Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC Meeting

Da Vinci B, The Colonnades

6 June 2019 11:00 - 6 June 2019 13:30

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Hertfordshire Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS

A PUBLIC Meeting of the Board of Directors

Date: Thursday 6th June 2019
Venue: The Colonnades, Beaconsfield Road, Hatfield AL10 8YE, Da Vinci B+C
Time: 11:00 – 13:30

Service User Story **10:30 – 11:00am**				
A G E N D A				
	SUBJECT	**BY**	**ACTION**	**ENCLOSED**
1	**Welcome and Apologies for Absence:**	Chair		
2	**Declarations of Interest**	Chair	**Note/Action**	Verbal
3	**Minutes of Meeting held on 9th May 2019**	Chair	**Approve**	Attached
4	**Matters Arising Schedule**	Chair	**Review & Update**	Attached
5	**CEO Brief**	Tom Cahill	**Receive**	Attached
6	**STP Update**	Tom Cahill	**To note**	Attached
QUALITY & PATIENT SAFETY				
7	**Report from the Integrated Governance Committee**	Sarah Betteley	**Receive**	Attached
8	**Annual Integrated Safety Report**	Dr Jane Padmore	**Receive**	Attached
9	**Quality Strategy**	Dr Jane Padmore	**Ratify**	Attached
10	**PSED Compliance and EDS2 Grading 18/19**	Dr Jane Padmore	**Approve**	Attached
11	**Safe Staffing Annual Report**	Dr Jane Padmore	**Receive**	Attached
12	**IPC Annual Report & Forward Plan**	Jacky Vincent	**Approve**	Attached
13	**Service User Experience Annual Report**	Sandra Brookes	**Receive**	Attached
OPERATIONAL AND PERFORMANCE				
14	**Report of the Finance & Investment Committee**	Simon Barter	**Receive**	Attached
15	**Finance Report**	Paul Ronald	**Receive**	Attached

GOVERNANCE AND REGULATORY				
16	**Trust Risk Register**	Dr Jane Padmore	**To Note**	Attached
17	**Refurbishment of Aston Ward Dormitories**	Keith Loveman	**Approve**	Attached
18	**Annual Speak Up & CQC Concerns Report 2018-19**	Dr Jane Padmore	**Receive**	Attached
19	**Guardian of Safe Working quarterly report**	Dr Billy Boland	**To Note**	Attached
20	**Chairs Action**	Loyola Weeks	**Approve**	Attached
21	**Any Other Business**	Chair		
	QUESTIONS FROM THE PUBLIC	Chair		

Date and Time of Next Public Meeting:
Thursday 1st August 2019, 11.00 – 13.30, Da Vinci B/C,

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 University
NHS Foundation Trust

Minutes of the PUBLIC Board of Directors Meeting
Held on Thursday 9th May 2019
Da Vinci B – Colonnades

Present:

NON-EXECUTIVE DIRECTORS	DESIGNATION
Christopher Lawrence | CL	Chair - up to and including item 7
Loyola Weeks | LW	Non-Executive Director
Simon Barter | SBa	Non-Executive Director
Sarah Betteley | SBe	Non-Executive Director - Chair from Item 8 onwards
Tanya Barron | TBa	Non-Executive Director
Janet Paraskeva | JPa	Non-Executive Director
Diane Herbert | DH	Non-Executive Director
Catherine Dugmore | CD	Non-Executive Director
EXECUTIVE DIRECTORS	
Tom Cahill | TC	Chief Executive Officer
Karen Taylor | KT	Director, Strategy and Integration
Mariejke Maciejewski | MM	Interim Director, Workforce & Organisational Development
Dr Jane Padmore | JPad	Director, Quality and Safety
Ronke Akerele | RA	Director, Innovation and Transformation
Sandra Brookes | SBr	Director, Service Delivery & Customer Experience
Keith Loveman | KL	Director, Finance
Dr Asif Zia | AZ	Director, Quality & Medical Leadership
IN ATTENDANCE	
Kathryn Wickham | KW	PA to Chairman and Company Secretary | Minute Taker
Sarita Dent | SD	Associate Non-Executive Director
David Atkinson | DA	Associate Non-Executive Director
Paul Ronald | PR	Deputy Director of Finance
MEMBERS OF THE PUBLC	
Barry Canterford	Public Governor
Jon Walmsley	Lead Governor
Maria Gregoriou	Associate Director of Workforce (attendance for item 15)
Natalie Rotherham	Head of Scrutiny, Herts County Council
APOLOGIES	
Mark Harvey	Principal Social Worker Adult Care Services
? Company Secretary	

Item	Subject	Action
040/19	**Service User Presentation** CL welcomed KM who presented his story as a carer and more recently as an active member of the carer council and STP co-production board. CL thanked Kevin for his presentation acknowledging the scale of the work he undertakes.	
041/19	**Welcome and Apologies for Absence** CL welcomed all to the meeting with an extended welcome to Diane Herbert, Non-Executive Director, David Atkinson, Associate Non-Executive Director and	

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	Sarita Dent, Non-Executive Director. There were no apologies for absence.	
042/19	**Declarations of Interest** There were no items declared.	
043/19	**Minutes of the meeting held on 7th March 2019** The minutes of the meeting held on the 7th March 2019 were discussed and agreed as an accurate account of the meeting. **APPROVED** **The Minutes of the 7th March 2019 were APPROVED**	
044/19	**Matters Arising** The matters arising schedule was discussed and updates noted.	
045/19	**CEO Brief** TC presented the report to the Board which was taken as read. The below key headlines were discussed and noted: **<u>National Update</u>** **European Elections** TC stated that on the 1st May 2019 NHS Improvement had published its pre-election guidance which was set out in the CEO Brief. The CQC result announcement would not be affected by this. **<u>Regional Update</u>** **STP** Plans were in place to consider a joint appointment between the STP and CCGs with an interim STP Head for a period of 6 – 9 months. Interviews were scheduled for the 15th May 2019. TC also noted the STP Design paper which outlined the possible future architecture for commissioning and provision in Herts and West Essex. **NHSI/NHSE East of England** TC commented on the appointment of Catherine O'Connell, Director of Commissioning who had been identified as the main link with the Herts and West Essex STP, confirming we would be working with Ann Radmore and her team to further understand the implications for us as a Trust and the new regulations. **<u>Trust-wide Update</u>** **Performance** The quarter-end performance results showed the highest ever volume of referrals into SPA however staff were performing well. There continues to be increasing pressures in CAMHS with demand outstripping capacity. There were also high demands on Adult Community 28 day waits from referral to	

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assessment which remain a Trust priority and there were a number of initiatives underway to address this.

Innovation
The Innovation Hub had been open since early March and was receiving positive feedback.

Suicide prevention
We continue to deliver the zero tolerance to suicides action plan. In collaboration with 'Spot the Signs' a new app 'Stay alive' is being launched on 9th May. This is an excellent resource whereby service users can hold their safety plans as well as find support and guidance when in crisis.

The Trust has been part of the public health audit into suicides with Public health, and the final findings will be presented next month.

Quality Strategy
The Quality Strategy was near completion and a final version would be presented to the Integrated Governance Committee and subsequently to the Board for ratification.

Health & Safety Executive (HSE)
The Health and Safety Executive (HSE) would be visiting the Trust for a three day inspection from 13th to 15th May 2019 in relation to the Health and Safety Act 1974. The inspection was one of twenty inspections planned nationally to examine management arrangements for prevention of violence and aggression and musculoskeletal disorders. JPad confirmed the tone for the inspection was very much a 'compliant/not compliant' approach.

Workforce & Organisational Development
The 10th Leadership Academy had commenced in April 2019
Recruitment for the Mary Seacole Programme was underway
Results of the Staff Survey showed positive feedback

Finance
The financial year ended well, with achievement of the set control total enabling receipt of additional PSF. However there were real pressures in-year and ongoing. The headlines were that the Trust would broadly break-even in 2018/19 but that the underlying pressures signalled a tough year ahead.

Recruitment
An advert to appoint to the Company Secretary post was out with interviews scheduled for the 5th June 2019. An advert was also out for the vacancy of Executive Director of People and OD with Gatenby Sanderson appointed to undertake the Executive search.

National Awards
A piece of work was underway to promote the Trust Awards Profile with more information provided to the Board in due course.

TC invited questions.

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	Suicide Prevention App. JPad noted the launch today (9th May 2019) of the Suicide Prevention App. **Individual Placement and Support (IPS**) KT raised the Individual Placement and Support (IPS) scheme. The IPS was a voluntary scheme and would be rolled out to 28 new local NHS areas with HPFT being one of those in the work plan. **CAMHS Steering Group** KT further noted the CAMHS steering group working with Herts County Council and commissioners to look at ways to drive down and stem the demand for referrals. The Board would be kept appraised of the work. **RECEIVED** **The Board discussed and RECEIVED the CEO report**	
046/19	**Report of the Integrated Governance Committee** SBe presented the Integrated Governance Committee report to the Board which was taken as read and confirmed there had been no significant issues for escalation to the Board. **Workforce and Organisational Development** There had been lots of positive work with improvements seen in time to hire metrics, recruitment and retention and the flexible working pilot. A Deep Dive on Organisational Development had been requested for the next meeting. **Flu Campaign** The Committee had held a discussion on the performance of the 2018 flu campaign and this would be discussed regularly ahead of this year's campaign. **QRMC** There were a number of policies approved for ratification with a request going forward for a quick reference guide to be provided for each policy. **Board Assurance Framework** SBe confirmed the BAF was now improved and a much stronger document. The BAF had also been moved up the IGC agenda so that it and the Trust Risk Register were at the top. Front Sheets for IGC papers also now indicated how they aligned to the TRR and BAF. SBe concluded the report welcoming the three new Non-Executives to attend an IGC meeting. **RECEIVED** **The Board RECEIVED the report**	
047/19	**Care Quality Commission: initial feedback and themes** JPad introduced the item and provided an update to the Board on the progress, initial themes and feedback.	

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	JPad advised the Board that the factual accuracy challenges to the report had been sent back to the CQC for consideration. The Trust were expecting to be in receipt of the final report by the 15th May 2019. Discussions were underway with staff on how they would like to celebrate. The informed feedback on areas of improvement would be developed into an Action Plan which would go to IGC and be included in the Internal Audit Plan for review. **RESOLVED** **The Board RECEIVED the report**	
11:30am	***The Chair left and Sarah Betteley, Deputy Chair, chaired the remainder of the meeting.***	
048/19	**Report of the Finance and Investment Committee** SBa presented the report to the Board advising the Board of the 19th March 2019 agenda and discussions. A Deep Dive had been undertaken on STP Planning, with the main agenda items covering: Planning for 2019/20 Business Development, with a particular focus on New Care Models Key elements of the Strategic Investment Programme o Bed provision E&N Herts o Dormitory removal – SBa confirmed the approval of funding would come to Board for formal sign off o Seclusion & Safe Space Programme Performance Report – Period to end February 2019 Financial Summary – Period to end February 2019 2018/19 Final Accounts update Capital Plan & Expenditure Summary • FIC Business Programme 2019 • SBa confirmed the major elements of discussions set out in the. **RESOLVED** **The Board RECEIVED the report**	
049/19	**Q4 Annual Plan 2018/19** KT summarised the paper to the Board highlighting that 2018/19 had been a hugely successful year seeing some areas of significant transformation and achieving demonstrable improvements in overall experience for our service users and their families. The key areas of achievement to note were: **Safety** This had been a significant focus for the Trust with the CQC recognising in their informal feedback the transformation made in this area. **Service Transformation** **System Changes**	

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	Learning The Trust has launched an improved e-learning system, Discovery which has completely overhauled the on-line learning experience. There has also been the introduction of SPIKE 2 and improvements made to PARIS. **CQI Programme** The establishment of the Innovation Hub signals our commitment to this approach with further investment planned for 2019/20. **Contract Renewal** 2019/19 saw the Trust successfully renegotiating and renewing all of its contracts with a five year contract for Hertfordshire and a seven year contract for Essex. There were a couple of areas where the Trust did not fully achieve on the priorities, however considerable work had taken place and was underway to ensure they remained central to the delivery of the Good to Great Strategy and were also included in the Annual Plan for 2019/20. KT stated that in summary, 2018/19 had been a transformational and successful year which was testament to the hard work of the staff. **RESOLVED** **The Board RECEIVED and NOTED the report**	
050/19	**Q4 Performance Report 18/19** RA presented the Q4 performance report to the Board which was taken as read. RA advised that overall performance for quarter 4 had remained balanced and was holding up against the pressures of the higher than average staff turnover rate. Service demands had also seen a 6% increase in referrals to SPA for the quarter. Q4 KPI metrics suggest that this quarter was the 4th highest performing quarter of the last 16 quarters (4 years). RA gave an overview of key issues to note, including:- **Access to services** CAMHS performance had decreased significantly in quarter 4 in relation to the 28 day waiting time target. The Trust was engaged with commissioners to look at funding. **EMDASS** Diagnosis within 12 weeks fell slightly in quarter 4 showing a 6 month decline in performance and an increase in demand. The Trust was confident that the approach being taken using CQI would support recovery of the position. **IAPT** 3 of the CCGs achieved the access target with Mid and West Essex not meeting the target due to lack of referrals. Overall quarter 4 had seen a generally good, strong performance. Quarter 1	

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	would focus on CQI. SBr commented on the work to reduce the backlog in CAMHS and EMDASS. SBr further commented that development work in Primary Care was underway to develop a common model from 4 pilot sites to stem the referral numbers. If demand continued our capacity was not sufficient to meet the demands and achieve the CAMHS 28 day. For CAMHS and EMDASS the pathways were being reviewed, these would then be piloted, tested and if successful, developed further. **RESOLVED** **The Board RECEIVED and NOTED the report**	
051/19	**Q4 Workforce Report 18/19** MM presented the Q4 Workforce and Organisational Development Report which was taken as read. Key areas to note were: • Improvement across all key indicators had been seen despite the ongoing challenges of recruitment and retention. The impact of a more streamlined recruitment process had provided a positive effect and the new time to hire improvements had brought this down to 9 weeks. Quarter 4 had seen 140 new starters join the Trust. • Sickness for the quarter had decreased from 4.61% in quarter 3 to 4.31% in quarter 4 but still remained above the Trust target of 4%, however for the month of March sickness fell to 3.3% which was the lowest ever achieved and may have had some impact from the CQC visit. • Significant work continues with health and wellbeing activities alongside prevention. • Compliance for Statutory and Mandatory training had increased in the quarter to 90.26%. The implementation of Discovery, the new learning management system was having a very positive effect with compliance reaching 92% in March. • Organisational Development Activity ○ The Big Listen was held in April with over 90 staff attending. Lots of positive feedback had been received. The first cohort of the 2 day Management Fundamentals Programme had been delivered with positive participant feedback. SBa acknowledged the work undertaken and asked about the reporting of the unplanned turnover rate querying whether this should be reported separately. MM confirmed this was reported through the Workforce & Organisational Development meeting (WODG) and that this more refined detail would be included in future Board reports. **RESOLVED** **The Board RECEIVED and NOTED the report**	

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052/19	**Finance Report to end of March 18/19** PR presented the summary for the Financial Year 1st April 2018 to 31st March 2019. The report was taken as read with the below highlights. The Control Total of £360k had been met with a surplus of £392k giving the Trust income from the Provider Sustainability Fund (PSF) which was expected to be £3.8m. It was highlighted that £17m of STF/PSF income had been received over the last three years due to the Trust meeting its targets. Main improvements in the position across the year were secondary commissioning, in particular CAMHS Tier 4 New Care Models, PICU and External Placements and reducing agency costs later in the year. It was noted that the position was also supported by the £1.4m release during quarter 1. The contracted funding for 19/20 was positive although PSF was mainly aimed at acute Trusts to support urgent and emergency care. For the Trust there would be the impact of the pay increase and a £6.5m CRES programme which were viewed as challenging. TC acknowledged the outstanding work from the staff but recognising the pressure still on going forward. **RESOLVED** **The Board RECEIVED and NOTED the report**	
053/19	**Annual Plan 2019/20** KT introduced the report confirming it had been to the Private Board in April and had been seen by the relevant Board sub-committees and the Council of Governors in terms of its development. The plan was presented to the Board today for ratification. SBe commented it was an excellent piece of work and acknowledged the hard work undertaken to achieve the plan. **APPROVED** **The Board APPROVED the Annual Plan 2019/20**	
054/19	**Financial Plan 2019/20** The Financial Plan 2019/20 was presented to the Board by PR who provided a summary and the below points highlighted. The Trust had submitted a draft plan to NHSI on the 12th February 2019 with a final submission made on the 4th April 2019. The changes between the draft and final submission were outlined in page 132 of 229 and the risks outlined in page 133 of 229 of the Board pack. It was understood the submission had been confirmed, but with feedback awaited. PR confirmed the Board were asked to receive the Financial Plan for 2019/20. **RESOLVED** **The Board RECEIVED the Financial Plan 2019/20**	

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055/19	**Gender Pay Gap** MM provided the Board with an update on the Trusts Gender Pay Gap position and asked to seek Board approval prior to publication of the Report. Key points to note were: From a benchmark perspective the Trust compared favourably. Very Senior Manager Pay (VSM). As a Foundation Trust we were able to determine the rates of pay – all those on VSM contracts are being looked at and addressed. It was highlighted there were only 5 posts that were affected by the VSM pay. Bonus Pay Gap – MM advised it had been reported that the Clinical Excellence Awards had more males applying. Work was already underway to encourage more females to apply. **RESOLVED** **The Board RECEIVED and NOTED the report**	
056/19	**Report of the Audit Committee** CD presented the Audit Committee report to the Board advising the last meeting had been held on the 24th April and that the key discussion had focused on the work and reports of internal audit and counter fraud. The below key points were discussed. **Equipment and Medical Device Maintenance** This had been given partial assurance however the committee noted they were comfortable with the work being done and the issues addressed. **Draft Internal Audit Report & Head of Internal Audit Opinion** The Head of Internal Audit Opinion had been presented, based on the work performed and the overall adequacy of HPFT's risk management, controls and governance processes during the year. A positive opinion has been given; however it was noted that the Trust has received slightly more partial opinions than in previous years which is a reflection of the audit areas being reviewed. The Committee agreed to track through where there have been any changes at the meeting in September. **Counter Fraud** The committee had noted the piece of work being undertaken around Conflicts of Interest and the Declaration of gifts/hospitality and that this would form part of the work plan for 2019/20. **Procurement Investigation – final report** This was a one off piece of work to undertake an advisory review on procurement processes following an HR investigation. The investigation had been welcomed by the committee and a Deep Dive on Procurement processes would be undertaken at the September meeting. CD highlighted to the new Non-Executive Directors that there was a one hour	

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	meeting on the 15th May to go through the Annual Report in detail ahead of the meeting on the 22nd May. Dial in details would be arranged. **External Audit** There were no significant issues. **RESOLVED** **The Board RECEIVED and NOTED the report**	
057/19	**Audit Committee Terms of Reference** CD reported that the Audit Committee Terms of Reference had been amended to ensure the meeting was quorate requiring a Non-Executive Director to be present from IGC and FIC. CD clarified that all Non-Executive Directors were members of the Audit Committee. **RESOLVED The Board APPROVED the Audit Committee terms of reference**	
058/19	**Trust Risk Register** JPad reported on the Trust Risk Register (TRR). There were currently 12 risks on the register with the report containing the Trusts top ten. The full register was seen by the Integrated Governance Committee. There were no changes to the ratings for the month of March 2019. JPad advised there had been one informal suggestion by the CQC to show whether the risk score increased or decreased over time. **RESOLVED** **The Board RECEIVED and NOTED the report**	
059/19	**NHSI – Compliance with Foundation Trust Code of Governance** KL informed the Board the report set out the Trusts self-assessment of compliance with NHSI's Code of Governance in relation to disclosures. KL advised that the Trust was of a view it was compliant against all disclosures. This had been discussed at the Audit Committee who made a recommendation to the Board for Approval. **RESOLVED** **The Board RECEIVED the recommendation and APPROVED the NHSI – Compliance with Foundation Trust Code of Governance**	
060/19	**Register of Board of Director Interests & Fit and Proper Persons Declaration** SBe confirmed the purpose of the reports was to inform the Board that its members had completed and signed the annual Declaration of Interest and Fit and Proper Persons form for the period 2019/20. **RESOLVED** **The Board RECEIVED the reports**	
061/19	**Any Other Business** No further business was put forward.	

