning notice (section 29a) in relation to the quality of care provided at the Broadland Clinic requiring significant improvement by 31st January 2018. The action plan which was in place for the possible section 31 has been reviewed against the actions required in the section 29a letter. It is reviewed weekly by the Exec team and submitted to the CQC on a weekly basis. Progress against the action plan includes: - Plans to build a new seclusion room (Capital funding has been identified) - Lighting and heating improvements to be included in the refurbishment works planned to be completed by Jan 2018. - Commissioning of an independent review of restraint techniques - Implementation of a short term assessment of Risk and Treatability, a concise clinical guide to the assessment of short term risk for violence and treatability. - Refurbishment of the area beyond the airlock to address any significant ligature issues. - Scoped and costed CCTV installation - Strengthened registered nurse presence - Strengthened supervision and leadership arrangements There is regular contact between the CQC relationship manager and the Executive Director of Quality and Safety in relation to progress against the action plan. The CQC have said they are pleased with the progress being made, the openness of the Trust and do not have any concerns in relation to progress.	Jane Padmore(Director Quality & Safety)	20/02/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
					weekly An increase in RNs per shift has been put in place. Internal quality assurance visits						

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
617	21/04/2016	Failure to provide an efficient and effective CAMHS service which impacts on the clinical care provided to young people.	Increasing level of demand on the CAMHS Service Increasing complexity of cases presenting to the CAMHS service High vacancy rates with specific teams CATT interface with Acute services CAMHS leadership cohesion needs to be strengthened to ensure clear lines of accountability and responsibility for service delivery and clinical professional standards.	16	Weekly performance reports and weekly management review HR Dashboards / HPFT Workforce Information Report Summary CAMHS leadership support team in place which includes CAMHS Consultant Lead, Interim Head of Recovery and Psychological Services, Deputy Head of Nursing and Quality and Interim Service Lead. Service Improvement plan Access Recovery Plan including weekly trajectories and quadrant level plans for recovery	12	6	Increasing complaints Increase severity / number of incidents Increased waiting times (Choice and Partnership) Increase in staff vacancy rates / caseloads Increase in CCATT A&E response times Clinical variation in access times across quadrants	Performance Choice waits are back on target above 95% since September. Weekly performance calls with SPA team continue and close working relationship now in place. Service Model Work on the CAMHS service model was completed by service wide QLT, clinical groups are being piloted and will be reviewed by the end of quarter 4 2017/2018. Tier 4 mobilisation project plan in place, recruitment for DBT and HTT in progress. All out of area T4 placements are being reviewed, weekly conference call with NHS England case manager taking place in preparation of handover date 4 Dec. Accommodation for HTT confirmed as Forest House and DBT team clinical and team accommodation still under discussion. Leadership CAMHS SLT OD sessions with Sandy Haslow nearing completion final session Jan 18 and established service wide QLT bringing together all 4 Quadrant teams as one now meeting bi-monthly. CAMHS Transformation lead appointed to commence early 2018 Recruitment All budgets reviewed, cost pressures accounted for in Quadrant teams and all vacant posts out to advert. Number of overall vacancies have reduced with newly recruited staff either in post or coming into post and some agency staff converted to permanent. High Risk Pathway Successfully recruited to the Watford Post. Lister post out to advert for the second time. FHAU Environment / Ligatures There has been an increase in attempted non-anchor ligatures. Forest House have reviewed the prohibited items and added earphones to this list, which reduced the number for a period of time, needs to be sustained.	Jess Lievesley (Director Of Service Delivery and Service User Experience)	30/03/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
801	16/06/2017	Statutory safeguarding delegated responsibilities are not consistently and effectively undertaken placing service users at risk	Patient safety risk: Risk to the identified 'person at risk' and other adults at risk. Safeguarding referrals raised about abuse and neglect have not been consistently been followed up or there is a lack of evidence to support actions taken to mitigate risk and safeguard the individual. Wider risks to other people have not consistently been considered or appropriately followed up. Serious Concerns process has commenced in relation to Hertsmere Community Mental Health Service (Borehamwood Adult Community Team) Contractual	16	Continued implementation of Serious Concerns action plan, sits in addition to the Safeguarding Improvement plan Serious Concerns Oversight Group, chaired by Exec Director Quality and Safety. Report to Partnership Operations Group (POG) and HCC chaired Serious concerns panel. SPIKE provides a management system for oversight of open safeguarding cases. Case by case review and RAG rating of all open safeguarding referrals, taking remedial action where necessary and appropriate. These are being done in conjunction with HCC and held centrally by corporate safeguarding to provide consistent and objective assurance. Case by case review of all cases closed within the last 12 months, ensuring the person at risk is safe and re-opening if there is an identified risk.	12	6	SPIKE flagging system Results from monthly and quarterly case audits Safeguarding live tracking via Datix	The Trust came out of serious concerns in September 2017. Internal audit report still in draft only gave partial assurance, only 70% of safeguarding referrals had been dealt with in a timely response Further dip audits have said we are now 100% and these results will be presented at QRMC in Quarter 4. Further dip audits planned to make sure embedded The risk will remain on the Trust Risk Register unit assurance is evident that changes have been embedded.	Jane Padmore(Director Quality & Safety)	20/02/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
			Risk: The Trust is in breach of its S113 agreement with Hertfordshire County Council (HCC) with the potential for a contact review / notice and withdrawal of safeguarding functions via termination of the agreement.		Immediate Practice Development sessions for S113 managers. Appointing fixed term Consultant Social Worker for statutory safeguarding functions to ensure consistency and pace of improvements						