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	QUESTIONS FROM THE PUBLIC SBe invited questions from the public. Jon Walmsley noted congratulations on a brilliant year for the Trust and asked what the Governors could do to assist. TC responded stating Governors could write to commissioners in relation to ongoing funding support for Trust services. TC also noted Healthwatch Hertfordshire who the Trust met with 3 times per year and the Public Communication Strategy and suggested we looked at this strategy at a future Board.	
Date and Time of Next Public Meeting: The next Public meeting is scheduled for Thursday 6th June 2019 @ 10:30am in Da Vinci B, The Colonnades		

Close of Meeting

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Hertfordshire Partnership University NHS Foundation Trust

Agenda Item 4

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 6th June 2019

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
29/11/18	**153/18**	Workforce & Organisational Development Report Quarter 2	Board Workshop to be held on Staff Engagement	It was agreed for this to be held in Quarter 2	JH	b/f	A

Board of Directors Public Meeting

Meeting Date:	6th June 2019	Agenda Item: 5
Subject:	CEO Brief	
Presented by:	Tom Cahill, CEO	

HPFT's Care Quality Commission inspection report

On 15 May 2019, the Care Quality Commission (CQC) published the Trust's inspection report, which saw us being rated as being *outstanding* overall. Thanks to the hard work and dedication of our staff, HPFT is now one of just five mental health and learning disabilities NHS trusts in the country to have this highest possible rating.

Overall the Trust was rated as *outstanding* for caring and being well-led, and *good* for safety, responsiveness and effectiveness. Four of HPFT's 11 services are now rated as being *outstanding*, with the remainder being *good*.

The report made great reading – in particular the CQC's comments about the Trust's staff. The inspectors highlighted the strong relationships they have with service users and carers, making specific mention of how caring and compassionate they are and how staff work with partner organisations to provide the very best care.

On the day the report was published, members of the executive team visited over 20 HPFT sites to reveal the news in person; it was great to see how proud staff were of this achievement.

National update

In this section of my briefing, I set out a number of recent national announcements and reports that will help shape and provide context to the work being undertaken by HPFT in providing consistent, high-quality care to service users and their carers.

CQC interim report on the review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism
Wednesday, 21 May 2019 saw the CQC publish a national report giving interim findings from its review of the use of restrictive interventions in places that provide care for people with mental health problems, a learning disability and/or autism.

In its report, the CQC called for an independent review of every person who is being held in segregation in such services, which should examine the quality of care, the safeguards to protect the person and the plans for their discharge. The review, which was commissioned by the Secretary of State for Health and Social Care, also highlighted the need for a better system of care for people with a learning disability or autism who are, or are at risk of, being hospitalised and segregated.

In responding to the report, the Secretary of State accepted the recommendations made by the CQC. In doing so, Mr Hancock announced that the government will fund specialist, independent advocates who will: work with families; help join-up services; and work to move people to the least restrictive care setting and then out into the community.

In terms of the Trust's inpatient services in Hertfordshire and Norfolk, they have been rated as *outstanding* by the CQC reflecting the considerable amount of work undertaken by our staff to make these facilities caring and safe environments for our service users. Work is now underway, however, to review the care and support received by the small number of people who may be segregated based on the recommendations set out in the CQC's report.

NHS accountability framework for 2019/20
In January this year the NHS, led by NHS England and NHS Improvement, published a new Long Term Plan, which sets out an ambitious programme of transformation over the next ten years to build an NHS that is both fit and sustainable for the future. On 21 May 2019, the Department of Health and Social Care published its 2019/20 accountability framework with NHS England and NHS Improvement, which sets out how the NHS will begin to deliver on this vision.

In terms of delivering the Long Term Plan, the framework sets out objectives for 2019/20 in terms of returning to financial balance, whilst at the same time maintaining and improving performance, and improving the quality and safety of services. It also sets out how the NHS should manage the effects of EU Exit on health and care.

NHS Clinical Commissioners report on the changing face of clinical commissioning
May 2019 saw NHS Clinical Commissioners publish a report on the commissioning role within the NHS based on there being a continued distinction between the planning and funding functions and the day-to-day delivery of clinical care.

The report concludes that whilst there still needs to be commissioning decisions made in the interests of people living in specific areas, CCGs will work increasingly across larger populations and more closely with provider and local authority colleagues. This principle of subsidiarity means that even as the new NHS landscape emerges, there will be a role for clinical commissioners.

It is clear that there are opportunities for more strategic commissioning across a larger population base, however, providing better value and becoming more outcomes-driven. This in turn creates opportunities for the role NHS providers could play within their local health and care system with scope for them to take on some of the activities that commissioners deliver currently, and to develop more collaborative approaches with their colleagues in commissioning. These discussions are being taken forward within the Hertfordshire and West Essex STP through the establishment of new integrated care systems.

EU Exit preparations
On 18 April 2019, Professor Keith Willett – EU Exit Strategic Commander for NHS England and NHS Improvement – informed the NHS about preparations for EU Exit, following the Government's agreement with the EU to a further extension of the Article 50 period to 31 October 2019. As a result, the requirement for daily situation reporting was stood down. Professor Willett has confirmed that NHS England continues to work closely with the Department of Health and Social Care and partners to review the position.

NHS England is working to ensure that the EU Exit structures and preparations put in place nationally, regionally and locally are adapted for this extension and will work to understand any implications for the NHS of further developments relating to any EU Exit deal, should one be approved before 31 October. Necessary preparations for a no-deal outcome must continue, though with sensibly adjusted timescales given the extension the Government has agreed.

Regional update

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

New Care Models, East of England Mental Health Collaborative

In some parts of the country, too many mentally ill young people and adults are being sent for specialist inpatient treatment many miles from their home. This practice, known as out of area placements, can make visiting very difficult for friends and family, as well as local clinicians. This in turn can affect a person's recovery and lead to increased lengths of stay. To help bring people back closer to home, NHS England has launched the New Care Models initiative – partnerships of mental health providers, set up to take on the commissioning role for a defined population in collaboration with commissioners.

New Care Models are the vehicle for greater integration of the patient care pathway, and key to supporting the delivery of the *Five Year Forward View for Mental Health* and future planning of mental health services. Initially partnerships are being established for specialist services commissioned by NHS England currently: child and adolescent mental health services; adult secure services (low and medium secure); adult eating disorder services; and perinatal services.

Here in the East of England, Cambridgeshire and Peterborough NHS Foundation Trust, Essex Partnership University NHS Foundation Trust, Hertfordshire Partnership NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust have come together to develop a collaborative to lead a mental health New Care Model for the region's 6.4 million population.

The collaborative has appointed four clinical leads – Dr Jaco Serfontein for eating disorders, Dr Raman Deo for low and medium secure, HPFT's Dr Linda Zirinsky for CAMHS and Dr Rebecca Horne for perinatal services. Alongside them, John Martin has been appointed as the collaborative development director. The four NHS trusts are committed to the co-production of the region's new Care Model, involving clinicians, partners and service users from the outset in its design. A launch event is being planned for the autumn across the region, about which further information will be provided in future briefings.

Hertfordshire and West Essex STP

Leadership

The STP has appointed a job-share partnership of senior health and social care leaders to work with its independent Chair, Paul Burstow, to navigate the next steps towards an integrated health and care system for the area's 1.5 million residents. The appointment of Iain MacBeath and Beverley Flowers as joint STP lead officers was announced on Wednesday, 22 May 2019. Iain is Hertfordshire County Council's director of adult care services and Beverley Flowers is the chief executive officer of the East and North Hertfordshire CCG.

This joint appointment, which is very much welcomed by HPFT, is a step towards the Hertfordshire and West Essex STP operating as a shadow integrated care system from April 2020.

Community transformation services funding application

The Trust is supporting the STP, which has been invited to submit proposals to access national funding to support the transformation of adult community mental health services. This first wave of funding is for 2019/20, when up to £4 million; the second wave will be for 2020/21, when up to £3.6 million of funding will be available.

Proposals are asked to focus on a new core primary and community service offer, with specific consideration for young people, along with working age and older adults. Additional focus is to be given to one or more of the following: adults with eating disorders; adults who are diagnosed with a personality disorder; and adults in need of mental health rehabilitation services

Proposals are to be submitted via the STP no later than 20 June 2019, with funding decisions expected to be announced nationally during w/c 8 July.

Trust-wide update

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

Operational performance

Since the start of the NHS year in April, the Trust has been experiencing significant pressures and demands for its services – which reflect similar pressures being experienced by MH/LD services nationally. HPFT has maintained its improved performance, however, with community teams seeing 100% of referrals for eating disorders in April and the rate of acute inpatient service users reporting feeling safe returning back above target at 82% for the first time in six months.

Out-of-area placements are rag-rated as amber in April 2019, with 78 days recorded against a target of 200 cumulative days for all of quarter one (i.e. April to June 2019). Pressure on inpatient beds has seen the level of such placements rise in recent months and is being monitored closely by services, with people being brought back into HPFT beds at the first available opportunity.

Significant challenges remain in achieving targets on key access indicators, including the 95% target on 28-day wait for CAMHS routine referrals and on 28-day wait for adult community referrals. This is attributed to a range of system-wide issues, including capacity within local individual teams and the speed with which primary mental health care models are being developed. The Trust is engaging proactively with the wider system to improve quality of early intervention in the community at Tier 1 and Tier 2, as well as supporting the review of the whole-system CAMHS service and working with commissioners to develop, at pace, locality models for primary mental health care.

Quality and safety

The Trust's new Quality Strategy has been discussed at, and received very positively by, HPFT's Information Governance Committee. The strategy sets out how safe and effective services, with the service user as partner in their own care and treatment as well as service development, will be achieved. Its objectives are set out across three domains – safe, effective and experience – as follows:

Safe

- Delivering safe care in top quality environments
- Fostering a learning and just culture
- Fostering a culture of safety

Effective

- Delivering evidence based care which is benchmarked nationally
- Delivering recovery focused care and clinical outcomes
- Continuously improving quality

Experience

- Responsive and accessible services
- Embedding shared decision-making
- Co-production at the heart of service development.

The next step is for the strategy to be submitted for consideration by the Trust Board at its June 2019 meeting.

Health and Safety Executive (HSE) visit

Between 13 and 15 May, the Trust received a visit from the HSE. HPFT had been chosen – purely at random – as one of 20 NHS trusts across the country to take part in a national HSE programme looking at how mental health and learning disabilities services work to reduce violence and aggression towards staff. The HSE is also using this work to consider how those experiencing injury at work are supported and looked after.

During the three days with HPFT, the HSE team was very complimentary about how they were received and engaged with by staff. Whilst the Trust is expecting to have received more detailed feedback by the end of May, thanks have been extended already to everyone who organised and/or took part in this visit.

Continuous Quality Improvement (CQI)
HPFT's Continuous Quality Improvement (CQI) approach will help address the Trust's challenges by: applying systematically data-driven, evidence-based root cause analysis; identifying near-term actions within HPFT's direct control; and articulating clearly the wider system response needed to help manage collective challenges together. The positive impact of this approach can be seen in improvement in EMDASS performance, which is showing signs of recovering in access performance through following of a multi-disciplinary approach, led by clinical colleagues to address some of the deep rooted challenges HPFT is facing.

Since the opening of the first Innovation Hub at the Colonnades in early March 2019, HPFT has received positive feedback and interest from diverse groups of individuals. Nearly 80 sessions have been undertaken, helping individuals and teams to think differently and work creatively and collaboratively in generating solutions to address the problems and realise the opportunities in delivering their services.

The Trust is now working towards having a specialist training provider in place by mid-July 2019 to support the development of HPFT's workforce with CQI skills and techniques.

Workforce and OD
Towards the end of April, the latest of HPFT's six-monthly Big Listen events was held at the Colonnades in Hatfield. Some 90 staff from across the Trust, representing nearly every service, attended, which is one of the highest turnouts recorded to date for these important events. Since the last Big Listen six months previously, the Trust has worked to address some of the matters raised then, including:

- Recruiting more staff than ever before, along with making the recruitment process quicker and easier
- Working to keep people here at HPFT, for example our new career conversation surgeries
- Improving your experience of working for the Trust, such as our buddy system for new starters
- Making the Trust's IT systems easier to use, including more and better PCs/laptops and faster ways to access IT help
- Improving how everyone at HPFT works, through easier access to online systems – for example through the roll-out of Discovery and SPIKE2

There is more to be done of course, and the event held on 25 April provided suggestions for improvements in a number of important areas – from facilities through to how everyone is supported to provide the best care for service users.

Recruitment and agency staffing
Whilst recruitment remains a challenge, the performance data showed another drop in vacancy rate and turnover for April 2019. The Trust continues to develop plans to enhance staff experience, with a *Buddy scheme* for new starters now in place and guidance available on what they should expect from HPFT in their first 100 days.

In addition, career conversations and HR surgeries are in place to support and engage existing staff and a briefing on the health and well-being support available through HPFT has also been circulated to existing staff and is shared with new starters. It is anticipated that this focus on staff experience will have a positive impact on the Trust's staff turnover rates.

Turning to nurse recruitment specifically, the Trust hosted a graduation ceremony for all the trainee nursing associates working for NHS organisations across Hertfordshire and West Essex. The ceremony was held on 14 May 2019 and represented the first cohort of nursing associates to qualify

since the role was created across the STP. Towards the end of May, the Trust met with over 50 student nurses due to qualify from the University of Hertfordshire this year who had been supported by the Trust, the majority of whom have accepted posts working at HPFT.

In terms of agency staffing, April showed a significant reduction of agency shifts compared to the same month in 2018 – and it represented the lowest level of agency usage in each April for the last five years. There is a growing evidence base that service users being cared for by staff with whom they are familiar experience higher quality care, which means that reductions in agency staff impacts positively on outcomes for service users, as well as reducing agency spend.

Training and development

The Trust's 10th Leadership Academy programme continued through May, as did the recruitment for delegates to the local Mary Seacole programme. The series of workshops for new managers, *Management Fundamentals*, continues to run and is being evaluated positively as a useful resource by those attending.

HPFT reported statutory and training compliance at the target of 92%, which is seen as being due in part to the use of *Discovery* – the Trust's online electronic learning management system – that has offered easier access for staff and clearer indication of their compliance.
It is anticipated that developments launched in April (*My Team Dashboard* and *SME Dashboard*) will have a further positive impact on compliance levels.

Work on improving the experience of BAME staff continues with the introduction of a BAME representative on all interview panels for band 8A posts and above.

Finance

The Trust finished the 2018/19 financial year strongly, which is great testament to the work of all staff here at HPFT. April, of course, saw the Trust's finances reset and another tough financial year is anticipated as the wider system focuses on addressing the large deficits within the acute sector.

In April, HPFT reported a surplus of £105,000 which is in line with the plan for the month. Within this overall position, however, there were strong signals of the challenges that lie ahead with an increasing level of out-of-area placements, particularly within PICU services, but also across a range of inpatient facilities – a situation that has continued into May. Continuing pressures were also evident within the Trust's estates costs.

For April, these pressures have been offset by pay savings as the Trust recruited in to the new teams funded by additional investment provided for 2019/20. The staff involved are working very hard to establish these new services, therefore this pay benefit will only be temporary. Good progress needs to be made, therefore, on the Trust's *Delivering Value* programme to ensure that its finances move into a strong position for the remainder of the year – a key focus for HPFT's operational leadership over the coming months.

Senior appointments

Executive Director for People and OD

The recruitment process for the Trust's substantive Executive Director of People and Organisation Development is now underway. It is anticipated that interviews will take place in mid-July.

Company Secretary

The Trust is now out to recruitment for HPFT's Company Secretary and is also seeking to appoint an interim until the post can be recruited to substantively.

Awards

National Positive Practice Children and Young People's Mental Health Awards
Representative from HPFT's Child and Adolescent Mental Health Service (CAMHS) and a young service user attended the National Positive Practice Children and Young People's Mental Health Awards, which were held in Stoke-on-Trent on 11 May.

The team won the Digital Innovation award for the new CAMHS website service, which went live at the end of last year. In making the award, the judges noted the importance the team placed on innovation being thought through genuinely, co-designed and co-produced with young people and their carers, as well as being user-friendly. The CAMHS Home Treatment Team received a highly commended award in the Intensive Support Services category.

Both entries will now go forward to the national Positive Practice in Mental Health Awards taking place at Duxford Air Museum, near Cambridge on World Mental Health Day, Thursday, 10 October 2019.

Tom Cahill,
Chief Executive

Board Meeting

Meeting Date:	6th June 2019	**Agenda Item: 6**
Subject:	Hertfordshire and West Essex STP update	**For Publication: Yes**
Author:	Dean Westcott, STP Finance Director & interim STP lead Dennis Carlton, Head of Programme Management Helen Edmondson, Associate Programme Director Alison Gilbert, Director of Delivery and Partnerships STP Harper Brown, Director of Strategy Charles Allan, Director of Transition and Performance	**Approved by:** Helen Edmondson, Associate Programme Director
Presented by:	Tom Cahill, Chief Executive	

Purpose of the report:

The report provides the Board with an update on the work of the STP.

Action required:

To note.

Summary and recommendations to the Board:

To note.

Relationship with the Business Plan & Assurance Framework:

Summary of Implications for:

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

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

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

STP Update

April 2019

Introduction

This paper provides an update from Hertfordshire and west Essex STP to be discussed at STP member organisations Board or Governing Body meetings.

In particular this report provides an update on:

- ICS/ ICA design work
- System opportunity analysis
- STP lead
- Comms update

1. ICS/ICA design work

A joint meeting between chief executives and chairs was held on the 16th April 2019 to discuss the detailed design brief developed by the STP CEO lead and Chair. The brief was endorsed by the group as the basis for developing a transition plan with the goal of moving to shadow working from April 2020 and an operational integrated care system and partnerships from April 2021. The STP Chair has updated the paper to reflect the feedback on the 16th April and circulated the revised paper to chief executives and chairs for boards to note.

2. System opportunity analysis

Following a request from the CEO board, the central PMO team has conducted an analysis of potential areas for productivity opportunities within our STP and compared these to known (and available) plans. Model Hospital and Right Care benchmarking data was reviewed (at a clinical service line level) for areas of unwarranted variation. The potential opportunity of reducing this variation was then reconciled with 18/19 outturn plans and 19/20 plans to establish if plans were already in place to realise the suggested opportunity.

The results of this analysis will be used to facilitate the prioritisation of our programme to areas with the largest opportunity.

3. STP Lead

The STP Independent Chair is currently leading a process to appoint an interim STP Lead following the retirement of Deborah Fielding in April. Expressions of interest have been sought from within the HWE system and interviews are scheduled with shortlisted candidates in mid-May. The appointment will be for between 6 and 9 months during which time work on the transition plan will be progressed and decisions taken regarding the final arrangements for executive leadership of our integrated care system and partnerships.

4. Communications and Engagement Update

The dashboard provided in appendix 1 gives a summary of the STP communications and engagement work that took place across Hertfordshire and west Essex during the previous month. It includes: details of media releases issued; media coverage received; social media highlights, including website stats; and internal and external communications activity, including stakeholder briefings and public engagement, flagging up future planned engagement.

5. Work Stream Update

5.1. Frailty

- The workstreams are starting to consider a tailored plan to prioritise the delivery of the all the emerging design elements , recognising the risk in potentially overwhelming the delivery units
- Dementia pathways have been designed and will be distributed for consultation
- A tissue viability STP needs assessment is complete and the pathways have been designed in line with the agreed vision for tissue viability. These will be presented to the work stream on 11th June.
- EOL priorities have been agreed with particular focus on the wider workforce training agenda
- Care home priorities are being progress and NHS mail roll out to all care homes remains a priority
- Frailty training identified as requiring a focus on the implementation planning and mobilisation of the 180 trained staff from the fusion 48. Training approach for senior leaders locally being explored
- An options paper will be presented to STP CEO's laying out the landscape and vision for the frailty hub development as one of the components of the approved frailty pathways and how this aligns with existing system developments across the STP
- A refreshed approach to engagement and communication of the work across the whole workstream has been recognised
- A commitment agreed for an improved focus on the oversight of the delivery plans at a local level
- Frailty modelling workshop has been held and the output and lesson learnt has been presented to STP FD's and the workstream. Work will continue but with a more local system approach to the ask

5.2. Planned Care

5.2.1. Outpatients

Following the successful Pan STP outpatient transformation workshop held on 12th March, all three localities were asked to each submit high-level plans of how outpatient services will be configured and delivered based on best practice. East & North Herts and West Essex systems have submitted their plans; and Herts Valley is committed to submitting by week ending 10th May. These high-level plans will be reviewed in May to ensure they are ambitious, robust and able to truly transform services for the benefits of patients.

After this, all three systems will work to flesh out their individual plans into detailed plans by end of July. These detailed plans will feed into the 5-year STP wide plan due for submission to NHS England by September.

5.2.2. **Ophthalmology**
An STP wide demand & capacity review was conducted and submitted to NHS England for feedback. Consideration will be given to NHSE feedback at the next joint commissioner/provider group on 17th May where the group will determine potential areas for Pan STP collaborative work and next steps going forward.