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
773	29/03/2017	Failure to respond effectively to demand resulting in a risk to safety, quality and effectiveness	Increased risk of being unable to respond effectively to demand in Adult Community Services and knock on effect on access times. Balancing inbound volumes of assessments with case management and treatment. Volume, acuity and complexity of caseloads is a risk leading to increased pressures on teams and potential workforce challenges.	12	Increased senior manager (SLL) input to monitor QI Service Improvement plan led by x2 Managing Directors Service caseload reviews in place Development plan for supervisors and team leaders Review of staff skill mix across quadrants and introduction of new roles Commencement of county wide FEP service caseload c. 500 Improved systems in SPA.	12	6	Vacancy Levels Agency spend Increase in incident reporting Number of cases pending allocation CATT caseloads Number of initial assessments Turnover of staff Increase in Complaints Performance against targets deteriorating staff feedback/raising of concerns	Agreement and implementation of recruitment & retention incentives has resulted in improved recruitment and good retention of staff supporting agency reduction. Launch of a new Signposting Directory on the staff intranet. The directory provides up to date contact details for local community and voluntary sector resources in each quadrant. The directory is being regularly updated by the MIND workers in the Wellbeing teams, and is now easily accessible to SPA and all other HPFT teams. Overall implementation of GP guidance and building referral form into System One to standardise referral process into SPA – SPA Project leading on this piece of work. Non Medical Prescribing will: a)Release care co-ordinator capacity – SUs who are very stable on depot can manage within the structured support of the clinic b)Release medic capacity – the Non Medical Prescribers will review stable service users every 6 months, with supervision from a consultant psychiatrist. The responsible psychiatrist will review all SUs open to the NMP clinics at least once every two years Low Intensity Treatment Teams The two clinic pilots are the first phase of a longer term ambition to move towards a Low Intensity Treatment Team model. The aim of this model, which is based on a similar model already operating in South London and Maudsley (SLAM), is to provide a less intensive service to SUs on Standard care, encouraging independence from services and firmly rooted in the recovery approach. It is anticipated that managing very stable SUs in this way will further embed recovery thinking across adult community. There is scope to create additional capacity on care co-ordinator caseloads – the caseload reviews are identifying SUs who are stable and who don't need intensive care co-ordination. The NMP / Low Intensity Team approach also has the potential to release capacity in outpatients, with stable SUs having their medication reviewed by NMPs rather than consultants. Pre discharge group being piloted at Holly Lodge Support for SUs moving on from services. Up to 10 per group.	Jess Lievesley (Director Of Service Delivery and Service User Experience)	30/03/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
									Pilots for improved primary care working due to start in Stevenage and Watford. Caseload Reviews – all quadrants Identification of cases that are ready for stepdown / discharge. Regular tracking of these cases to ensure plans are being actioned. Piloting a 'whole system' approach at Cygnet House Tighter MDT management and oversight of cases coming into the team and those being discharged. Better use of CPA levels and clustering to inform practice; testing 'zoning' as a system for managing the work of the team STR worker posts converted to PB posts in E&SE Increased capacity for Band 5/6 CPNs and SWs as these workers will be doing PB reviews. On-going monitoring of caseloads and activity to ensure maximum efficiency and improved staff retention Consistency around caseloads in all quadrants and improved caseload monitoring system via Spike. Introducing 3rd sector roles work alongside our teams (e.g MIND) Agreement reached with commissioners and at TMG 29.11.2017 to introduce improved clinical decision making process for service users who DNA.		