5.2.3. Urogynaecology
The Pan STP Urogynaecology task & finish group led by Dr Rachel Joyce STP Medical Director completed the design of two new pathways – a) GP pathway for managing female adult urinary incontinence and prolapse; and b) Urogynaecology triage pathway. Also, a standardised Urogynaecology referral form that will enable efficient triage of patients to the most appropriate services has been developed. These new pathways and referral process have been signed-off by clinicians across all systems and approved by planned care programme board. When implemented, these new pathways will:

a) Avoid unnecessary appointments especially in hospital outpatient clinics
b) Reduce unwarranted variations in care
c) Ensure patients are cared for at the right setting and on time

5.2.4. **MSK**
Following the Pan STP MSK meeting held earlier in the year, a core group of stakeholders led by Dr Rachel Joyce will meet on 10th May to develop draft care model of how to integrate IAPT into MSK services. When implemented, this model will enable care to be delivered for at the right setting whilst further equipping patients with the right knowledge on how to better manage their conditions.

5.2.5. Diabetes
STP wide diabetes steering group led by Dr Peter Winocour met in April. At this meeting, the group shared success stories around a telehealth support worker pilot scheme aimed at 16 – 30 year olds support by dedicated diabetes specialist nurse. This innovation has led to improved blood sugar control, increased blood & urine tests and increased uptake of retinal screening. This initial pilot success was also presented at the April planned care programme board. Dr Winocour has highlighted this innovation as an area that could be prioritised and has agreed to lead a business case on how this and other initiatives can be scaled across the STP footprint.

5.3 Urgent & Emergency care

A Discharge to Assess Programme Manager was appointed in February 2019. The first Pan-STP Programme Board took place on 30th April 2019 with representation commissioners and providers across the system. The programme governance, aims and objectives were signed off and Quarter 1 and 2 deliverables agreed for the work streams. The primary focus for the programme is:

- Agree standardised outcomes (& KPIs) for D2A pathways
- Agree standardised targets for the above
- Develop system dashboard for measurement of item 2 & 3
- 'As-is' Baseline regarding approaches to D2A pathways across the system
- Agree standardised pathways (using best practice in system & national evidence base)
- Gap analysis of system against the standardised pathway and deliver outcomes
- Develop plan to reduce variation
- Report plans and progress on plans to relevant governance boards

5.4 Cancer

5.4.1 Transformation Funds
The STP was recently notified of the allocation of £15m transformation revenue funding to the East of England Cancer Alliance. There has been no indication of any capital funding. The Cancer Alliance made a submission to the national team to secure this funding and details of how the allocation is being split centrally and locally and the priorities are detailed below:

- Centrally held £3.5m Cancer Alliance funding to cover:
    - Sustainable cancer performance through the delivery of all eight cancer waiting times standards via increases capacity, encourage effective, cross-organisational working and broker agreements between providers to balance supply and demand more effectively across the system
    - Demonstrable impact on uptake of the screening programmes, based on local need
    - Implement one RDC for a defined population within the Alliance geography

There will also be funding available for the following centrally funded projects allocated to specific STPs:

- Luton and Thurrock STP's - Working as part of the national Targeted Lung Health Checks Programme, develop and implement a plan for year one
- Improved quality of cancer care reviews with an extension on the current cancer care in the Community projects in Cambridge and Peterborough, Norfolk & Waveney and BLMK STP's.
- Papworth Lung Pathway

Details of what this should cover and how much will be retained centrally for pan STP work is in the process of being finalised. It is expected that STP members are likely to see increased funding for transformation in 2019/20 and details of this and how it will be accessed should become available soon.

- Current indications of priorities for STP the revenue allocation of £1,492,000 are to cover:

- Demonstrable improvement in number of cancer patients receiving a diagnosis or being told that cancer has been ruled out within 28 days on a lung, prostate and colorectal pathway.
- Implementation of oesophago-gastric timed pathway in all Trusts across the STP with a specific allocation of £120k for the OG centre.
- Personalised/patient centred follow-up for patients with early breast cancer, stable prostate cancer and colorectal cancer.
- Personalised care/improved quality of cancer care reviews

Schemes funded from 2018/19 transformation are well underway including a series of capital projects e.g. MpMRI at Princess Alexandra Hospital and FIT testing across the STP. Both the revenue and capital funding did not arrive at the STP until late in 2018/early 2019 and this has created an added pressure to implement the schemes at significant pace, a challenge that the system has risen well to meeting.

5.4.2. Workforce

Early in 2019 the Cancer Alliance commissioned GE Healthcare to review hospital system workforce in order to support six STPs to address their workforce challenges across the whole pathway of cancer care. Inclusive of care delivered to patients from screening/diagnosis, through treatment, to living with and beyond cancer.

The primary focus of the programme is to

- Determine how the current workforce manages and delivers current cancer activity and care today
- Use this understanding to form a clear view as to how planned transformation initiatives impact on workforce and activity in the future (five years)
- Model future models of care for specified pathways.

The STP is currently in the mobilisation phase, which includes collection of work force and activity data. This will be followed by interviews and engagement, including data analysis and presentation of the current view. The final phase involves workshops with STPs to define future view and presentation of the results to each STP which will be presented in a final report.

5.4.3. Recruitment

As part of the 2018/19 revenue allocation there was funding identified to support the recruitment of project management resource to support the scoping and implementation of two of the key workstreams. These were Early Diagnosis and Cancer Care in the Community. The delays in receipt of the final quarters of the funding impacted on the timelines for recruitment and an inability to appoint a suitable candidate in initial interviews had delayed this further. However a second round of interviews has now taken place with a successful appointment being made for the Early Diagnosis Project Manager post, with a potential start date of mid May 2019 and the Cancer Care in the Community post going to second interview early May 2019.

5.5 Mental Health

The workstream has undertaken an STP Mental Health Investment standard meeting to correlate intended funding and delivery plans for 19/20 to ensure delivery against the Mental Health Five Year Forward view requirements and begin the process

toward building a five year plan related to the NHS 10 year plan. Furthermore, the new 5-year Hertfordshire Partnership University NHS Foundation Trust (HPFT) NHS standard contract has now been successfully negotiated and signed by all parties [HPFT, East & North Hertfordshire Clinical Commissioning Group (ENHCCG), Herts Valleys Clinical Commissioning Group (HVCCG), Cambridge & Peterborough Clinical Commissioning Group (CPCCG) and Hertfordshire County Council (HCC)]. From 1st April 2019, the contract will significantly contribute to delivering the ambitions laid out in the Adult Care Service 3 year plan (which fits in with the "15 Year Direction for Adult Social Care"); the Child and Adolescent Mental Health Services (CAMHS) transformation plan and the mental health and learning disability priorities set out in the Five Year Forward View and newly published NHS Long Term Plan.

Herts Valleys CCG and East and North Herts CCG have been successful in their bid for NHSE transformation funding Individual Placement Support (IPS). £543k in total over two years will provide employment support for around 380 service users with severe and enduring mental illness, bringing the Hertfordshire provision in line with that offered in West Essex. Employment specialists offer coaching and advice, along with practical tips on finding a job and preparing for interviews. They can also search for jobs and engage with employers directly on patient's behalf to identify well-suited roles - acting as a crucial link between patient, their employer and medical team.

Both Herts Valleys CCG and E&NHCCG have supported the expansion of primary care mental health models in 19/20 with over £650k each, progressing from pilots to a proof of concept phase. This will reduce DNA's and wait times by providing appropriate care and support in a familiar setting, bridging the gap between primary and secondary care. WECCG are setting out their mobilisation plan in Q1 for implementation in 19/20.

The STP CAMHS leads are currently developing our bid for Wave 2 or 3 of the CAMHS Trailblazers which were released for expressions of interest earlier in April to implement CYP Mental Health Support Teams in Schools (MHST) in 2019/20. Hertfordshire was one of 25 areas awarded Wave 1 funding, but there is a desire to further increase the coverage of this provision.

5.6 Workforce

There has been excellent progress in the last quarter as resources have been brought on board to support delivery for newly defined workstreams and the more advanced workstreams (Workforce Planning, Temporary Staffing and HR Services) continued to implement the agreed next stages of their plans, as well as determine the next steps for 19/20.

In addition the developing workforce strategy has been discussed with many stakeholders, through the monthly workstream leads meeting and a 'strategy development meeting. The strategy has been presented to the LWAB meeting following a very successful session at the STP CEO's meeting on 2nd April 2019. At this meeting the CEOs were very positive about the strategy and were pleased with the ambition shown, supporting all the key areas of strategic focus and now the elements of the strategy work plans are being been defined through the existing

workstreams, but also areas where implementation plans and mechanisms of delivery need to be defined.

Two key risks worthy of particular note are:

a) Capacity of workstream leads and teams to support implementation these major programmes of work. *Mitigation: Identify deputies for each of the major workstreams, increase the number of people participating in the programmes and align activities where possible.*
b) Sustainability of resources to support the ambitions of the workforce strategy and associated programme. *Mitigation: Gain clarity on future HEE funding, proactively agree future funding requirements for workstreams and agree through system CEOs and executives*

5.6.1 *Attraction, Recruitment, Retention - Progress* and Next Steps

1. The team attended the Lincolnshire Talent Academy Workshop (LTA) on 24th January 2019 to learn more about their experience of setting up the academy and lessons learnt. Two key elements that came out of the day were:
    a. Herts and West Essex may be able to use the technology developed by Lincolnshire – this will accelerate the development of the portal which is integral to the project. We are awaiting further details from LTA and HEE.
    b. As well as supporting delivery of the Attraction Strategy, the talent academy could be a delivery vehicle for key elements of the Leadership and OD, and Workforce Redesign and Development workstreams e.g. managing apprenticeships across HWE, graduate development programmes and managing training pathways. This has been discussed with workstream leads and it has been agreed in principle that we should develop this in a joined up way across the three workstreams.
2. In the meantime, two foundations pieces are being developed – an HWE Work Experience approach (building on existing work e.g. PAH) and developing the brand (based on the values / behaviours of partner organisations across HWE).
3. In addition the first 'Future Heroes' event of the year was successfully run on 2nd April. There was great interest in the event with 700 students signed up (17% up on last year).
4. These pieces of work will continue and in addition resources are being sought to undertake a short piece of work on understanding current retention initiatives across HWE, identifying synergies and gaps, and making recommendations on HWE cross-cutting activities.

5.6.2 *Leadership and OD - Progress* and Next Steps

1. A mapping process for existing leadership programmes is now underway across the STP. Several Trusts are already in a place where they can open up places to STP partners. Work is now taking place on the communications and booking process to enable this to happen.

2. A Temporary website is being evaluated in order to facilitate communication and booking of system training whilst a permanent portal is being scoped out and developed
3. Key contacts are being identified across the system. Up to date contacts and organisation structures are being collated in order to give a clear picture of what resource there is within leadership and OD across the system
4. Mary Seacole process for expansion has been agreed with the original 4 partners provisionally. Contract negotiations are now taking place and funding has been provisionally secured for next 2 years.
5. Organisations across the STP are working together to create a system wide approach to this year's Graduate Management Training Scheme placements. Requests for around 20 GMTs have been made from partnership organisations. The aim is to provide placements in a variety of settings across the system.
6. Links have also been made with 2 key contacts within the system to provide masters level training across the system, using the apprenticeship levy.

5.6.3 Workforce Redesign and Development - Progress and Next Steps

1. A PID is broadly agreed and a project plan, programme delivery mechanisms have been created.
2. A short-term process for commissioning of roles for this year and communication of this has been agreed. Alignment between commissioning requirements and ongoing gaps demonstrated in workforce planning is being developed.
3. Newly qualified demand for 2023/24 has been sent through from organisations, STP demand forecast is being created.
4. Meetings have taken place with HEI's to understand expectations, previous challenges and discuss strategic direction.
5. Apprenticeships – Following the last LWAB there have been three main areas of focus:
   - The transfer of apprenticeship levy from levy-paying organisations to primary care is being explored. Meetings are taking place with CCG's to understand logistics. Two TNA apprenticeship posts in Primary Care are confirmed for the next cohort.
   - Existing strategy and plans for use of apprenticeship levy within organisations are under review. The review aims to identify commonalities and disparities and conjoin where appropriate to maximise spend
   - Process underway to identify expertise within organisations that are capable of delivering apprenticeship training for the system, understand capacity and operational requirements.

5.6.4 WS4 HR Services - Progress and Next Steps

Occupational Health: First stakeholder engagement workshop was held (Jan19) to launch the work around establishing one OH service for the STP. The current provision was reviewed, outlining improvements needed in the delivery of the service for each provider and recommendations for collaboration. (Including: Transactional Occupational Health Services (TOHS), Employee Assistance Programmes (EAP) and Fast-Track Musculoskeletal services (FTMS). These have been approved and

two working groups will take this forward. Mini market tests were conducted to establish interested parties for delivering an OH service for HWE, with 8 expressions of interest.

Payroll: A scoping exercise was conducted to establish the current delivery of payroll services across the STP. East and North Hertfordshire NHS Trust (E&NHT) is the provider of payroll services for six of the eight organisations. A mini market test was conducted to ascertain the potential interest of providers wishing to provide services for the STP if required. One party provided an EoL.

Mandatory and Statutory Training Passport (MaST): A survey was conducted across the STP to map the current provision of mandatory and statutory training CSTF, and to highlight the differences in delivery. The MaST group has agreed an STP action plan to address misaligned areas.

East of England's ESR team have been engaged to support organisations to implement enablers to allow the automatic transfer of training records between NHS organisations for new starters and leavers. Action plans have been agreed.

5.6.5 WS5 Temporary Staffing- Progress and Next Steps

1. DHSC pilot completed successfully on 31st March 2019 with DHSC report due April/May
2. The numbers of organisations that now make up The Bank Network has moved from 3 to 5 and for the first time we have genuine interoperability that allows mixed provision within a shared bank.
3. Decision making process has begun re future management of bank provision as contract with current incumbent, NHSP expires in April 2020.
4. Appetite has been sought across the East of England to extend and develop the medical locum initiative with the key areas suggested as follows:
    - Continued creation of ceiling rates to enable consistency
    - Bank rate alignment where reasonable
    - Aligned procurement strategy
    - Internal controls framework
5. Other areas being investigated through the Medical Locum Consortium are the full potential of the app market and also should doctors be included in the bank network.

5.6.6 Workforce Planning - Progress and Next Steps

Current Workforce

- Workforce Information / Planners group met Jan 19 / Feb 19
- Benchmarking information was returned and Q3 18/19 report has been completed
- Sources of information have been identified for profiling. Profile information is available.
- Initial update on STP workforce numbers and profile has been completed
- In addition Trust provider NHSI workforce plans have been collated and summarised for H&WE (workforce projections and narrative). This has been used for discussions and reporting with NHSE and NHSI.
- HEE toolkits demonstration viewed – the use of these analytical tools is being evaluated.
- It has now been agreed that there will be a quarterly refresh of current workforce numbers

Future Workforce

- A plan is being developed for developing an approach to understanding future workforce requirements – this has two elements – quantitative and qualitative. Both elements will involve working with HWE Clinical workstreams as well as developing an overarching workforce view.
- The Kings Fund / Nuffield are keen to work with HWE on the qualitative work and building workforce capability
- A tendering exercise is also beginning to build a quantitative future modelling capability which can then be used by the system.

5.7 Medicines Optimisation

The medicines optimisation workstream has undertaken a stock take of its priorities and has aligned the design of these through the Integrated Pharmacy Integration Programme (IMOP), which the HWE STP has been chosen as one of 7 STP test sites.

The priorities include:

1. De-prescribing / polypharmacy reviews in the moderately and severe frail population - Start-stop. This will be designed in close connection with the STP frailty programme and aims to embed the delivery and design of this through the standardised assessment tool - Rockwood.

2. Education and training of the wider workforce on medicines optimisation through the appointment of a frailty pharmacy consultant.

3. Development of a pan STP pharmacy workforce offer for the pharmacy element of PCN's.
4. Linking in a pharmacist bank to the pan STP wider workforce bank

5.8 Primary care

The primary care workstream has started to scope the detail of the programme to design the three agreed STP priorities which include:

- Primary care networks functioning
- The further development Integrated social prescribing model
- Design and oversight of the existing GP practice on line consultation roll out

The draft primary care strategic framework has been circulated by the SRO for comment into the STP senior leadership teams and the work programme will be developed in line with this. This has been supported by the STP CEO's.

Current thinking is that the priorities agreed all align under the design of the future functioning of the PCN's and are components to the PCN functional development.

5.9 Technology

A renewed STP Technology workstream structure was proposed and agreed at the STP Technology Board on 15th April. The new structure responds directly to the NHS 10-year plan and the STP Health and Care strategy.

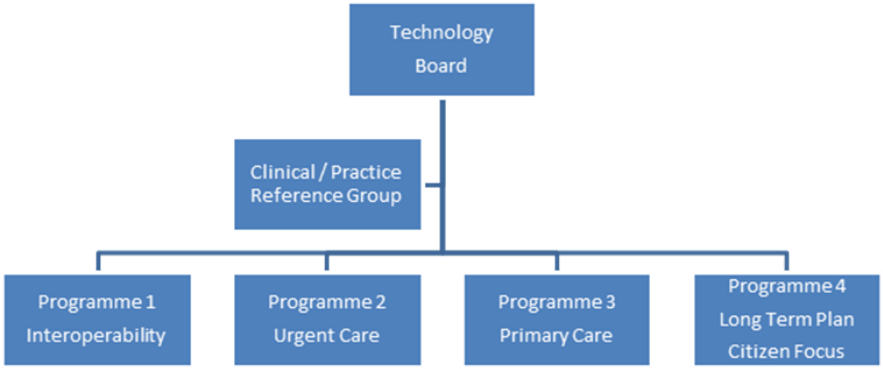

Fig 1. New STP Technology structure

A meeting has been held between our STP Technology leads and NHSE representatives to discuss our strategic plans for interoperability and funding availability for the coming years (including HSLI).

A paper to STP Technology Board – proposing that the Shared Intelligence workstream move to the new Population Health Management structure – was approved and work is ongoing to ensure an effective transition.

The live dashboard (SHREWD) portfolio of projects has been reinvigorated by a project manager coming into post. There has been positive engagement with leads from across the STP and papers have been tabled at all LDB / SRG meetings to promote engagement. There is some national interest (NHSE, NHSD) in this project, so expedited delivery is desirable.

The Programme Manager for the work stream will finish on 1st May and recruitment for a successor is being worked on.

5.10 <u>Integrated clinical oversight group</u>

Dr Rachel Joyce has taken up the chair of the Integrated Care oversight Group (ICOG) and the group has now reviewed and discussed the implementation of the TOR agreed at the STP CEO meeting.
A priority for the group will be the engagement and collaboration with clinical and professional leaders across the STP and further development of the integrated care strategy outcomes framework.
It has been agreed that the first STP workstream deep dive at the May meeting will be the technology workstream.

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Communications and engagement update – March 2019

This dashboard is a summary of the STP communications and engagement work that took place across the STP in March. For more information, contact nuala.milbourn@nhs.net

Internal comms

Weekly updates - STP updates are shared with communication and engagement leads for circulation every week. This month these included feedback on the events listed below and the appointment of our new Clinical and Professional Director, Dr Rachel Joyce.

Engagement

Incentivising innovation in outpatients – making the first contact count. Supported a workshop with over 40 senior clinicians, service managers, patient representatives and commissioners to share examples of outpatient and out-of-hospital service transformation, alongside presentations from the Academic Health Science Networks and NHS Right Care. The next steps for outpatient reform are now in development (12 March)

Engagement with the voluntary sector – presented the STP's Integrated Health and Care Strategy at a meeting of CEOs from many of the Hertfordshire- based voluntary sector organisations and discussed how best the STP can work with them (12 March)

Integrated pharmacy and medicines optimisation regional event - STP pharmacy professional leads, Anurita Rohilla and Pauline Walton, hosted a regional conference with NHSE to share information on a wide range of STP initiatives. Over 60 attendees attended (13 March)

Meeting with Hertfordshire Healthwatch CEO to discuss engagement regarding strategy and NHS Long Term Plan with hard to reach groups (19 March)

The future of personalised care in Hertfordshire & west Essex – supported workshop to update over 30 health and care professionals, carers and patients with lived experience on what has been achieved so far in relation to personalised care in our region and to discuss steps and a vision for the future (21 March)

External comms

The following press releases were issued by the STP comms team in March and can be read in the 'news' section of the STP website.

- STP pharmacists lead new national medicines pilot (07.03.19)
- Hertsmere plan to help housebound residents cut medicines waste (18.03.19)
- STP appoints new clinical and professional director (28.03.19)

Social media

Four week 'winter' messages advertising campaign via buses and social media (awaiting stats)

Paid for advertising campaign

A STP- wide winter health campaign ran between February and March. Using funding from NHSE, Herts Valleys CCG and East and North Herts CCG, the campaign had three main aims:

1) Encourage the public to think 'pharmacy first'
2) Encourage the public to get the 'flu jab and take preventative health measures
3) Encourage the public to use the free NHS111 advice service.

Advertising targeted:

- people with long term conditions
- people aged 55-75
- parents of young children
- young adults ages 18-25

Messages were disseminated through social media and through adverts on internal bus panels and the backs of buses. Buses routes that ran across Hertfordshire and west Essex were used.