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
387	23/07/2015	Management of demand and capacity for those individuals pending care coordination allocation	Service users pending care co-ordination allocation remains a significant risk for the service area.	16	The number of cases pending care co-ordinator allocation in the adult community teams is tracked. Monitored weekly by the Team Leaders and service users are contacted regularly to minimise risk. Performance Monitoring of these cases is now available via SPIKE	12	6	Serious Incidents linked to cases pending allocation. Increased number of complaints from GPs, carers and SUs regarding cases pending allocation. Increased length of time to be allocated a care coordinator Increase in the total amount of cases pending allocation or as a % of overall community team caseloads	The number of cases pending care co-ordinator allocation in the adult community teams is being tracked, although the absence of a care co-ordinator does not mean that individuals have no access to support from HPFT community services. Quadrants are implementing a number of changes around Demand and Capacity, and the number of cases pending care co-ordinator allocation needs to be understood within this context. These changes include: i) reducing the number of agency staff in the teams ii) achieving consistency in caseload numbers and ensuring reasonable caseload numbers as part of measures to retain staff iii) responding to increasing demand for assessments from primary care iv) a detailed caseload review with the aim of discharging or 'stepping down' service users who are no longer in need of care co-ordination v) improving systems at team level for categorising unallocated work vi) improving MDT oversight of 'flow' through the system, including new work coming into the teams and cases that are ready to be discharged	Jess Lievesley (Director Of Service Delivery and Service User Experience)	30/03/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
116	05/10/2009	The Trust does not have sufficient resources to ensure short term and long term financial stability	Failure to maintain recurrent and sustainable financial performance, specifically: (1) Failure to secure sufficient funding from commissioners to meet service quality and/or activity requirements (2) Failure to address underlying demand and/or cost pressures and/or to deliver required efficiency savings such that the underlying financial performance is not sustainable Cost Pressures: •Agency expenditure and NHSI cap •Double running costs for transformation of older people inpatient	16	Strengthened CRES Programme Assurance Board, monthly monitoring Dedicated finance resource: Head of Finance – Efficiencies Programme Weekly monitoring of agency cap 'breaches' Raised authorisation levels for agency expenditure Regular Placement Panel with cross-SBU coordination of placements pathway Provision for older peoples transformation programme in place Regular Reports are made to the Trust Board, Finance & Investment Committee, Executive Team and Trust Management Group. 2017/18 Contract variations in place for health and social care contracts. Relationship management with commissioners HPFT have started to work formally with	12	6	Day One 'flash forecasts' for monthly outturn Quarterly Review / Horizon Scanning Agreed income tariff uplifts Increased agency spend Increased number of placements outside HPFT CRES programme RAG rating Negotiations with commissioners	The Trust's overall NHS Improvement Use of Resources Risk Rating is 1, the highest performance, although agency spend only achieves a rating of 2 under the Single Oversight Framework model. The Trust has a strong relationship with NHSI 2016/17 surplus £8.9m and on-going strong balance sheet with provisions against recognised potential material liabilities Cost Pressures: Agency expenditure above NHSI cap (forecast £9.5m versus £8.5m), this is mainly out of hours and medical cover. Short term delays to older peoples transformation programme due to shortage of beds in independent sector 2017/18: No demographic uplift for West Herts (£600k) from Herts Valley CCG and no additional resources for demand pressures. CRES - shortfall in robust schemes c£0.5m HVCCG commitment to develop demand management approach (work still to get real traction) Active discussions with commissioners particularly HVCCG, concerning funding streams Risk linked to SBU LD&F risk on the Essex LD Procurement for which the Trust has already appointed a project lead and the risk around the transforming care agenda and the potential impact on bed based service income. Carter Review work - involved in cohort	Keith Loveman (Director of Finance)	14/02/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
			services Demand Pressures: - Social Care Placements - External PICU Placements Key Issues 2017/18: •No Demographic uplift for west Herts •4.4% social care savings requirement •CRES requirement £5.7m •HVCCG c.£38m unidentified QIPP requirement.		HCT on some areas of service integration and development of consolidation opportunities for 'Back Office'. Estates and Facilities consultation being developed.						

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
366	08/07/2015	To ensure sufficient AMHP coverage is in place to meet county requirements.	To ensure that sufficient AMPS are available within HPFT and County Council to meet demand. Limitations in out of hour availability that rest with County Council service Nb. Service is jointly provided by HPFT and County Council	12	New service management established for rota management within HPFT including strengthened duty desk functions. Improved rota fill and county wide coordination across HPFT services. Active joint working with HCC to ensure 24/7 coverage to meet demand	12	6	Turnover of AMHPS Gaps in rota Increase in AMHP waiting times Increase in reported incidents of unavailability or delays in AMHPs S136 audits	The safeguarding /AMHP out of hours service has been co-located at Kingfisher court alongside our S136 suites during our peak period Thursday to Monday morning. 9 staff have been put forward for training and recruitment for new cohort has started. The increased AMHP allowance has now been implemented across HPFT and HCC as of 1st December 2016 A further development that took effect in Jan 17 was the transition of the central AHMP rota and service into the E&N SBU to strengthen the effectiveness and resilience of the service. Line management is by MD. Recruitment to AMHP service manager secondment post has taken place - due to start August 17. Review of structure to support AMHP service underway. Exploration of new models of 24/7 AMHP provision underway with HCC. Additional referral advisor roles introduced to support functioning of Duty Desk.	Jess Lievesley (Director Of Service Delivery and Service User Experience)	17/01/2018

ID	Opened	Title	Description	Rating (initial)	Controls in place	Rating (current)	TRR Rating (Target)	Early warning indicators	Current Position	Executive Lead	Next review date
862	06/11/2017	Statutory and mandatory training compliance levels lead to staff being insufficiently trained to appropriate levels	A review of all statutory and mandatory training compliance has shown that the recovery plans have not been as successful as anticipated following changes which needed to be made to ensure that the correct level of training was being provided to the correct target audience. This could result in not enough staff trained to deliver safe and effective care. Specifically in relation to Moving and Handling, Safeguarding, Infection Control, Intermediate and Basic Life Support mandatory training.	12	Task and Finish Group to drive necessary recovery with Executive Director SRO. Monitoring of compliance rates at Exec and WODG	12	6	Current compliance rates	Safeguarding - All non-clinical staff are expected to undertake safeguarding adults and children level 1 training via e-learning. All clinical staff are expected to undertake safeguarding adults and children level 2 training. Those staff who are working within children's settings are expected to do safeguarding children level 3 training instead of level 2 - Low compliance rates based on the correct training being delivered to the appropriate staff. - Solutions to achieving compliance have been identified including additional classroom space, training via video conferencing, implementation of e-learning training package. Resuscitation (ILS/ BLS) - The true compliance based on the revised training being delivered to the appropriate staff is 60-65% - There are enough training sessions to reach compliance by the end of the financial year Additional training materials and classroom space have been arranged Infection Control - In accordance with the Core Skills Training Framework all healthcare staff involved in direct patient care or services are required to undertake level 2 Infection Prevention and Control and all other staff are required to complete level 1 Infection Prevention and Control - The true compliance based on the revised training being delivered to the appropriate staff is low - Solutions to achieving compliance have been identified and additional e-learning opportunities are being explored Moving and Handling - All non-clinical staff need to complete level 1 moving and handling via e learning every 3 years. All clinical inpatient staff need to complete level 2 hoist and all clinical community staff need to complete level 2 non hoist every 2 years - A significant amount of work needs to be done to increase compliance rates for moving and handling level 2 - Solutions to achieving compliance have been identified including additional training and classroom space Compliance in all of the recovery plans is expected by end of March 2018, decisions and immediate issues to resolve have been allocated. Report reviewed by Exec - November 2017	Jinjer Kandola (Director of Workforce & Organisational Development, Deputy CE)	14/02/2018