Our digital advertisements were displayed on devices more than 1 million times in the campaign period, generating over 2,000 hits to either the NHS111 website or the 'Stay well this winter' page. In addition, promotional videos were viewed for at least 10 seconds on more than 149,000 occasions.

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Top Tweet earned 1,862 impressions

Learning about new outpatient models such as teleconsultations and virtual clinics which can reduce wait times and provide other benefits for patients @UCLPartners @TheEAHSN #HWEoutpatients @ENHertsCCG @nhswestessex @HVCCG #patientcare pic.twitter.com/ecK4hMWYS7

4 10

Social media statistics (As compared with February 2019)		STP website statistics (As compared with February 2019)	
	37 Tweets (25) **651** followers (613) **144** mentions see top tweets above	Unique users:	**867** (844)
	Follows **53 (43)**	Page views:	**2,709** (2,466)
	Norovirus video: **584 views total** Winter advice for respiratory conditions: **189 views total**	Busiest day:	**28 March**

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Top 10 most viewed pages www.healthierfuture.org.uk website

1. Home: **572** (552)
2. Publications: **137** (148)
3. News – new clinical and professional director: **80 (new story)**
4. Venues: **71**
5. News (main page): **64** (74**)**
6. News (Hertsmere pharmacy initiative): **62** (new story)
7. STP organisations: **59**
8. Jobs: **52** (100)
9. System leadership/workstream news: **51** (66)
10. Search page: **50**

Pledges & sign-ups

671 direct subscriptions to Healthier Future Newsletter (up 18). Subscribe here.

Local and regional media coverage

Media coverag

New Clinical and Professional Director

Bishops Stortford Independent, 30 March

https://www.bishopsstortfordindependent.co.uk/news/new-top-job-for-medical-director-for-east-and-north-hertfordshire-clinical-commissioning-group-9065692/

Hertsmere plan to help housebound residents cut medicines waste

Borehamwood & Elstree Times, 21 March

https://www.borehamwoodtimes.co.uk/news/17518135.initiative-launched-in-hertsmere-to-reduce-risk-of-elderly-people-stockpiling-medicines/ (+)

Watford Observer, 21 March

https://www.watfordobserver.co.uk/news/17518139.initiative-launched-in-hertsmere-to-reduce-risk-of-elderly-people-stockpiling-medicines/ (+)

Hertfordshire Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	6th June 2019	**Agenda Item:** 7
Subject:	Integrated Governance Committee	**For Publication: No**
Author:	Shari Payne, Head of New Care Models	**Approved by:** Sarah Betteley, Non-Executive Director
Presented by:	Sarah Betteley, Non-Executive Director	

Purpose of the report:

The purpose of the report is to provide Board with an overview of the work undertaken by the Integrated Governance Committee at its meeting on the 22nd May 2019.

Action required:

The Board are asked to note the report

Summary and recommendations to the Committee:

An overview of the work that was undertaken is outlined in the report. No issues were noted to be escalated to the Board of Directors.

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

Priorities 1,2 and 3

Summary of Implications for:

N/A

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

N/A

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

N/A

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

N/A

Hertfordshire

1.0 Introduction

1.1 The Integrated Governance Committee took place on the 22nd May 2019. This report sets out the key matters that were discussed.

1.2 No matters were identified as needing to be escalated to the Board.

2.0 Governance

2.1 Board Assurance Framework was received with only slight amendments from the last quarter and nothing materially to raise to the committee.

2.2 Trust Risk Register was received with the following risk being agreed and added to the register:

- Impact of the failure of HCT to retain Adult Community Services in Herts Valley

2.3 The committee received the Q4 report for Guardian of Safe Working Hours. IGC noted an area of concern where staff are not reporting, especially from Acute hospitals where there are no rest rooms or supervision. It was felt that difficulties are rarely reported here because they are supported in other ways. The Trust recognises these challenges and appoints agency staff where we can.

2.4 The Q4 Policy Report was received. It was noted that although the Trust is within the target for reviewing policies there remain some that are significantly overdue and these will be prioritised in Q1. Regular updates will be presented to future IGC meetings.

2.5 The Annual Speak Up & CQC Concerns Report was received. It was noted that all Speak Up concerns are securely stored on the Datix system with restricted access. The Trust's Freedom to Speak up Guardian (FTSUG) was appointed in August 2018. The Guardian and the Risk and Compliance team have actively promoted the role of "Guardian" and how to access and raise concerns. This has included visits to sites, attending the Big Listen, taking part in induction and ensuring wide marketing of the champion, through posters on wards and non-clinical areas. A total of 18 concerns were raised in 2018/19, compared to 20 in 2017/18. There were no themes identified.

2.6 The committee received the Q4 Annual Claims Report. The committee noted;

- 13 new LTPS (Staff and Public Liability) claims received.
- 6 new CNST (Clinical Negligence) claims received.
- 60% of claims settled were successfully defended, with no payments made to the claimants.

2.7 The Annual Mental Health Legislation update was received. The committee noted that Changes in legislation in December 2017 continue to impact on the service for individuals under Section 135/6. This has resulted in a number of service users being unlawfully detained. Work continues to be undertaken with operational staff and partner agencies to address the factors that impact on this.

3.0 Workforce

3.1 The Organisational Development Deep Drive was presented and received by the committee. Key highlights included;

- Our Good to Great Strategy – in the third year of our OD Strategy.
- Key themes of our Organisational Development (OD) Strategy – based around the values within the organisation, these include culture, customer experience, Leadership, organisational effectiveness and design and staff experience and capability.
- Feedback – the following areas were identified as areas of focus for the OD Strategy:
    - Being able to make improvements at work.

    - Making adequate adjustments to carry out work.
    - Acting fairly regarding career progression and promotion.
    - Experiencing bullying, harassment, abuse or physical violence at work from managers.
    - Taking positive action on health and wellbeing.
    - Receiving clear feedback from immediate manager.
    - Unrealistic time pressures and having adequate equipment to do my work.
  - Gap analysis – identifying gaps are and remedial actions.
  - Next steps – embedding Continuous Quality Improvement (CQI)

3.2 An update was received on the Ability to Recruit Audit. The report highlighted the outcomes from the audit, the level of assurance received (partial) and progress against the four actions.

3.3 The outcomes of the EDS2 were received by the committee. The purpose of the report was to provide assurance of compliance with the Public Sector Equality Duty (PSED). It was noted that good progress has been made and results will be published on the Trust website pending Board approval.

4.0 Quality

4.1 The Quality and Delivery Strategy was received which is currently in the draft stage before being presented at Board for agreement

5.0 Safety

5.1 The committee received the Q3 Safeguarding report. It was noted that during Q3 the Safeguarding Team continued progress the Safeguarding Improvement Plan 2018/19.

5.2 The Annual Integrated Safety Report was received. The committee noted the progress in relation to ensuring safe services are delivered and that service users remain safe whilst in the Trusts care. It was also noted that the National Staff Survey showed the Trust with the highest score for safety culture and the CQC rated the Trust as 'Good' for safety.

5.3 The committee received the Safer Staffing Annual Report which provides the detail of progress the Trust has made in relation to safer staffing and identifies the areas of challenge during the year as well as the achievements that have been made. It was noted there has seen successes with the use of SafeCare and eRostering in the inpatient services. Also, Heads of Nursing have continued to monitor the staffing levels, enabling services to support each other in order to run safe and effective services whilst being compliant with the safer staffing requirements, to ensure the Trust has the right staff, in the right place, with the right skills, at the right time.

5.4 The Annual Report on Infection, Prevention and Control was received noting that the Trust continues to deliver high standards in IPC owing to strong and open working relationships. There are remaining actions in the IPC programme, which will be incorporated into the 2019/20 programme.

6.0 Effectiveness

6.1 The Committee noted the Quality Account, which is part of the Annual reporting process, was ratified at the Audit Committee along with the Annual Report and the financial accounts. The committee thanked Jacky Vincent for her hard work to deliver the report and the excellent content.

6.2 The report on Quality Impact Assessment was received. The committee noted that there are currently two CRES schemes being developed for 2019/20.

  - Finance shared services
  - Warren Court staffing

The schemes are a continuation from last financial year.

It was also noted that the CRES challenges in 2019/20 are significant, relating to achieving much greater efficiencies with regard to agency spend and placements.

6.3 The CQUIN update was received where the position was presented on the performance and income on Hertfordshire's five CQUIN goals for 2018/19. The predicted CQUIN value for the Hertfordshire schemes is currently £2.76m (78.55%).

6.4 Annual Research and Development Report was received noting there had been no research related complaints during the last 12 months. Research within the Trust was inspected by the CQC in both 2018 and 2019 as part of the Well Led inspection. No concerns were raised.

6.5 Annual Practice and Clinical Effectiveness report was received. The committee noted the proposed PACE annual programme for 2019/20 consisting of 77 audits in total. All audits will be presented to PAIG for final sign off.

6.6 The Practice Audit Implementation Group Annual Report was received noting a total of 40 audits being approved in 2018/19 with 11 being escalated. In the last 12 months, PAIG strengthened the membership by introducing service user and carer representation.

7.0 Experience

7.1 The operational services update was received. It was noted that during Q4 there has been an increase in demand into services with an impact particularly in Adult community services, CAMHS and inpatient areas. Despite high demand and acuity, transformation of services has continued, for example in terms of remodelling of the Personality Disorder pathway, Psychosis pathway, Crisis services, development of Older People's Community services and the Essex Partnership.

7.2 The Q4 Complaints and Service Experience Report was received noting that 1,546 pieces of feedback (not including PALS, compliments or complaints) were received in the quarter. During the quarter we received 82 formal complaints, 224 PALS contacts and 408 compliments. The Ombudsmen returned 2 decisions as not being investigated and no further action needed from the Trust. This represents an increase in complaints, compliments and PALS concerns.

8.0 Conclusion

8.1 The committee decided there were no issues to be escalated to the Board

Hertfordshire Partnership University NHS Foundation Trust

Trust Board

Meeting Date:	6th June 2019	Agenda Item: 8
Subject:	Annual Integrated Safety Report 2018/19 (including Q4 reporting)	For Publication: Yes
Authors:	Carolyn Fowler, Deputy Director Safer Care and Standards Bela Da Costa, Legal Services Lead, Nikki Willmott, Head of Safer Care and Standards,	Approved by: Dr Jane Padmore, Executive Director for Quality and Safety (Chief Nurse)
Presented by:	Dr Jane Padmore, Executive Director for Quality and Safety (Chief Nurse)	

Purpose of the report:

To report to the Board on patient safety during 2018/19, and give assurance that the Trust is meeting its requirements and delivering safe services.

Action required:

To Approve: to formally agree the receipt of report and the overview of analysis, learning and activity for 2018/19 and Quarter 4 reporting.
For Assurance: to appraise the Board that controls and assurances are in place.

Summary and recommendations:

This report provides the detail of the progress the Trust has made in relation to ensuring safe services are delivered and that service users remain safe whilst under our care in the year 2018/19, including quarter 4 reporting. The report identifies the patient safety priorities that the trust has implemented to minimise risks to service users, staff and visitors.

The report discusses the impact of the CQC visit and the final report that was published in April 2018, considering the actions taken to improve safety.

Safety initiates in light of CQC feedback and the trust's drive for continuous improvement included the implementation of the moderate harm review panel, safety huddles, safeward methodology, zonal safe and supportive observations and a review by Mersey Care of our seclusion and restrictive practice.

The Trust reported a similar number of incidents during 2018/19 in comparison to 2017/18, however there was an increase in moderate harm incidents and the number of serious incidents reported. This is partially due to the introduction of the moderate harm panel and will be discussed in more detail.

The annual plan objectives of reducing suicides and incidents relating to violence and aggression were challenging and although these were not met, a number of initiatives were implemented, that is hoped will have impact during 2019/20.

Building on the work this year a number of priorities have been set. These have taken into account national and local drivers, including learning from incidents. In summary these are:

Annual Plan
- Reducing suicides
- Feeling safe
- Reducing harm in relation to violence and aggression
- Seclusion environments and practice

Strategy
- Quality Strategy
- Making our Services Safer Together (MOSS 2gether)

Governance
- Safety Dashboard on Spike 2
- Implement the updated Serious Incident Framework (due to be published in 2019)

Learning from incidents
- Implementation of NEWS2 and SBARD
- Suicide Prevention Plan

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

Relation to the Trust Risk Register: (Specific risks)

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

Relation to the BAF: (Strategic objectives)

1. We will provide **safe** services, so that people feel safe and are protected from avoidable harm.
2. We will deliver a great **experience** of our services, so that those who need to receive our support feel positively about their experience
3. We will improve the health of our service users & support recovery through the delivery of **effective** evidence based practice

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

There are no overt financial implications.

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

No Equality and Diversity and Public & Patient Involvement Implications.

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

Safety KLOE for CQC.

Seen by the following committee(s) on date:

IGC – 22/5/2019

Executive Summary

1. Introduction

1.1 Delivering safe services to our service users is a key priority for the Trust. The Trust is committed to learning from incidents and ensuring continuous improvement. This report seeks to provide assurance on how the Trust's patient safety related data compares nationally and with previous years in order to benchmark HPFT with performance of other trusts and progress that has been made. It also considers areas of risk and the mitigation with actions taken to manage this risk.

1.2 This annual report is an overview of safety relating to service users, and includes health, safety and security reporting, where relative to service users. Quarter 4 is included in the report rather than provided as a separate report.

2. Overview of 2018/19

Background

2.1 In April 2018, the Trust received the CQC inspection report, following the inspection visit in February 2018. The Trust was rated 'Good' overall but 'Requires Improvement' for safety. Key areas of good practice were identified but a number of areas relating to safety required action. In March 2019, the Trust was inspected again, with informal feedback indicating that safety had significantly improved. The final report was received May 2019, outside the reporting period, and the Trust received 'Good' across the services for safety.

2.2 The Trust committed to implementing recommendations from CQC and restructuring committees to ensure robust continuous quality improvement. The vision was to primarily achieve the improvements by developing a culture of safety, where safety was the focus for everyone.

Initiatives

2.3 The improvements in safety were achieved through refocusing the safety committee to include clinical directors and heads of nursing. Also, a new suicide prevention group was established, which commissioned a deep dive audit of unexpected deaths and self-harm and has multiagency membership. The learning from this has informed the development of new risk assessment training. The implementation of the new 'Sexual Safety on Mental Health Wards Guidance' by CQC has been initiated through a task and finish group.

2.4 The Trust implemented a Moderate Harm Panel to improve the reporting of and learning from serious incidents. A Continuous Quality Improvement project was undertaken to support this process.

2.5 Learning from incidents became a key aspect with the introduction of SWARMS, a reflective session for staff to establish immediate and longer term learning. Schwartz rounds and staff support sessions already embedded, continued to be developed.

2.6 A number of other safety initiatives were developed that included safety crosses, Safety pods, safety huddles and zonal observations.

2.7 A review of seclusion practice and documentation was undertaken by Mersey Care NHS Foundation Trust in July 2018. Recommendations have been implemented and an improvement in documentation and processes has been seen. The new RESPECT training was rolled out to staff, following a detailed review of the programme.

2.8 More robust systems have been implemented for assessing and managing ligature and blind spot risks. This has included the ANT technology and using pictures at handover/

Outcome

2.9 The annual plan priorities in relation to safety were to reduce the number of suicides by 10% and decrease the number of violence and aggression incidents by service users. Unfortunately neither of these outcomes were achieved but significant work has been undertaken and these priorities remain in the 2019/20 annual plan. The annual plan also prioritised service users feeling safe and the target was achieved.

2.10 The number of incidents reported remains similar to last year, although the number of resulting in moderate harm increased significantly. This could be attributed to changes in the processes and the implementation of the moderate harm panel at the beginning of 2018/19. The number of serious incidents reported also increased, partially due to the implementation of the moderate harm panel but also due to an increase in unexpected deaths and violence and aggression to our staff by service users.

2.11 Pressure ulcers have increased, in particular Grade 2 and 3. The grade 3 pressure ulcers have been investigated as serious incidents, and there has been a focus on risk assessment training following the outcomes. Accurate reporting has been championed this year and this may also be one of the reasons for this increase.

2.12 The Trust achieved the highest score nationally in the 2018 Staff Survey results among mental health and learning disabilities trusts, for the theme of safety culture, a reflection of the outcome of the work undertaken in 2018/19.

2.13 Falls have decreased slightly, with better clarification of the type of fall, that is, whether the fall was seen or unseen.

2.14 Ligature incidents have reduced significantly in 2018/19, due to improved processes, including a new weekly audit of change, blind spot photographs on the wards and floor plans.

2.15 Absconding incidents have remained the same, with decreases in missing persons and an increase in absence without authorised leave (AWOL) for the first 3 quarters of 2018/19 with a significant drop in quarter 4 by (62%).

Looking forward

2.16 In 2019/20 the work that was started in 2018/19 will continue to be embedded and developed further. This will be underpinned by the Quality Strategy which has been co-produced with staff, service users and carers, and this will be launched early in 2019/20.

2.17 The Making Our Service Better Strategy (MOSS) came to an end and was extended to cover 2018/19 whilst the consultation for the new strategy took place. The new 'MOSS together' will also be launched in 2019/20 and will incorporate Shared Decision Making.

3. Conclusion

3.1 The National Staff Survey showed the Trust with the highest score for safety culture and the CQC rated the Trust as 'Good' for safety. This is a good reflection of the continuous improvement seen for safety during 2018/19, despite not achieving all the priorities in the annual plan. The learning from this year has been used to inform the priorities for 2019/20.A number of priorities have been identified for 2019/20.

4. Key priorities for 2019/20 include:

- Annual Plan
  - Reducing suicides
  - Feeling safe
  - Reducing harm in relation to violence and aggression
  - Seclusion environments and practice
- Strategy
  - Quality Strategy
  - Making our Services Safer Together (MOSS 2gether)
- Governance
  - Safety Dashboard on Spike 2
  - Implement the updated Serious Incident Framework (due to be published in 2019)
- Learning from incidents
  - Implementation of NEWS2 and SBARD
  - Suicide Prevention Plan

Annual Integrated Safety Report 2018/19 (including Q4 reporting)

1. Introduction

1.1 The Annual Patient Safety Report provides members with an overview of incidents and serious incidents reported on the Trust's Datix incident reporting system during 2018/19. It includes a review of mortality data and serious incidents reported and investigated by the Trust. Datix is a live data base and therefore is subject to change. All data in this report was taken on 24 April 2019.

1.2 The report provides a review of trends, themes and identified learning. The Board received quarterly Patient Safety Reports in Quarters 1 to 3. Quarter 4 is integrated into this report.

1.3 The report is divided into the following sections:

- Part A Governance and assurance
- Part B Analysis of Incidents
- Part C Learning and Changing Practice
- Part D Conclusion

1.4 The report gives an overview of Trust incident data, with comparison against 2018/19, this includes: serious incidents, falls, pressure ulcers, ligature risk, absent without leave and violence & aggression.

1.5 There are key areas of learning and actions taken, that are discussed in the report with an outline of the education and training the Trust delivers to support safe care.

1.6 The Trust's annual plan objective for safety was:

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

Key priorities were:

- We will continue our drive to reduce suicides and prevent avoidable harm.
- We will ensure restrictive practices are in line with best practice.
- We will target activities to reduce violence against service users and staff.

Part A- GOVERNANCE AND ASSURANCE

1. Introduction

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

1.2. The Quality and Risk Management Committee (QRMC) reports to IGC on the work of QRMC and its subcommittees. The safety committee oversees all the work relating to safety in the Trust and holds the safety risk register. The mortality governance group, the moderate harm panel, the restrictive practice task and finish group and the sexual safety group have all played a significant role in the work and governance relating to safety this year.

2. Priorities

2.1. A number of priorities were set in relation to safety in the Trust's 2018/19 Annual Plan:

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

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

3. Trust Risk Register

3.1. The Trust's Risk Register has been reviewed regularly throughout the year and has a number of risks that relate specifically to safety; those below have a significant impact on safety and service user harm:

- The Trust is unable to recruit staff to be able to deliver safe services due to national shortages of key staff.
- The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services.
- Implications for the Trust of differing scenarios arising from Brexit
- The Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff.
- Failure to respond effectively to increasing demand in Adult Community resulting in a risk to safety, quality and effectiveness

3.2. These are reported in the quarterly Trust Risk Register Reports. This report provides the IGC with additional information about the work that is being undertaken to address and to mitigate against these risks.

4. Safety Dashboard

4.1. A draft safety dashboard with the relevant KPIs has been agreed in this year and will become operational in 2019/20. This will be hosted on 'SPIKE 2' and allow real time data to be viewed at Trust, Strategic Business Unit (SBU) and service level. This will support the identification of any hot spot areas, and be a clear method of tracking declining or improving positions and learning from this.

5. Care Quality Commission (CQC) Safety Key Lines of Enquiry (KLOE)

5.1. The Trust was inspected in February 2018, with the final report published in April 2018. A significant number of actions were taken as a direct result of the findings in the report including:

- Weekly environmental audits to support a new system of managing ligature risk provided by Advanced New Technologies (ANT).
- Ligature risk assessments have been updated and services have developed systems to support staff to recognise risk, these include books of photographs and floor plans.
- The Mersey Care review was completed in July 2018 and the final report and recommendations are being taken forward.
- Refurbishment of seclusion rooms to meet identified best standards.
- RESPECT training has been reviewed and additional course content has been added including human factors and new techniques.
- The implementation of the Moderate Harm Panel, which meets weekly, with membership of Clinical Directors, Managing Director's, Safeguarding Lead, Deputy Medical Director, Deputy Directors and the Head of Safer Care & Standards.

5.2. In March (Quarter 4) 2019 the CQC inspected the following core services along with a well led inspection:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for Older People with mental health problems

5.3. The CQC's final report was published on 15 May 2019, outside of this reporting period, but was published at the time of writing. As it pertains to the reporting year it will be included in this report.

5.4. The Trust received one regulatory notice under effectiveness but none for safety. Every service line received a 'Good' rating and the Trust received a 'Good' for safety overall.

5.5. The CQC Insight report is updated every two months. During this quarter it was received in January 2019. The Insight report is a monitoring tool which tracks trends in quality (declining or improving) at provider, location and/or core service level to support decision making by the CQC. CQC Insight aims to make it easier for inspectors to monitor their portfolio and identify potential changes in quality by having routine access to key information.

5.6. There was one change since the last refresh of this report and report to IGC. This is in relation to the rate of recorded self-harm per 100 learning disability inpatients on secure (level 1-3) wards. The Trust is reported to be worse than the national average with

38.7% against a national score of 28.6%. In the November 2018 report the Trust was considered in line with the national average. (Data source MHMDS Jan 2019).

5.7. The self-harm data relates to a small number of services users who have a high number of self-harm incidents. Staff are supporting these individuals and reviewing their care, as a multidisciplinary team regularly.

6. **Conclusion**

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

Part B- INCIDENTS INCLUDING SERIOUS INCIDENTS

1. Introduction

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

2. Trust Incident Reporting

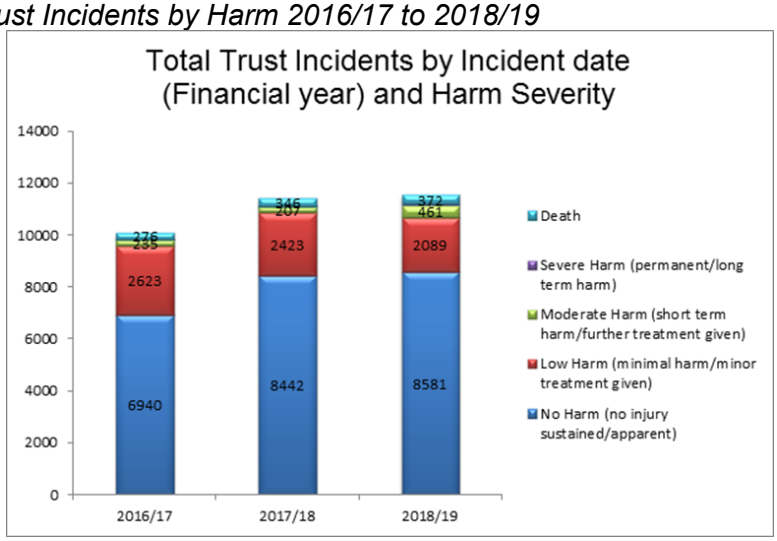
1.1 Patient safety incidents are defined as *'any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe*.' NHS Improvement 2017.

1.2 Datix is the information management system the Trust uses to record and analyse incidents. Training is provided for staff on using Datix which provides a forum for education to enable improvements in the consistency of the quality of incident reporting and the types of incidents that should and should not be reported on Datix. There is local monitoring and oversight of data by each Strategic Business Unit (SBU) and additional quality assurance checks undertaken by the Safer Care Team.

1.3 All team leaders and modern matrons have access to incident dashboards on Datix to enable the use of incident reporting for team reflection and learning. During 2018/19 work commenced on a Safety Dashboard on Spike 2, with a set of agreed safety Key Performance Indicators (KPIs). This is in addition to generic and bespoke Dashboards available on Datix for subject matter experts, team managers and SBU management teams.

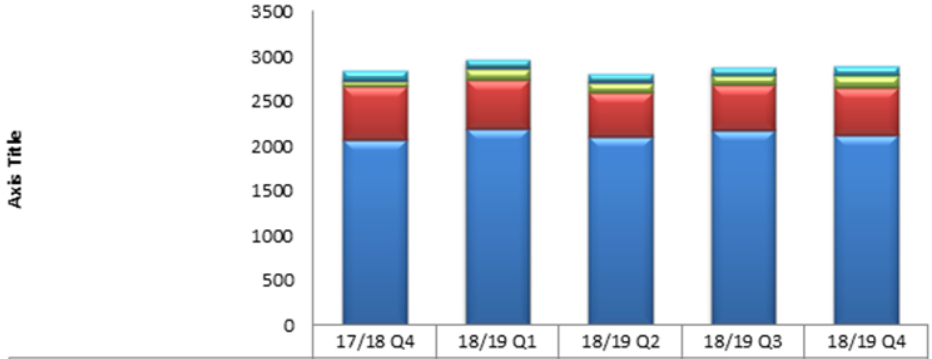
1.4 The number of incidents reported in 2017/18 increased from 2016/17 following a campaign to raise the importance of reporting incidents. It can be seen (Table 1) that this improvement was sustained, with a 1% increase in the number of reports from 2017/18 to 2018/19. A Trust with a positive safety culture and committed to learning expects to have a reporting culture that encourages staff to report incidents and near misses, but where harm remains low.

Chart 1 Total Trust Incidents by Harm 2016/17 to 2018/19



1.5 Moderate harm incidents have increased by over 50%. This was related to an increase in reporting of unexpected deaths, self-harm and Safeguarding Adult & Children (Chart 2). Changes in the type of incident reported was expected following the implementation of the moderate harm panel, where incidents are subject to greater review and scrutiny by a wider group of professionals.

Chart 2 Total Trust Incidents by Harm by Quarter 2017/18 Q4 to 2018/19



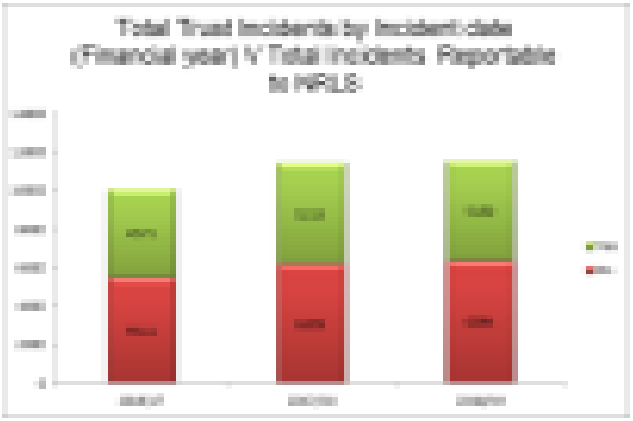
	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Death	111	89	87	97	99
Severe Harm (permanent/long term harm)	3	18	8	2	12
Moderate Harm (short term harm/further treatment given)	57	117	109	108	127
Low Harm (minimal harm/minor treatment given)	596	551	499	500	539
No Harm (no injury sustained/apparent)	2072	2189	2100	2177	2115

3. National Reporting and Learning System (NRLS) Benchmarking Data

3.1. The Trust reports patient safety incidents to the National Reporting and Learning System (NRLS) in accordance with the national guidance. Not all incidents are reportable to NRLS as safeguarding incidents and staff incidents are not included.

3.2. The latest release of the Organisational Patient Safety Incident Report data for NHS organisations (March 2019) provided information about incident data. There was a 2% decrease in the number of incidents reportable to NRLS in 2018/19 when compared to 2017/18 (chart 3). Due to the number of bed days not being available in the National Data, it is not yet possible to compare with other providers. When this is available it will be reported through future safety reports.

Chart 3 Total of Trust incidents 2018/19

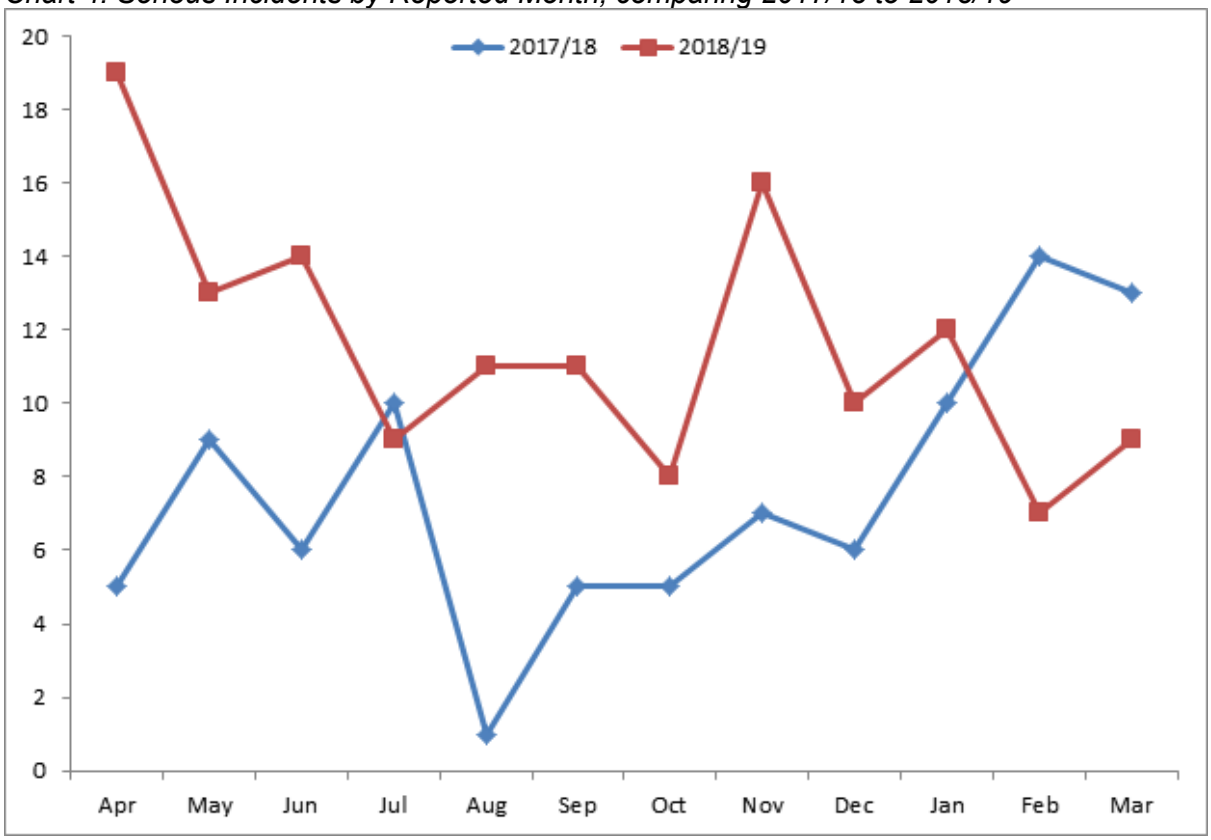


4. Serious Incident Overview

4.1. 'Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified' (*Serious Incident Framework 2015)*. The Trust awaits the publication of the updated Serious Incident Framework expected in 2019/20, following the consultation, which ended in July 2018. The Board will be briefed on the outcome, implications and Trust plans for implementation at that time.

4.2. Serious Incidents are reported externally via the national Strategic Executive Information System (StEIS). The Trust saw a significant increase in reporting following the CQC visit at the beginning of the year when a retrospective review of incidents as well as a more robust approach to reviewing incidents was put in place (Chart 4).

Chart 4: Serious Incidents by Reported Month, comparing 2017/18 to 2018/19



4.3. The Trust reported a total of 139 Serious Incidents in 2018/19 (Table 1) when compared to 91 in 2017/18; an increase of 53%.

4.4. The introduction of the Moderate Harm Panel in May 2018 has strengthened the process of reviewing moderate harm or above incidents and raised the profile of the importance of reporting incidents.

4.5. There has been a significant increase in unexpected deaths, this category includes substance misuse related deaths, unknown cause and suspected suicides. The inquest will not have been held to it is not possible to accurately determine the cause of death at the time of reporting.

4.6. An increase in violent and aggressive incidents that were reportable was noted in the year which may be, partially due to the moderate harm panel making a decision to report something that may not have been reported in previous years. The self-harm incidents are also likely to have been affected by the new reviewing process as these are the most difficult to categorise due to the subjective nature of the categorisation.

Table 1: Serious Incidents reported in 2017/18 and 2018/19 by StEIS category

Category	2017/18	2018/19
Unexpected/avoidable deaths	49	65
Disruptive/aggressive/ violent behaviour	3	24
Apparent/actual/suspected self-inflicted harm	11	24
Slip/trip/fall	9	7
Medication incident	1	6
Unauthorised absence	2	4
Pressure Ulcer meeting SI criteria	0	3
Sub optimal care of deteriorating patient	0	2
Confidential information leak/information governance breach	6	1
Abuse/alleged abuse of adult patient by third party	3	1
Incident threatening organisations ability to continue to deliver an acceptable quality of healthcare services		1
Mental Health Act paperwork	0	1
HCAI/Infection control	2	0
Accident e.g. collision/scald (not slip/trip/fall)	1	0
Adverse media coverage or public concern about the organisation or the wider NHS	1	0
Apparent/actual/suspected homicide	1	0
Major incident/ emergency preparedness resilience and response/ suspension of services	1	0
Treatment delay	1	0
TOTAL	91	139

5. Duty of Candour

5.1. The Trust's Duty of Candour policy sets out the requirement to meet the Statutory Duty and this is assessed through the quality schedule. It is a requirement for reviewers to attempt to make contact with the service user or the family to inform the review process.

5.2. A copy of the serious incident report is shared in full with the family and also HM Coroner. The Trust has supported families to become involved in suicide prevention work following the death of a service user.

5.3. The Trust is committed to obtaining, listening and ensuring that feedback from bereaved families is shared with staff, included in our serious incident reports and informs local suicide prevention work streams. This feedback has highlighted the importance of support for carers and the importance of information that families and carers hold that can inform a risk management or safety plan.

6. Investigation Process improvements

6.1. The increased reporting of incidents lead to a backlog of incidents that were not being completed within the national timeframes. To address this, the Serious Incident process

was developed into a Continuous Quality Improvement Project with an aim to improve the quality of the learning and efficiency of the process, leading to improved compliance with reporting timeframes.

6.2. This project led to the updating of the investigation guidance, a new 72 hour report and use of a reviewer checklist setting out key milestones for checks during the investigation process. A key challenge was identified during the process regarding the allocation of investigations to appropriately trained investigators and so the Trust recruited to a second serious incident investigator post in March 2019 as part of its commitment to investigate and learn from serious incidents.

6.3. A recovery plan, agreed with the two Hertfordshire CCGs, was put in place to finalise and submit serious incident reviews in process outside of the 60 working day timeframe by the end of May 2019. The Trust has made good progress and is aiming to meet the agreed trajectory by that date.

6.4. It also agreed to ensure that those reported after October 2018 would be kept within the timeframe. Although timeliness has improved significantly, the Trust is still challenged to keep within the 60 day timeframe. With the new investigator in post and further continuous quality improvement work the positon is expected to continually improve.

6.5. It is crucial that investigators have the appropriate training and Root Case Analysis investigation training was delivered to 65 staff in in 2018/19. A rolling programme of training is in place for 2019/20 and the Trust is committed to rolling out Human Factors training for staff to continuously improve learning from incidents.

7. Suicide Data and Suicide Prevention

7.1. The Trust is committed to Zero Suicides and to the Hertfordshire Suicide Prevention Network's vision '*to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option.'*

7.2. The Trust set an aspiration, through its annual plan, to reduce suicides by 10%. The Trust developed a suicide prevention group and commissioned a deep dive into unexpected deaths and serious self-harm, implementing the identified learning. The impact of this work is yet to be realised and will continue into 2019/20.

7.3. Suicide and Open conclusions that were reported as Serious Incidents 2005-2019, where the inquest has been concluded (Chart 5), show an upward trend. It should be noted that all inquests have been concluded from 2005/06 to 2015/16 and therefore the data within this reporting period will not change.

7.4. There are remaining inquests still to be heard for 2016/17 and 2017/18; therefore at the time of this report the graphs do not contain all the deaths, as outcomes have not been concluded. Chart 6 shows the overview of all deaths and where in the process they are, giving an overview of expected outcomes.

Chart 5: Suicide/Open Conclusions by Incident Date (April 2005 – March 2019)

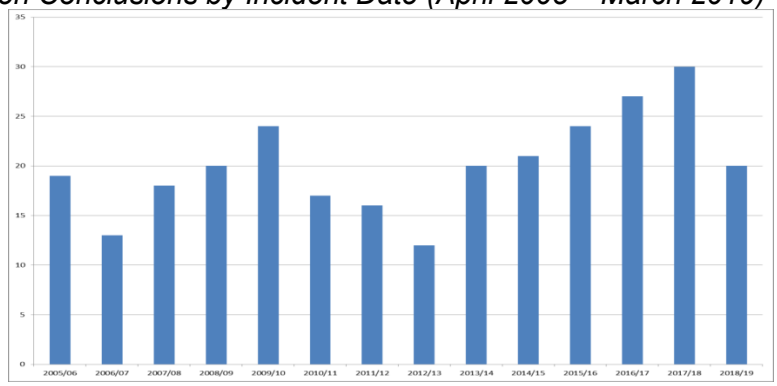
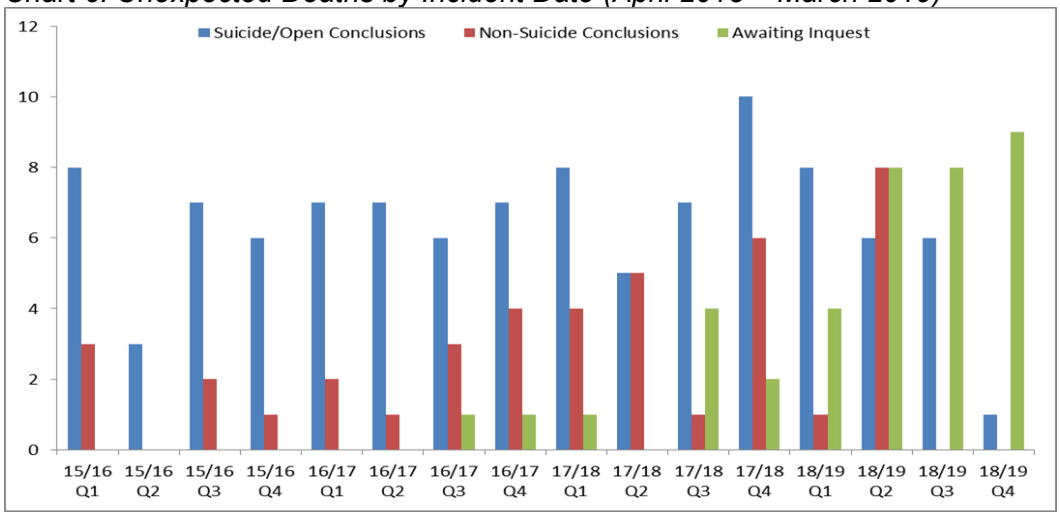


Chart 6: Unexpected Deaths by Incident Date (April 2015 – March 2019)



7.5. The Trust has been a key partner in the development and launch of the Hertfordshire Suicide Prevention Strategy (November 2017) and has representation on the Public Health Programme Board, the Steering Group and across the Task & Finish Groups. The Trust is also a member of the Zero Suicide Alliance. The Head of Safer Care and Standards chairs the Hertfordshire Support for the Bereaved by Suicide Task & Finish Group whose members have lived experience of suicide.

7.6. On World Suicide Prevention Day (7 September 2018) the Trust was represented at the launch event for the Hertfordshire Journalists Charter to commit to sensitive reporting of suicides. The Charter is based on research by the Samaritans that indicates that the way in which possible suicides are reported in the media can have a profound impact on people who might be considering taking their lives.

7.7. In 2018, the Trust implemented its own internal Suicide Prevention Committee, as part of a commitment to its zero suicide ambition. Membership includes Care Grow Live (CGL) Drug & Alcohol Services, Primary Care, a service user and carer. The Committee commissioned a deep dive into unexpected deaths and serious self-harm reported as serious incidents in the first 6 months of 2018.