End of Report

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD MEETING

Meeting Date:	25.01.18	**Agenda Item: 18**
Subject:	Annual Review of Board Sub-Committee Terms of Reference	**For Publication:**
Author:	Jonathan Elwood Company Secretary	**Approved by:** Jonathan Elwood Company Secretary
Presented by:	Jonathan Elwood Company Secretary	

Purpose of the report:

Each Board Sub-Committee is required annually to review its Terms of Reference (ToR) and refer any changes to the Trust Board for approval. The Board may also review and modify a Sub-Committee ToR any time.

The Audit Committee and the Finance and Investment Committee have recently reviewed and made minor drafting changes to their ToR. These are attached for Board review and approval.

The Integrated Governance Committee reviewed its ToR in early 2017 and these are due for review in April 2018. As a result of an impending change to the ToR of the Nominations and Remuneration Committee their ToR will be reviewed at a future meeting and brought back to Board for approval.

In order to streamline the review process in future all Sub-Committee ToR will be brought for review and approval to the same Board meeting each year.

Action required:

Board are asked to review and approve the attached ToR for Audit and FIC and note the review timescales for IGC and RemCom.

Summary and recommendations to the Board:

It is recommended that the ToR are approved as amended.

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

Summary of Financial, IT, Staffing & Legal Implications:

none

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

none

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

Evidence of robust governance review processes

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

Audit and FIC

Hertfordshire Partnership NHS
University NHS Foundation Trust

TERMS OF REFERENCE

Audit Committee

Status:	The Audit Committee is a non-executive sub-committee of the Trust Board.
Chair:	**Non – Executive Director**
Membership:	The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of : Non-Executive Directors (x5 including Chair) In attendance: Director of Finance Representatives of Internal Audit Representatives of External Audit Company Secretary The Chief Executive will be invited to attend at least once meeting per annum.
Frequency of Meetings:	5 meetings per annum
Frequency of Attendance:	Members will be expected to attend all meetings. If members miss two consecutive meetings, membership will be reconsidered by the Committee Chair (subject to exceptional circumstances).
Quorum:	A quorum shall be at least two members.

1. Remit

1.1 The Audit Committee is a non-executive committee of the Board and has no executive powers, other than those delegated in the Terms of Reference.

1.2 The remit of the Group is:

> "To review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisations objectives."

2. Accountability

2.1 A report will be made by the Chair to the Trust Board following each committee meeting. The report will contain:

- A note of all the items discussed by the committee
- Matters for noting by the Board
- Recommendations to the Board regarding decisions to be taken by the Board on governance matters
- Matters for escalation to the Board from the committee
- Annually the committee will report on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the risk management system in the organisation and the integration of governance arrangements.
- Any other issues as agreed by the Chair & Company Secretary.

2.2 The minutes of Audit Committee meetings shall be formally recorded by the Company Secretary.

2.3 A report will be included within the annual report describing the work of the committee in how it has discharged its responsibilities. The committee chair will attend the annual general meeting at which the annual report is presented.