7.8. Key areas for learning were identified, primarily a review of risk assessment training which is currently being developed by a task and finish group. The group is also incorporating the self-harm and suicide competency frameworks published by Health Education England. Other key findings were:

- Inconsistencies in recording of risk factors
- Involving service users, families, carers and other health professionals in risk assessment varied across the cases
- Formulation/communication of crisis management plan was not always evidenced
- Monitoring of DNAs and cancellations not always in line with the HPFT policy

7.9. The Trust has supported two families and a service user with lived experience of suicide to speak at a national learning conference and Hertfordshire suicide prevention events.

7.10. The Trust is working across the system with Network Rail, and other key partners to attend escalation meetings where there have been three or more incidents at a specific railway station. The Trust participated in a workshop, alongside partners from Herts Police, Public Health, Samaritans, the Community Safety Partnership and the Coroner's Office to work on a community approach to preventing suicide on the railway in Hertfordshire.

7.11. This work will be taken forward and developed in 2019/20 to include a collaborative approach working with the Samaritans in relation to supporting discharge and the launch of the Stay Alive App, which has tools to help keep people safe, together with details of emergency or support services to contact in Hertfordshire. The Trust has in place a suicide prevention action plan as part of the requirement by NHS Improvement for all mental health trusts to have zero inpatient suicides.

8. **Sexual Safety**

8.1. In January 2019, the Trust set up a Sexual Safety Task & Finish Group to consider and action recommendations made in the Care Quality Commission 'Sexual Safety on Mental Health Wards Report' September 2018. The Group is chaired by the Head of Social Work and Safeguarding and has external representation from Hertfordshire Constabulary, Sexual Health Services and the Sexual Assault Referral Centre (SARC).

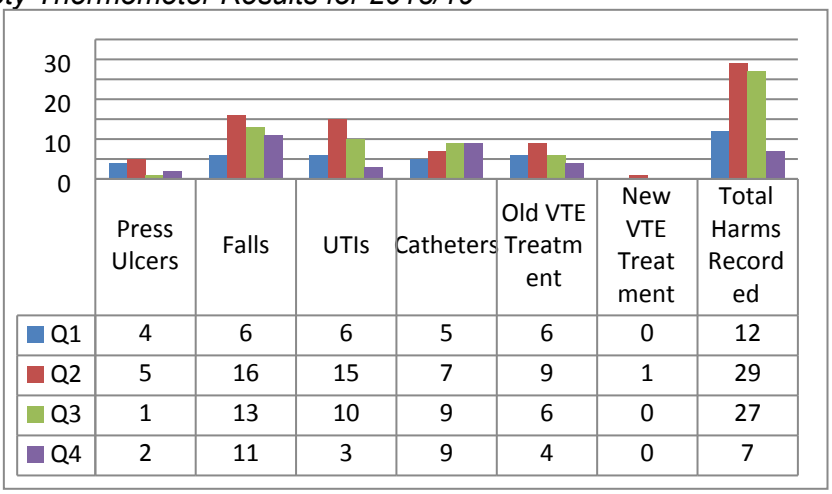
8.2. The group has undertaken work on a co-produced leaflet for service users on reporting sexual abuse, a flowchart for pathway when disclosures are made and a leaflet for Trust staff on responding to claims of sexual assault. This work will continue in 2019/20.

9. **Safety Thermometer**

9.1. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care at a single point in time. The tool measures five key service user safety issues. The tool is a snap shot at one point of the month and therefore is used to triangulate with other safety data to inform learning.

9.2. The Trust collects data from Older Adult Inpatient & Learning Disability Inpatient Teams (chart 7). There were 75 harms recorded on the days of submission. This compares to 108 harms reported in 2017/18 on the Safety Thermometer. It should be noted that in June 2018 the submission list for the Trust Safety Thermometer was reviewed at the Safety Committee and it was agreed that the Trust would cease collecting data from the community teams with data from the inpatient teams would continue. A direct comparison with the previous year cannot therefore be made.

Chart 7 Safety Thermometer Results for 2018/19



	Press Ulcers	Falls	UTIs	Catheters	Old VTE Treatment	New VTE Treatment	Total Harms Recorded
Q1	4	6	6	5	6	0	12
Q2	5	16	15	7	9	1	29
Q3	1	13	10	9	6	0	27
Q4	2	11	3	9	4	0	7

10. **Pressure Ulcers**

10.1. Pressure ulcer incidents have increased from 2017/18 to 2018/19 (chart 8), however, there has been a focus on increasing reporting and assuring the correct categorisation as well as improving the quality of risk assessments. The Trust continues to have a zero tolerance approach to avoidable pressure ulcers.

Chart 8: Pressure Ulcers Acquired in HPFT Care by number of incidents reported.

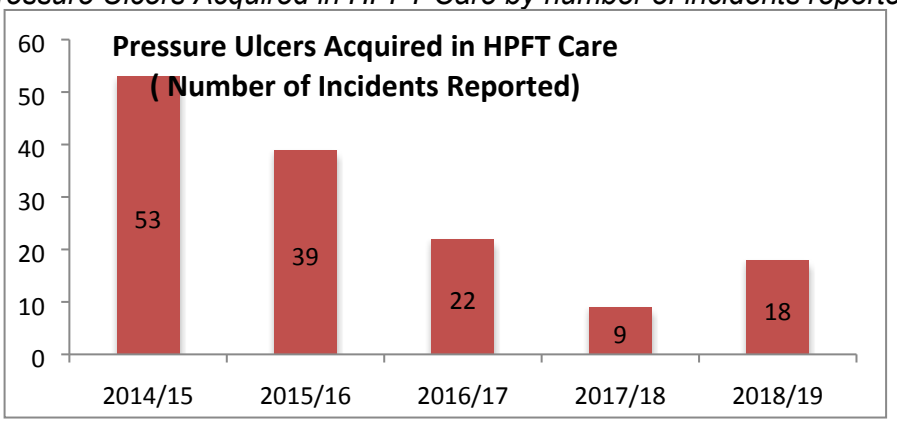
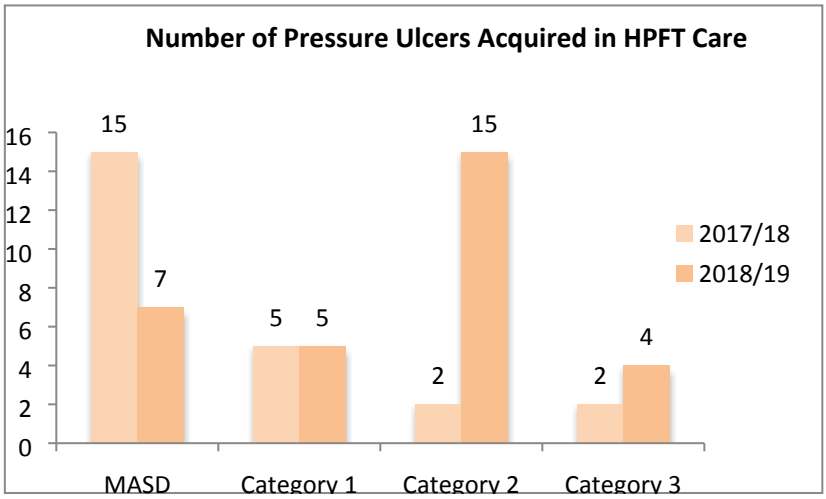


Chart 9: Comparison of Pressure Ulcer Acquired in HPFT in 2017/18 and 2018/19



10.2. There has been an increase is in Grade 2 and 3 (chart 9). The grade 3 pressure ulcers were reported as serious incidents and the root cause analysis presented by ward staff to the safety committee for wider learning. The quality of risk assessment emerged as a theme and training is being delivered to services.

10.3. The highest number of incidents have been in Older People's Services, particularly in Continuing Care, where service users are physically frail. Victoria Court has the highest incidence reported and training has been targeted there in the first instance. The most commonly acquired are sacral and heel pressure ulcers, reflecting a national themes.

10.4. The Trust has a substantive Tissue Viability Nurse in post and a clear system in place to ensure staff have education, information, tools and understanding to improve reporting and care. Learning has included improving the body map and risk assessments.

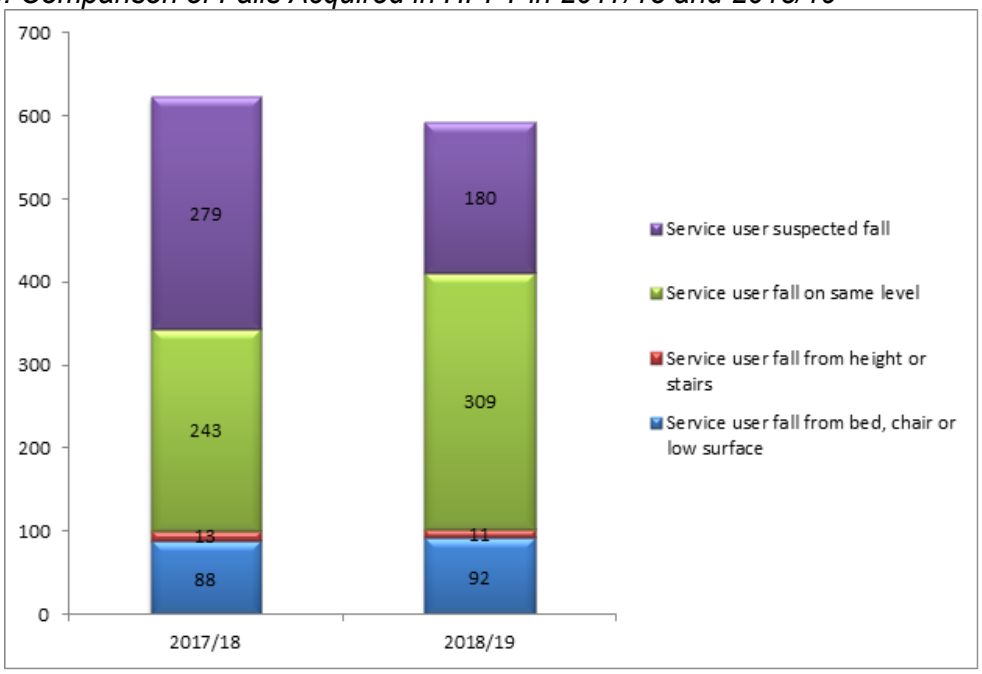
10.5. The Trust is fully engaged with the pressure ulcer pathway which is part of the frail /complex pathway with the Sustainability Transformation Plan (STP) and took part in the National Stop the Pressure Day in 2018.

10.6. The Trust presented a deep dive on pressure ulcers to the Quality and Risk Committee (commissioning quality meetings) and a further deep dive of the grade 2 pressure ulcers for 2018/19 is being undertaken. New guidance on pressure ulcer definition and measurement in England was published by NHS Improvement (NHSI) in 2018 for implementation in April 2019 which is being taken forward.

11. **Falls Prevention**

11.1. Falls incidents have decreased from 623 (2017/18) to 592 (2018/19), approximately 5%. The number of suspected (unwitnessed) falls has reduced since the introduction of zonal observations in several units (chart 10). There has been an increase in the number of falls where staff are able to identify the sub-category of fall, e.g. fall on same level.

Chart 10: Comparison of Falls Acquired in HPFT in 2017/18 and 2018/19



11.2. The Trust has a Falls Group that reviews incident data, trends and themes, and implements any learning. It links to the frailty work in the STP, and innovation around falls prevention.

11.3. A number of prevention initiative have had positive resultsand have included piloting of zonal observations in Older Peoples' Services and medicines management to reduce falls associated with medication.

11.4. The Trust has recruited to a physiotherapist post in Older Peoples' Services has proved to have an impact and has led to the introduction and education around use of footwear on the wards, encouraging families to bring in appropriate footwear including outdoor footwear for garden. Also, 'gummy socks', that have been shown to reduce service users slipping are in use on the wards as safe footwear, where assessed as appropriate.

12. **Never Events**

12.1. Never Events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented. The Trust reported no Never Events during 2018/19.

12.2. There is a list of National agreed Never Events, one relates specifically to mental health trusts; 'the failure to install functional collapsible shower or curtain rails'. The *Learning from Never Events* report was published in February 2019. The Care Quality Commission undertook a thematic review of Never Events in collaboration with NHS Improvement to get a better understanding of what can be done to prevent the occurrence of Never Events. A summary of the report findings will be shared and disseminated via the Safety Committee in May 2019.

13. **Mortality Governance**

13.1. The Mortality Governance Team consists of the Mortality Governance Lead, a Mortality Governance Consultant Psychiatrist and a Mortality Governance Administrator. The role of the team is to ensure a robust system of reviewing of and learning from deaths. The team also monitors LeDeR reviews and outcomes, and works in partnership with the Hertfordshire LeDeR programme.

13.2. Deaths of service users receiving services at the time of death or discharged within 12 months prior to death are reported on Datix. 443 were reported in the year (Table 2) of which 62 deaths were reported as a serious incident, 56 deaths were reported to the LeDeR programme and 34 were service users who were in the Trust's inpatient services at the time of their death.

Table 2 Deaths by Quarter and SBU 2018/19

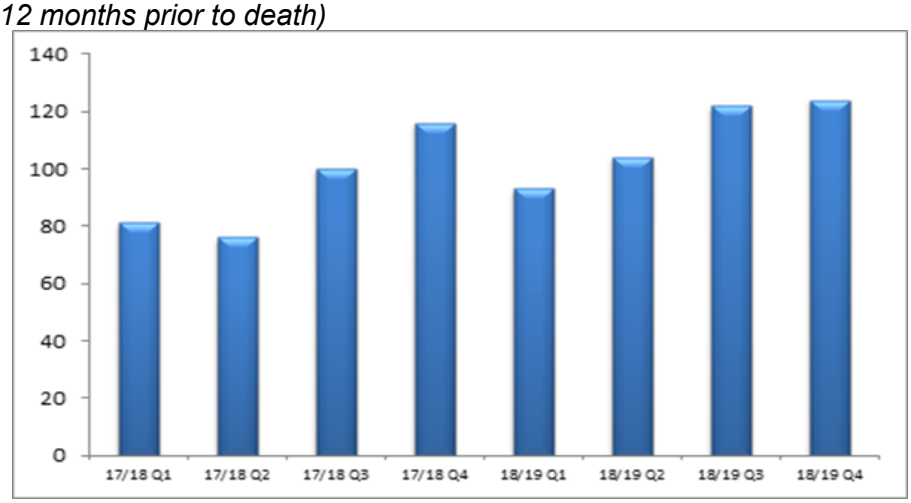
	East and North Hertfordshire SBU	Essex & IAPT SBU	Learning Disabilities & Forensic SBU	West Hertfordshire SBU	Total
Q1	42	0	18	33	93
Q2	59	0	15	30	104
Q3	75	0	17	30	122
Q4	72	12	16	24	124
Total	248	12	66	117	443

13.3. When considered quarter by quarter, the expected seasonal variation is evident. In addition there is an increased in the number of reported deaths between 2017/18 and 2018/19 (chart 11). The mortality governance process was implemented in this year and it is likely that this increase is due to an increase in reporting.

13.4. All deaths reported on Datix are screened to identify red flags as set out nationally by the Royal College of Psychiatrists. These red flags include: diagnosis of eating disorder/psychosis, staff or family/carer/staff concern, inpatient or under care of crisis team at time of death. The cases which meet the 'red flag' criteria are subject to a Structured Judgement Review (SJR) which is a case note review methodology for reviewing care prior to death.

13.5. Findings and identified learning of completed Structured Judgement Reviews are shared with the clinical teams. HPFT was one of eleven NHS trusts nationally that took part in the Royal College of Psychiatrists Pilot Study to inform the Royal College of Physicians template to better suit the needs of mental health, learning disability and community trusts.

Chart 11 Summary of all Deaths reported by quarter in 2017/18 and 2018/19 (known to HPFT in 12 months prior to death)



13.6. Nineteen structured judgement reviews have been completed during 2018/19 under red flag criteria of Psychosis, Inpatient, Staff concern, Family/carer concern and Learning Disability death where the Trust were the main care provider and random case selection for the Pilot study.

13.7. The learning themes from Structured Judgement Reviews completed during 2018/19 were:

- Mental health act- staff use and understanding
- Multidisciplinary and multiagency working
- Monitoring and interventions in physical health
- Clarity regarding service user's mental capacity
- Continuity of care
- Quality of risk assessment
- Medication and adherence to Trust and NICE guidance

- Unnecessary interventions that lack purpose
- Non-directive instructions such as monitor and support with no clinical rationale
- Timely involvement of appropriate disciplines

13.8. Excellent practice was also noted, including: safeguarding practice, End of life Care, Duty of Candour and Care of the family beyond the death of service user.

13.9. In November 2018, the team presented at the Launch Event for the Mortality Screening Tool at the Royal College of Psychiatrists and presented a poster on the outcomes of the Pilot study in the Trust. In March 2019 the Trust attended the Eastern Academic Health Science Network: Learning from Deaths Forum to present on 'Mental health: introducing and embedding learning from deaths'.

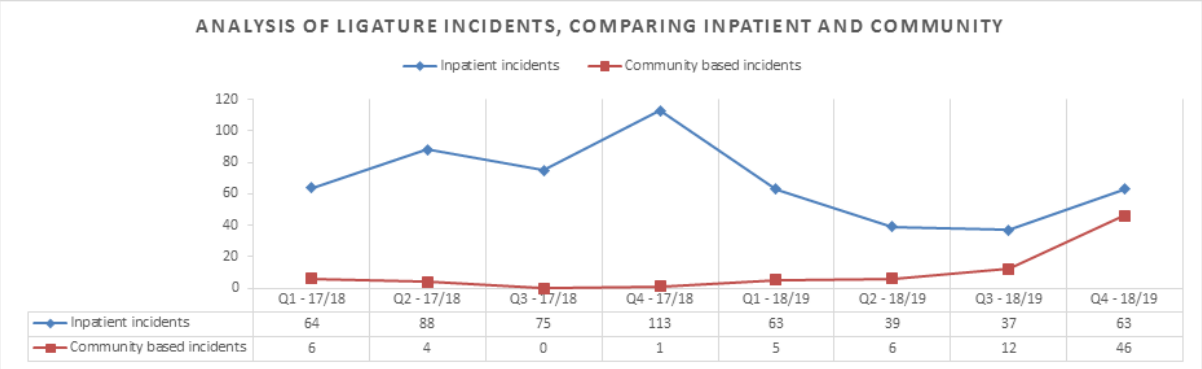
13.10. The Trust's Learning from Deaths Policy was updated in Q4 2018/19 in the light of the Care Quality Commission publication - *Learning From Deaths A review of the first year of NHS trusts implementing the national guidance* (March 2019).

14. **Ligature Incidents**

14.1. Ligature incidents have reduced by 35% during 2018/19 (chart 12). Concerns identified by the Care Quality Commission (CQC) resulted in a review of all the processes relating to identifying and managing ligatures and the strengthening of the annual ligature audits and development of line of sight maps, photographs of known risks and how these are managed.

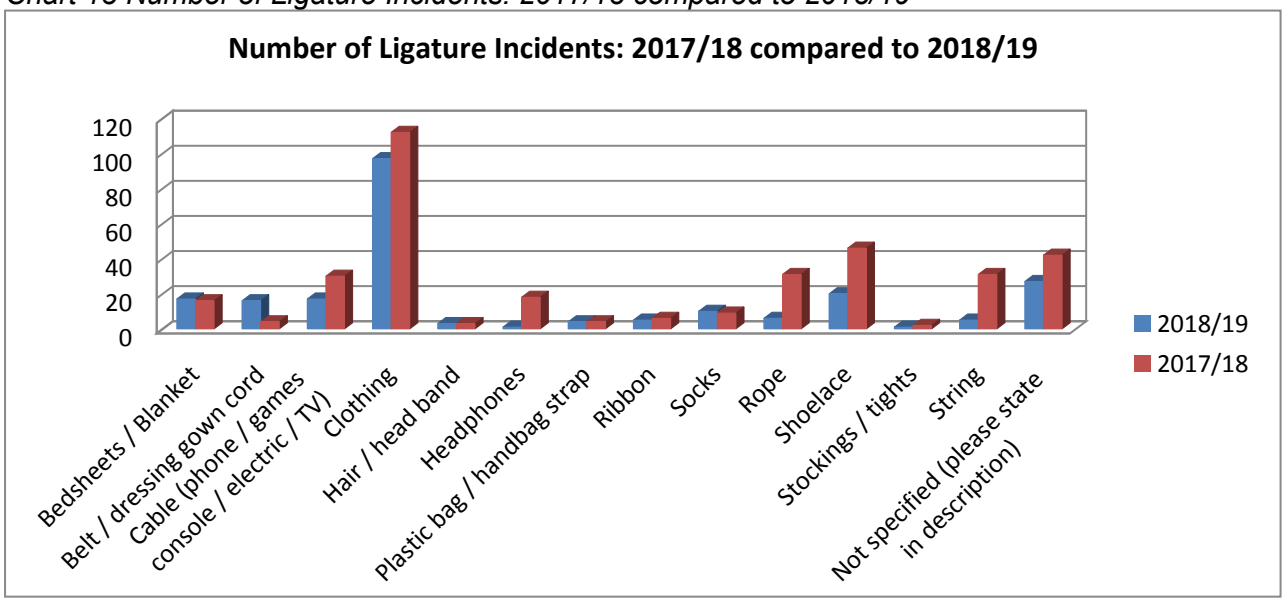
14.2. A weekly assessment was introduced during 2018/19 to manage any changes of risk, with actions agreed and communicated via an e-mail audit called Advanced New Technologies (ANT).