3. Responsibilities & Duties

The duties of the Committee can be categorised as follows:

3.1 Governance, Risk Management and Internal Control

The Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and compliance with registration requirements), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.2 Internal Audit
The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- annual review of the effectiveness of internal audit

3.3 External Audit
The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- consideration and recommendation to the Board of Governors of the appointment and performance of the External Auditor.
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan.
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review all External Audit reports, including agreement of the management letter before submission to the Trust Board and Board of Governors and any work carried outside the annual audit plan, together with the appropriateness of management responses.

3.4 Other Assurance Functions
The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Integrated Governance Committee and any Risk Management committees that are established.

In reviewing the work of the Integrated Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function. The Audit Committee places reliance on the work of the Integrated Governance Committee to review and assess the assurance framework and report any significant control issues. As a result the Audit Committee requires a six monthly update report from the Integrated Governance Committee on these issues (to include the Trust Risk Register).

3.5 Counter Fraud
The Audit Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

3.6 Management
The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

3.7 Financial Reporting
The Audit Committee shall review and scrutinise the content of the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the clarity of wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee,
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgmental areas
- significant adjustments resulting from the audit.

The Committee should also ensure that the systems for financial reporting to the Board and NHS Improvement, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board and NHS Improvement.

The Audit Committee shall be informed of the work of the Finance and Investment Committee of the Board and receive a six monthly update report for this purpose.

3.8 Quality Reporting
The Audit Committee shall review and scrutinise the content of the Quality Report and Quality Accounts prior to their submission to the Board for approval.

The Committee should also ensure that the systems for reporting to the Board and NHS Improvement are subject to review as to completeness and accuracy of the information provided to the Board and NHS Improvement.

3.8.1 Board Committees
In addition to the work of the Finance and Investment Committee and the Integrated Governance Committee, the Audit Committee shall review the work of any other committee set up by the Board as appropriate, the period and regularity of the reporting to be determined by the Audit Committee to reflect the nature and purpose of the committee.

5. Other Matters

The Committee shall be supported administratively by the Company Secretary, whose duties in this respect will include:

- agreement of agenda with the Chair and attendees and collation of papers
- taking the minutes & keeping a record of matters arising and issues to be carried forward
- advising the Committee on pertinent areas

6. Monitoring of Effectiveness

5.1 The group will review its own performance and terms of reference at least once a year to ensure it is operating at maximum effectiveness.

Terms of Reference ratified by: Audit Committee

Date of Ratification: **December 2017**

Date of Review: **December 2018**

Terms of Reference Version: 2017/1.1

Hertfordshire Partnership NHS
University NHS Foundation Trust

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 not less than three members including: Non-Executive Directors (x5 including committee Chair) Director of Finance Deputy Chief Executive Director of Quality and Safety / Director Quality & Medical Leadership Director of Service Delivery and Customer Experience Director Strategy & Integration Director of Innovation and Transformation
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 by the Trust Secretary 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 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 Monitor's requirements.

3.3 Performance Monitoring and Reporting

3.3.1 To consider the Trust's 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 Company Secretary, whose duties in this respect will include:

- agreement of agenda with Chairman and attendees and collation of papers
- taking the minutes & keeping a record of matters arising and issues to be carried forward
- advising the Committee on pertinent areas

5. Monitoring of Effectiveness

5.1 The group will review its own performance and terms of reference at least once a year to ensure it is operating at maximum effectiveness.

Terms of Reference ratified by: FIC

Date of Ratification: **January 2018**

Date of Review: **December 2018**

Terms of Reference Version: **2017/1.5**

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	25.01.18	**Agenda Item: 22**
Subject:	Resolution to approve Private Session	**For Publication:** Yes
Author:	Jonathan Elwood, Company Secretary	**Approved by:** Jonathan Elwood, Company Secretary
Presented by:	Christopher Lawrence, Chair	

Purpose of the resolution:

To permit the Board to sit in private session

Action required:

The Board is asked to approve the resolution.

Summary and recommendations:

Prior to meeting in private the Board must pass the following resolution:

'That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest'.

To enable the Board to receive reports containing confidential information it is recommended that the Board approves this resolution and continues to sit in private session for the duration of the meeting

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

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

Equality & Diversity /Service User & Carer Involvement implications:

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

Essential for compliance with the Trusts Constitution

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