Chart 12 Analysis of ligature incidents, comparing inpatient and community services



	Q1 - 17/18	Q2 - 17/18	Q3 - 17/18	Q4 - 17/18	Q1 - 18/19	Q2 - 18/19	Q3 - 18/19	Q4 - 18/19
Inpatient incidents	64	88	75	113	63	39	37	63
Community based incidents	6	4	0	1	5	6	12	46

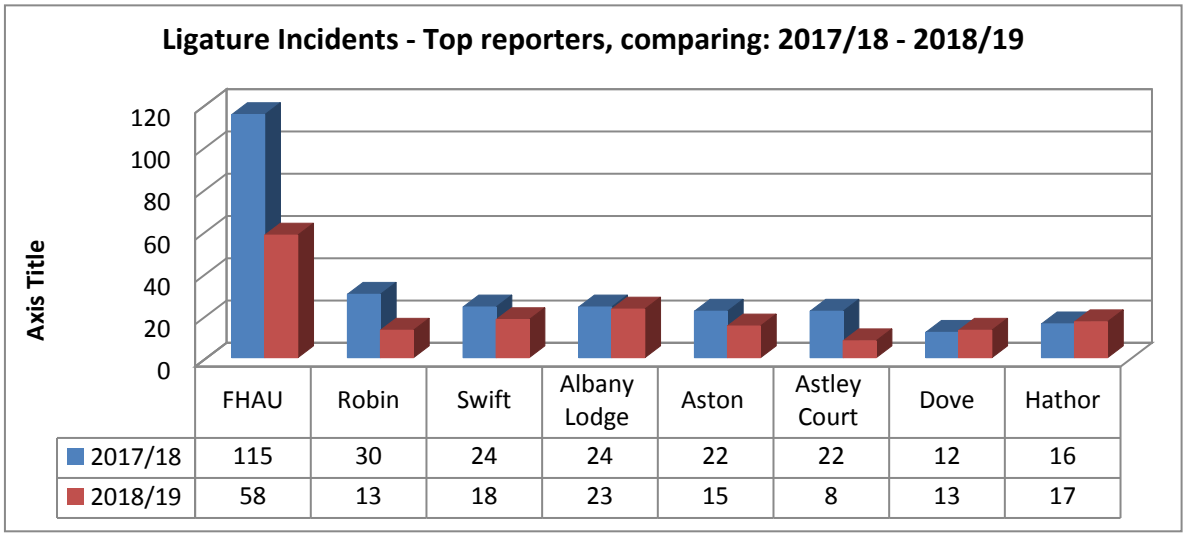
Chart 13 Number of Ligature Incidents: 2017/18 compared to 2018/19



14.3. There has been a decrease of ligature reported events by 125 (35%) when compared to last year. Clothing remains the most reported item used and this remains a significant challenge, however, there has been a 13% (112 to 97) reduction which indicates progress has been made.

14.4. The two highest reporting areas have both seen significant reduction in reporting since last year, as a result of the work that has been targeted in this area (Chart 14). These were Forest House (49% reduction), and Robin ward, (55% reduction).

Chart 14 Ligature Incidents-Top reporters, comparing 2017/18 to 2018/19



	FHAU	Robin	Swift	Albany Lodge	Aston	Astley Court	Dove	Hathor
2017/18	115	30	24	24	22	22	12	16
2018/19	58	13	18	23	15	8	13	17

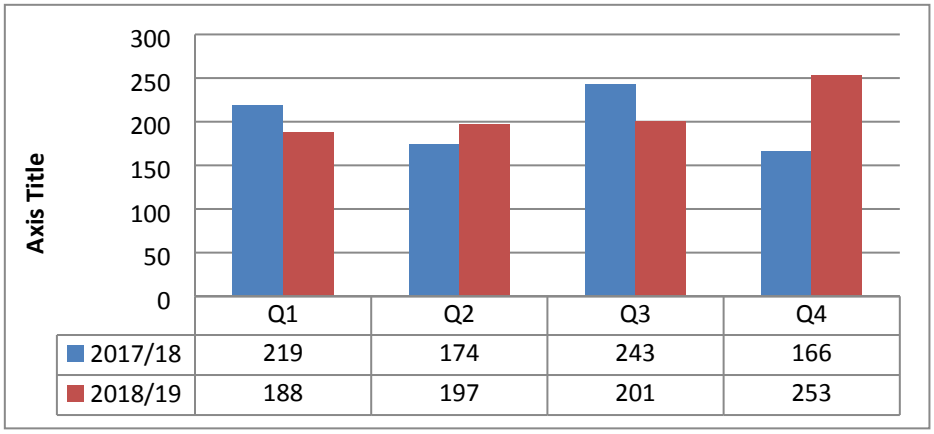
14.5. Changes in practice, shorter lengths of stay, the development of outreach teams, increased inpatient activities, the use of Dialectal Behaviour Therapy (DBT) and review of service pathways have seen a notable reduction in reported ligature incidents.

14.6. Community environmental risk assessments were piloted in the Child and Adolescent Mental Health (CAMHS) community hubs this year and will be rolled out to all services throughout 2019/20.

15. **Violence and Aggression**

15.1. This year has seen an increase in violence and aggression incidents. This can be broken down into an increase of service user to service user actual assaults by 10% (35) (graph 14) and an increase of service user to staff assaults by 5% (37) (graph 15).

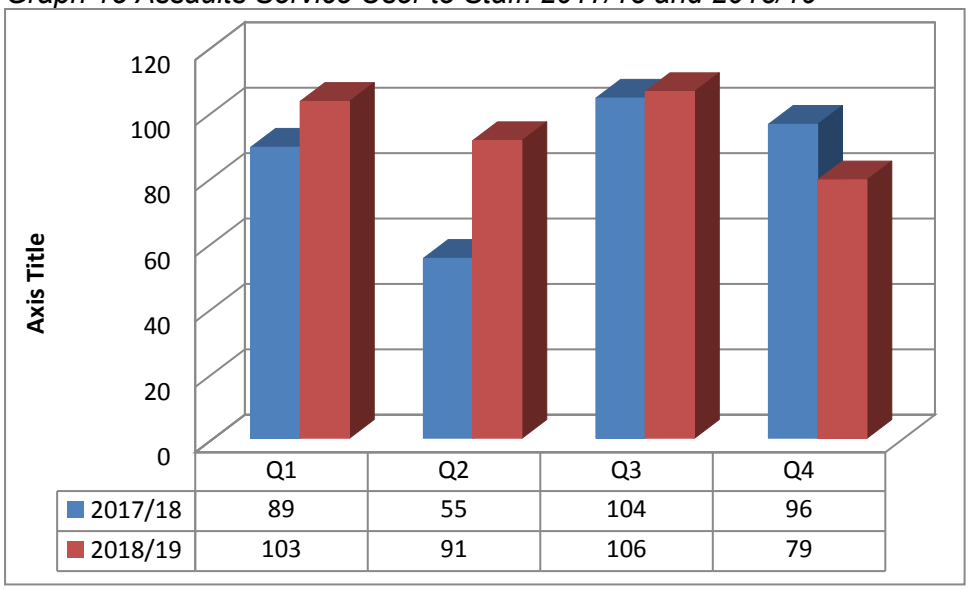
Graph 14 Assaults Service User to Service User: 2017/18 and 2018/19



	Q1	Q2	Q3	Q4
2017/18	219	174	243	166
2018/19	188	197	201	253

15.2. Robin Ward, Astley Court, Lexden and Logandene saw the highest incidence of service user to service user violence and aggression. When the incidents are considered it can be seen that a small number of services users were involved in these incidents. This reflects the findings from last year, although relating to a different set of wards, the high level of violence and aggression involved a small number of individuals

Graph 15 Assaults Service User to Staff: 2017/18 and 2018/19



	Q1	Q2	Q3	Q4
2017/18	89	55	104	96
2018/19	103	91	106	79

15.3. The services which have the highest incidents of assaults service user to staff were Astley Court, Lexden and Dove Ward, all in the Learning Disability Services.

15.4. On reviewing the incidents it can be seen that that when service users are acutely unwell one service user may have been involved in repeated assaults on staff and other service users. In the Learning Disability services, behavioural support plans have been reviewed and staff have received specific training by a psychologist in relation to developing these plans.

15.5. The Trust has respond to the increase in incidents by learning from other Trusts and listening to staff. The initiatives, such as, SWARM, Safety Huddles, the use of Safe Ward interventions and the recent review of RESPECT techniques and seclusion practices were all highlighted by CQC as areas of good practice.

15.6. The implementation of the 10 Safe Wards interventions continues to support the Trust in realising its ambition of a reduction in assaults. These include managing bad news through a process of intervention and mitigation, clear mutual expectations focusing on joint values and rules that are agreed between the service user and staff.

15.7. The introduction of the Safety POD (a large bean bag), used to support the service user in uncomfortable restraint, has been introduced during 2018/19 and will be evaluated in the next year.

15.8. Due to the challenging behaviour of a few service users, Essex SBU have started a to pilot a new approach to managing the trauma that staff may suffer as a result of high risk and complex incidents, using a method called Trauma Risk Management (TRiM). This will also support learning and new ways of working with individual service users.

15.9. The introduction of a restrictive intervention reduction initiative, such as the 'HOPE' model, is planned for 2019/20. These approaches are focused on supporting proactive strategies that support recovery and co-production and the use of least restrictive interventions in practice. This is being further developed in the next reporting year, with the inclusion of Continuous Quality Improvement (CQI) as part of an updated Making our Services Safer together (MOSS 2gether) strategy.

16. **AWOL and Missing Persons**

16.1. This incident type relates to service users who leave the support of the service in an unplanned way and are therefore considered:

- AWOL (formally detained under the Mental Health Act (MHA) 1983)
- Missing (have informal status and are admitted voluntarily).

16.2. Some of these incidents can result in concerns about safety but also need to be seen within the context of positive risk taking as part of planned care and work towards discharge. The Executive Team is briefed on the AWOL and missing person incidents each week.

16.3. The Trust has maintained the improvements in AWOL and missing person's incidents that were seen in the previous year, when we had seen a reduction following a focus on this area of risk. There was a rise in AWOLs at the beginning of the year and then a significant decrease from quarter 3 to quarter 4 (by 62%) following some targeted work.

16.4. The AWOL incidents relating to a breach of the perimeter security peaked in October 2018 (54% of the 11 incidents relating to breaches in perimeter security: via the garden (Oak), via the roof line (Albany) and escape from Hampden House. The Belfast Roll was trialled on Swift ward in the 'active' garden area, aiming to prevent escape across the roof. The Belfast Roll is a large cylindrical structure fitted on the roof line aimed at significantly reducing the risk of escape onto the roof, where risk is far higher. This will continue to be evaluated into 2019/20 to understand its effectiveness prior to considering its use on other sites.

16.5. Failure to return from approved leave has shown a 20% decrease. This is when a service user is given leave from an in-patient ward, usually as part of the managed risk as they move towards discharge, and do not return at the agreed time.

16.6. The Trust's AWOL and Missing Persons Policy was updated, with clear areas of actions. This included a grab sheet for the Police, so key characteristics are identified and early return is facilitated. It also included the Managed Entry and Exit Procedure (MEEP), with risk assessment and signing in and out books to compliment continuous assessment of risk as part of on-going proactive management of risk.

16.7. Learning from incidents relating to AWOLs and missing persons has identified the need for service users to be supported when transferring to rehabilitation services, as safe access to public houses and other activities may not have been explored before transfer due to the proximity of acute services like Kingfisher Court.

17. Medication Safety

17.1. Full details of medication safety and management incidents and actions taken in response to learning will be reported on separately in the Annual Pharmacy and Medicines Optimisation Report 2018/19.

17.2. The Medicines Policy has been updated to include the amended Ten Rights of Medication Administration poster. A medication safety report containing medication data by SBU, a summary of incidents resulting in harm and learning themes is presented to the Safety Committee quarterly.

18. Prevention of Future Deaths (PFDs)

18.1. During 2018/19 the Trust received no Regulation 28 Prevention of Future Deaths reports from HM Coroners.

18.2. The Safer Care Team screen the Courts and Tribunals Judiciary Prevention of Future Deaths reports issued nationally. Learning that is relevant is identified and a dashboard on Datix has been developed, learning notes cascaded and discussions had at the Mortality Governance Group and Safety Committee. An example of this is the identification of SBAR (Situation, Background, Assessment, and Recommendation) as an important handover tool which is being rolled out in conjunction with the new NEWS2 training.

19. **Conclusion**

19.1. This report gives an overview of the incidents, including serious incidents that have occurred in the year 2018/19. It identifies where action was taken when possible trends or learning opportunities were identified. The next part of this report will build on this exploring the main areas the Trust has worked on to improve safety.

PART C LEARNING FROM INCIDENTS AND CHANGING PRACTICE

1. Introduction

1.1. Learning from incidents, serious incidents, complaints, feedback and mortality reviews, is integral to the Trust's safety culture. The Trust has various ways in which to share learning including, reflective learning sessions, local and Trust patient safety meetings, SBU Quality Risk Meetings, case study presentations and learning notes.

1.2. Oversight processes as well as clinical practice improvements have been developed this year, which have all contributed to the high culture of safety score in the staff survey and the moving from Requires Improvement to Good in the Safety KLOE of the CQC report.

1.3. Learning themes and actions taken in response to these are included in the quarterly Integrated Patient Safety reports to Board. This part of the report will summaries some, but not all of the initiatives that have taken place in the year.

2. Oversight Improvements

Moderate Harm Panel

2.1. One of the key developments of 2018/19 was the introduction of the Moderate Harm Panel in April 2018 which meets weekly to review incidents reported on Datix as moderate or severe harm or death (not natural causes). This is a multi-professional group that reviews and discusses incidents, identifying learning, serious incidents and ensures implementation of staff support.

2.2. This forum provides an opportunity to share learning from incidents across the SBU's, monitor and discuss potential trends or themes where targeted actions may be required. It provides assurance to the Board of Directors that the Trust has a robust process to identify and report serious incident in keeping with the NHS Serious Incident Framework and to triangulate incident data with other work streams such as falls prevention, suicide prevention, physical healthcare and mortality governance. Outcomes of the discussion are added to the Datix record.

Safety Committee

2.3. The Trust's Safety Committee replaced the Clinical Risks and Learning Lessons Meeting. The membership was reviewed to ensure senior professionals who could influence change were present. The committee meets monthly and reports to the Quality and Risk Management Committee through to Integrated Governance Committee. The Safety Committee has responsibility for discussing safety related data, sharing of learning and identifying and oversight of specific work and innovations.

2.4. The learning identified at the safety committee is cascaded through the services by multiple means including learning notes, email, handovers notes and supervision. Learning is further supported by the delivery of Schwartz Rounds, case study presentations, Staff Support and Task and Finish groups.

3. Practice developments

3.1. In 2018/19 the Trust implemented many safety initiatives which were reported in the quarterly reports and the deep dives that were presented to IGC. Key issues are also

included in section B of this report. This section of the report will draw out a selection of initiatives that have not been explored already.

3.2. SWARM, a facilitated reflective learning session which is held in a team following a serious incident, has been rolled out which has proved extremely productive as a way of identifying immediate actions and supporting staff to learn.

3.3. A number of other safety initiatives have been implemented through this reporting period including Safety Huddles (real time discussion on safety concerns), Safety Crosses (locally generated visual recording of incidents, shared with staff and services users), a focus on service users reporting feeling safe, zonal safe and supportive observations and supporting established activities such as 'Safewards' to support less restrictive approaches to care.

3.4. In Quarter 3 ICG received a deep dive into restrictive practice which detailed the significant amount of work that has taken place in relation to this area of work. This included seclusion practices and environments as well as the RESPECT training developments.

3.5. Frailty is a clinically recognised long term condition of increased vulnerability that results from ageing and living with complex conditions. It is often associated with a decline in the body's physical and psychological reserves. Frailty is closely associated with risk of falls, and people who are severely frail are likely to be approaching the end of their life.

3.6. Frailty is one of the main clinical priorities for the Hertfordshire and West Essex Sustainability and Transformation Partnership and HPFT has committed to working to integrate physical and mental health services and to working across care settings to improve patients' experience of care as staff working for different organisations coordinate their approach and the patient's personalised goals of care are at the heart of any intervention or plan.

4. Staff Support

4.1. 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. Feedback from these sessions has shown them to be a very positive experience for teams and that it enables teams to contribute to learning and recommendations.

5. Education and Training

5.1. The Trust continues to develop and offer a number of training opportunities to cover all aspects of safety. Training content is updated and refreshed in light of learning from incidents. Subject matter experts (SME) ensure training is accessible to all staff, where ever they may work.

5.2. The new risk formulation training is a direct result of the learning from the deep dive into unexpected deaths and serious self-harm.

5.3. Many staff in 2018/19 completed training in Continuous Quality improvement and it is expected that this will be influence improving safety practices in 2019/20.

6. Conclusion

6.1. The Trust committed to improving the safety culture at the beginning of the year as well as the experience and safe care of our service users. Progress has been made which was evidenced by both the best score for safety culture for mental health and Learning Disability trusts in the 2018 staff survey and the 2019 CQC Inspection report.

6.2. A number of safety issues required further development and scrutiny, including the moderate harm and serious incident process, seclusion practice and ligature risk. There is substantial evidence to show significant improvement in these areas. The continuing commitment to safety is reflected in the annual objectives for 2019/20, the continuing drive to reduce suicides and Violence and Aggression.

7. Priorities for 2019/20

7.1. Building on the work this year a number of priorities have been set. These have taken into account national and local drivers, including learning from incidents. In summary these are:

7.2. Annual Plan

- Reducing suicides
- Feeling safe
- Reducing harm in relation to violence and aggression
- Seclusion environments and practice

8. Strategy
   - Quality Strategy
   - Making our Services Safer Together (MOSS 2gether)
9. Governance
   - Safety Dashboard on Spike 2
   - Implement the updated Serious Incident Framework (due to be published in 2019)
10. Learning from incidents
    - Implementation of NEWS2 and SBARD
    - Suicide Prevention Plan

Hertfordshire Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	6th June 2019	**Agenda Item:** 9
Subject:	Quality Strategy	**For Publication:** tbc
Author:	Jacky Vincent, Deputy Director of Nursing and Quality Dr Jane Padmore, Director of Quality and Safety	**Approved by:** Dr Jane Padmore, Director of Quality and Safety
Presented by:	Dr Jane Padmore, Director of Quality and Safety	

Purpose of the report:

To present the Quality strategy to the Board of Directors for ratification.

Action required:

To discuss and ratify the Quality Strategy.

Summary and recommendations:

The Quality Strategy has been developed through reviewing the Quality and Service Delivery Strategy and a number of Consultations. The strategy sets out three objectives under each of the three quality domains:

- **Safe**
  - Delivering safe care in top quality environments
  - Fostering a learning and just culture
  - Fostering a culture of safety
- **Effective**
  - Delivering evidence based care which is benchmarked nationally
  - Delivering recovery focused care and clinical outcomes
  - Continuously improving quality
- **Experience**
  - Responsive and accessible services
  - Embedding shared decision making
  - Co-production at the heart of service development

The strategy details the three priorities under each of these objectives and what this will mean for service users, carers and staff.

The Board is asked to consider and discuss the strategy and the implications for the Trust and then ratify the strategy.

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

Priority one, two and three in the annual plan.

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

N/A

Equality & Diversity /Service User & Carer Involvement implications:

Not applicable

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

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

IGC- 22nd May 2019

Quality Strategy

2019-2024

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Lived Experience of the Quality Strategy

Shazia had become unwell many years ago as a young woman at university in another part of the country. Sadly, her struggles eventually meant that she had to give up her studies and there followed a lengthy period of many years where she grappled unproductively with trying to make sense of what had happened to her. During this time she made use of mental health services but never seemed to find anything that she could connect with, nor make use of. In many ways, Shazia's life had come to a standstill; she was deeply unhappy, lonely and felt that she lived a life without meaning.

A change in her circumstances meant that she and her family came to live in Hertfordshire and on the first contact with the Trust during her Care Programme Approach transfer, one of the team asked her a very simple question, but one that was to bring change to her life - she was asked, quite simply, "What do you want to be different"? This threw her a little at first; it had been many years since she had thought that anything could be different at all. The staff member explained that the Trust could offer her a number of different sources of support, including a range of evidence-based interventions on a care pathway but the key thing, right at the outset, would be for them to work together to co-produce some goals to work towards. She learned that this approach was called 'shared decision making' and was a part of the 'recovery approach' to mental health problems. She was given some literature that had been written in collaboration with other people who had been service users and carers at the Trust and this explained these approaches further. Shared decision making, it was explained, helped service users to take back control of their agency - their sense of ownership of their lives and their futures. It had developed from the recovery approach which, in turn, had itself been developed by service users and carers and was a movement of people who had learned to adapt to their challenges and live fulfilling lives alongside them. Shazia felt that there was something different about these ways of working and she instinctively opened her ears to them and was curious.

Over the preceding months in Trust services, a new Quality Strategy had been embedded in the clinical teams, one that had been co-produced with service users and carers who had themselves directly taken part in rolling this out across the organisation and training clinicians and other staff. This initiative had been based on the Trust's *Good to Great* strategy – a way of focussing care on the three domains of quality – safety, effectiveness and experience. At the heart of this was a drive towards compassionate partnership, driven by recovery values, evidence-based care, continuous quality improvement and shared decision making. These all distilled into a way of offering care to people which put them at the middle of the process and promoted their experience of this as a central test of its value.

It was this, and the attitude of the staff member working with her that had grabbed Shazia's attention – she had experienced lots of care over the years but there was something about this that felt different and which led her to want to hear more, and hear more she did. She was gently challenged to describe a specific goal to work towards – in the past the professionals she had worked with seemed only to be interested in her symptoms and whether she was feeling suicidal. This member of the team seemed to be interested in her as a person in her own right. She found herself saying that she wanted to reconnect with people again – something she had yearned for in her loneliness but was frightened of – she also wanted to spend more time outside amongst nature. The staff member she was working with seemed to be very interested in these goals and asked her to rate how possible it was for her to do these things now and explained that this would be useful later when it came to demonstrating how effectively they had been working together. These ratings were complemented by some more formal measures that it was explained were given to everyone entering the service.

And this was how it started…..over the next few weeks and months, and constantly in collaboration with her, Shazia was supported to work towards her goals. This was not easy, and it was not as if nobody ever mentioned her symptoms, nor listened when she spoke of them, but somehow they were no longer at the centre of the conversation. At some stage fairly early on, she was offered some training, along with other service users, on the topic of shared decision making – this, it was explained, might help her have more useful conversations with professionals and ultimately lead to more effective care. One of the trainers shared with the group his story of learning how to live with hearing voices and how he had grown to be able to speak to the doctors about his medication in a way that gave him a sense of control. Shazia was keen to try this at her next outpatient appointment with her psychiatrist, who had herself had a very similar training session with the same man.

For some years, Shazia had been unable to find a good balance between mental health services and her family and her partner who was her carer. Often she felt that she wanted to keep things to herself and not share them with her family and there were other times when she found that she desperately needed them to be more involved. However, on these occasions staff were often standoffish and unsure of what could be talked about. In the Trust, considerable work had gone into developing authentic and co-productive relationships with carers and this had produced the necessary conditions for this idea of compassionate partnership to take root in front line services. Staff had been directly helped by Experts by Experience to understand the Triangle of Care and this was openly discussed at an early stage in her engagement with the local team. This meant that all three points of the Triangle of Care knew more or less where they stood when it came to involvement and information sharing. This helped Shazia feel more secure and confident that both hers and her family's positions were understood.

Staff felt more confident too and discovered that once explored, these sometimes difficult issues were easier to manage.

As her journey forwards unfolded Shazia began to grow in confidence and self-belief – she could have control, often alongside her anxieties, but nonetheless it was control. She could have a different future, although this might not mean that she was never troubled again. As she and the team she was working with progressed, they were able to keep an eye on improvements through the ratings and the questionnaires she had completed at the beginning. She saw that there were patterns in her journey, sometimes backwards but ultimately forwards and she also saw that using the ratings helped her understand a bit more about her experience out in the world. This was also helpful in the evidence-based psychological therapy that she had been engaging in and using, to learn how to cope with her distressing symptoms. She was beginning to mix with people a bit more and was able to join in country walks that she had been connected with through the team – she was achieving her goals and this had all started with a question that she had stopped asking herself all those years ago when it had seemed that change would never be possible again…..

Executive Summary

Background

Our *Good to Great Strategy* (2016-2021) describes how we at Hertfordshire Partnership NHS University Foundation Trust (the Trust) are delivering our vision of '*Delivering Great care, Achieving Great Outcomes – Together'*.

Through providing consistently high quality care that is joined up, individuals will be supported and empowered to recover and to manage their mental and physical wellbeing. This will enable us to achieve our mission – '*We will help people of all ages live their lives to their fullest potential by supporting them to keep mentally and physically well.*'

This strategy sets out how safe and effective services, with the service user as partner in their own care and treatment as well as service development will be achieved.

The objectives of this strategy are set out across three domains, safe, effective and experience, and are:

Safe

- Delivering safe care in top quality environments
- Fostering a learning and just culture
- Fostering a culture of safety

Effective

- Delivering evidence based care which is benchmarked nationally
- Delivering recovery focused care and clinical outcomes
- Continuously improving quality

Experience

- Responsive and accessible services
- Embedding shared decision making
- Co-production at the heart of service development.

1. Introduction

Our *Good to Great Strategy* (2016-2021) describes how we at Hertfordshire Partnership NHS University Foundation Trust (the Trust) are delivering our vision of '*Delivering Great care, Achieving Great Outcomes – Together*'.

Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we will consistently achieve the outcomes that matter to those individuals who use our services and their families and carers, by working in partnership with them and others who support them.

Furthermore, it means we keep people safe from avoidable harm, whilst ensuring our care and services are effective. That they achieve the very best clinical outcomes, support individual recovery and are of the highest quality.

Our *Good to Great* Strategy (diagram 1) demonstrates the key areas of focus for the Trust, in terms of the people, the organisation and partnerships. It focuses on the three domains of quality – safety, effectiveness and experience.

Diagram 1

Through providing consistently high quality care that is joined up, individuals will be supported and empowered to recover and to manage their mental and physical wellbeing. This will enable us to achieve our mission – '*We will help people of all ages live their lives to their fullest potential by supporting them to keep mentally and physically well.*'

This strategy will enable the Trust to deliver on the strategic objectives for 2016-2021 (table 1).

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

Table 1

2. Purpose

The Quality Strategy sets the direction for the delivery of quality services within the Trust for the next five years. It supports and builds upon the Trust's proven delivery of high quality services, whilst supporting its ambition for a continuous improvement of services and sustainable growth.

The Quality Strategy sets out an approach which aims to put quality right at the heart of everything we do in order to deliver our *Good to Great Strategy*. It ensures that quality services are delivered in the Trust in response to the specific requirements of our service users, carers, our staff, the public, our commissioners and regulators. It is also underpinned by the delivery of the service strategies.

Core to this Strategy is the Trust's values and related behaviours. These apply to how as a Trust we value our workforce as well as service users, carers, colleagues and members of the public:

- We are *welcoming* so you feel valued as a person
- We are *kind* so you can feel cared for
- We are *supportive* so you can feel supported and included
- We are *respectful* so you can feel listened to and heard
- We are *professional* so you can feel safe and confident.

This Quality Strategy describes a consistent and integrated approach to providing quality services across the Trust. Its purpose is to set out the Trust's framework within which the Trust leads, directs and delivers high quality services.

It is an enabler of the Trust's vision and is supported through the Trust's organisational development of work. It underpins the Trust's performance and reputation and is fully endorsed by the Trust Board.

3. Aims, Objectives and Priorities

The aim of the Quality Strategy (Diagram 2) is to deliver *Great Care and achieve Great Outcomes together*. The objectives, three for each domain, are:

- **Safe**
  - Delivering safe care in top quality environments
  - Fostering a learning and just culture
  - Fostering a culture of safety
- **Effective**
  - Delivering evidence based care which is benchmarked nationally
  - Delivering recovery focused care and clinical outcomes
  - Continuously improving quality
- **Experience**
  - Responsive and accessible services
  - Embedding shared decision making
  - Co-production at the heart of service development.

Diagram 2

Each key focus area of quality - safety, effectiveness and experience, with the objective is set out below with the key priorities and what it will mean for service users, carers and staff (summarised in a table in Appendix A).

SAFETY

Keeping our service users, carers and staff safe is a key priority for the Trust. The Trust will consistently **deliver high quality care in top quality environments** and this will be achieved through prioritising**:**

1. The development and implementation of the Making Our Services Safer Together Strategy (MOSS2gether), with clear work streams, actions and outcomes
2. Introducing the Hope (or similar) Model and rolling this out which will result in the least restrictive practice being used
3. Reducing the level of harm that is sustained as a result of incidents.

Through this objective, safe and compassionate care will be delivered in top quality environments through staff, service users and carers working together.

A **learning and just culture will be fostered** by:

4. Ensuring timely investigations into serious incidents that enable learning to be embedded swiftly
5. Innovative ways, such as SWARM, will be embedded across the Trust to ensure swift learning from incidents
6. The Trust will have a Just Culture that will support consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents.

This will result in swift learning when something goes wrong, where everyone's experience is valued and action is taken to prevent it happening again.

A **culture of safety** will be fostered through:

7. Shared beliefs, perceptions and values in relation to the risks within the Trust
8. The High Performing Teams initiative is rolled out with safety as one of the areas for teams to work on together
9. Communication is strengthened in relation to safety, sharing learning from multiple sources including national reports, advances in the evidence and incidents that occur in the Trust.

This will ensure safety is a priority for all, with shared decision making that includes positive risk taking.

EFFECTIVENESS

Deliver evidence based care, which is nationally benchmarked, by

1. Care pathways developed that take account of the evidence base and are nationally benchmarked
2. Training Needs Analysis informs how staff are trained, developed and supervised to ensure the best evidence based care is provided
3. The Trust Research Strategy developed to include the generation and application of evidence as well as the research capacity within the Trust.

Through this objective and priorities, the workforce will be skilled to deliver the care and treatment that is planned in partnership with service users and carers, based on the best available evidence.

Recovery focused care and outcomes will be delivered through:

1. Service and care pathway developments are underpinned by recovery focussed care as well as individuals' care
2. Care plans (including the well-being plan) are reviewed and embedded to ensure a consistent approach that is responsive to service needs
3. Care pathways are developed with clear outcome measures enabling an understanding of the effectiveness of care and services.

This objective will ensure that service users' recovery aims are considered and outcomes that are meaningful are achieved.

Continuously improving quality will be achieved through:

1. Continuous quality improvement methodology (PDSA) to drive positive changes in safety, effectiveness and experience
2. The outcomes from continuous quality improvement projects used to shape service development and inform research
3. Research capacity and capability developed across professions and services and used to improve the quality of care.

As a result, outcomes will be shared and used to improve services and continuously improve.

EXPERIENCE

Responsive and accessible services will be provided by:

1. Improved data quality so that there is a full understanding of the population that enables services to be developed in response to their needs

2. Teams take ownership of their feedback, share it within teams and actively use it to promote learning and improvements & to celebrate good practice
3. Having an Expert by Experience on every recruitment panel, utilising their expertise and valuing their views & opinions which will support the best outcome.

This objective will ensure that personalised services are delivered that are responsive to the interests, culture and beliefs of individuals.

Shared decision making will be embedded by:

1. The shared decision making model is used to ensure that care and service options are fully explored, along with their risks and benefits
2. Different choices that are available to the service user are discussed and informed decision made
3. Decisions are reached in partnership.

This will ensure that all are equal partners in shaping the individual's personalised care.

Co-production is at the heart of service development by:

1. Co-production is strengthened further, with a wider range of individuals involved
2. All new initiatives and approaches to implementing personalised care are co-produced with people who have experience of the systems
3. Quality reviews, visits, audits should routinely involve experts by experience.

This will ensure that service developments and improvements are informed by lived experience in a rewarding and meaningful way.

4. Review

This Quality Strategy has been developed in light of currently available information, guidance and legislation, which may be subject to change. This strategy will be reviewed annually along with the actions and outcomes and any changes will be considered and approved by the Integrated Governance Committee.

5. Conclusion

The Quality Strategy has been developed through reviewing the Quality and Service Delivery Strategy and a number of Consultations. The strategy sets out three objectives under each of the three quality domains:

- **Safe**
  - Delivering safe care in top quality environments
  - Fostering a learning and just culture
  - Fostering a culture of safety

- **Effective**
  - Delivering evidence based care which is benchmarked nationally
  - Delivering recovery focused care and clinical outcomes
  - Continuously improving quality
- **Experience**
  - Responsive and accessible services
  - Embedding shared decision making
  - Co-production at the heart of service development

The strategy details the three priorities under each of these objectives and what this will mean for service users, carers and staff.

Appendix A- Summary of Objectives and Priorities

SAFE	
Objective one: Delivering consistently safe care in top quality environments	
Key Priorities: • Develop the Making Our Services Safer Together Strategy (MOSS2gether) with clear work streams, actions and outcomes • The Hope model is introduced and rolled out resulting in the least restrictive practice is used • Reducing the level of harm that is sustained as a result of incidents.	
What it will mean:	
For service users	I will experience safe & compassionate care in an environment that safely and effectively delivers my treatment.
For carers	I will feel confident that safe & compassionate care is delivered consistently in partnership in top quality environments.
For staff	I feel confident that we are working together with the right skills & environment to deliver safe & compassionate care.
Objective two: Fostering a learning and just culture	
Key Priorities: • Timely investigations into serious incidents that ensure learning is swiftly embedded • Explore and embed ways to swiftly learn from incidents, including, but not exclusively, using SWARM across the Trust • Introduce Just Culture to support consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents.	
What it will mean:	
For service users	When something goes wrong, I am involved in the learning & action taken to prevent it happening to someone else.
For carers	When something goes wrong, my experience is valued in the learning & action taken to prevent it happening to someone else.
For staff	I will be part of a just culture that ensures system learning is embedded to prevent it happening again.
Objective three: Fostering a culture of safety	
Key Priority: • Beliefs, perceptions and values are shared in relation to the risks within the Trust • The High Performing Teams initiative is rolled out with safety as one of the areas for teams to work on together • Communication will be strengthened in relation to safety, sharing learning from multiple sources including national reports, advances in the evidence and incidents that occur in the Trust.	
What it will mean:	
For service users	I work in partnership to make my care safe, with positive risk taking & know my safety is taken seriously.
For carers	I am listened to, ensuring safe care is delivered & I work in partnership to support positive risk taking.
For staff	I feel confident to deliver safe, compassionate care consistently and as part of inclusive leadership.

EFFECTIVE	
Objective four: Delivering evidence based care which is nationally benchmarked	
Key Priority- • Care pathways will be developed that take account of the evidence base and are nationally benchmarked • A Training Needs Analysis will inform how staff are trained, developed and supervised to ensure the best evidence based care is provided • The Trust Research Strategy will be developed to include the generation and application of evidence as well as the research capacity within the Trust.	
What it will mean:	
For service users	Decisions about my treatment are taken in partnership with me, ensuring I am informed of the evidence and knowledge available about my condition and its treatment.
For carers	I will feel confident that evidence based care is delivered consistently.
For staff	My Personal Development Plan (PDP) is tailored to my learning and development needs and in line with the best evidence available in my area of practice.
Objective five: Delivering recovery focused care and outcomes	
Key Priority- • Recovery focussed care will underpin service and care pathway development as well as individuals' care • Care plans (including the well-being plan) are reviewed and embedded to ensure a consistent approach that is responsive to service needs • Care pathways are developed with clear outcome measures enabling an understanding of the effectiveness of care and services.	
What it will mean:	
For service users	My care is delivered to achieve my recovery aims, which will be developed in collaboration with me.
For carers	My carer expertise will be valued in supporting the recovery aims that are set.
For staff	I understand the principles of Recovery-focussed care and feel confident to work in this way in order to achieve the outcomes service users have developed with me.
Objective six: Continuously improving quality	
Key Priority- • Continuous quality improvement methodology (PDSA) will be used to drive positive changes in safety, effectiveness and experience • The outcomes from continuous quality improvement projects will be used to shape service development and inform research • Research capacity and capability will be developed across professions and services and used to improve the quality of care.	
What it will mean:	
For service users	The outcomes of my care are shared with me and used to help improve services
For carers	I will be involved in shaping services to ensure that they are continuously improving.
For staff	I will be skilled and supported to make changes that will ensure that services are continuously improving.

EXPERIENCE	
Objective seven: Responsive and accessible services	
Key Priority- • Data quality is improved so that there is a full understanding of the population that enables services to be developed in response to their needs • Teams to take ownership of their feedback, share it within teams and actively use it to promote learning and improvements & to celebrate good practice • Having an Expert by Experience on every recruitment panel, utilising their expertise & valuing their views & opinions which will support the best outcome.	
What it will mean:	
For service users	I will experience care that is personalised because people are interested in my experiences, culture and beliefs.
For carers	My knowledge and understanding of the service user, their culture and beliefs, is valued and used to inform care and the services they receive.
For staff	I am confident and able to explore the culture and beliefs and use this to inform how I develop personalised care.
Objective eight: Embedding shared decision making	
Key Priority- • The shared decision making model is used to ensure that care and service options are fully explored, along with their risks and benefits • Different choices that are available to the service user are discussed and informed decisions made • Decisions are reached in partnership.	
What it will mean:	
For service users	I am spontaneously offered the opportunity to join staff, as an equal partner in shaping my care and working towards my goals and given access to information that enables me to make decisions about my care.
For carers	I am spontaneously offered the opportunity to join staff as an equal partner in shaping the care.
For staff	I have training in shared-decision making and understand how to work in this way with service users.
Objective nine: Co-production at the heart of service development	
Key Priority – • Co-production will be strengthened further, with a wider range of individuals involved • All new initiatives and approaches to implementing personalised care are co-produced with people who have experience of the systems • Quality reviews, visits, audits should routinely involve experts by experience.	
For service users	I have a key role, informed by my lived experience, in shaping services and am routinely involved in service development and improvement
For carers	I have a key role in service development & improvement
For staff	I have rewarding and meaningful experiences of working with service users and carers to shape and improve services; & as a consequence routinely involve them when considering making changes to the way services are delivered

Appendix B - Background information

Approach to developing the strategy

The Quality Strategy was developed through consultation with service users, carers and staff and built on a number of pieces of work that have taken place in recent times and the associated consultation with the staff, service users and carers. This included, but was not solely, in relation to:

- Trust Strategies
- Quality Accounts
- Quality Report
- Care Quality Commission inspection reports
- Audit results including Safety Culture audit
- Research and evidence base.

In addition, Quality Strategies from across industries have also been considered as well as the National and Local Drivers.

Context

Lord Darzi, in 2008, defined quality care as "clinically effective, personal and safe, with our service users being treated with compassion, kindness, dignity and respect". This is the working definition used across the NHS. High quality care in the Trust means 'Delivering Great Care and Achieving Great Outcomes – Together'. Quality therefore encompasses safety, effectiveness and experience for our service users, carers and our staff.

National Context

The National Quality Board, in its *'Shared Commitment to Quality,'* considers the challenges within the healthcare setting whilst maintaining and improving quality. The document states that quality must be the organising principle of our health and care services, as it matters most to those who use our services

The *NHS Five Year Forward View* confirms a national commitment to high-quality person-centred care for all, describing the changes that are needed to deliver a sustainable health and care system

The Care Quality Commission (CQC) in their *'Quality Improvement in Hospital Trusts'* refer to the significant improvements they have seen in their quality of care through their regulatory processes, citing good examples of practice.

Furthermore, to have an understanding of quality meaningful engagement and involvement with service users in service development is essential, systematically integrated into Quality Improvement

The CQC's Fundamental Standards are key to this Quality Strategy and are the standards below which the care we provide must never fall and which everybody has the right to expect:

- *Person-centred care* – providing care or treatment tailored to the individual which meets their needs and preferences
- *Dignity and respect* – treating individuals with dignity and respect at all times whilst receiving our care and treatment
- *Consent* – obtaining consent from individuals (or anybody legally acting on their behalf) before any care or treatment is given
- *Safety* – not giving unsafe care or treatment or putting individuals at risk of harm that could be avoided
- *Safeguarding from abuse* – ensuring individuals do not suffer any form of abuse or improper treatment whilst receiving our care
- *Food and drink* – ensuring individuals have enough to eat and drink to keep them in good health whilst receiving our care and treatment
- *Premises and equipment* – providing clean, suitable and looked after property and equipment used in it
- *Complaints* – enabling individuals to complain about their care and treatment
- *Good governance* – providing plans that ensures the care can meet these standards
- *Staffing* – having enough suitably qualified, competent and experienced staff to make sure we can meet these standards
- *Fit and proper staff* – employing people who can provide care and treatment appropriate to their role. Having a strong recruitment procedure in place and carrying out relevant checks
- *Duty of candour* – being open and transparent with individuals about their care and treatment
- *Display of ratings* – displaying our CQC rating in a place where it can be seen.

The National Institute for Health and Care Excellence (NICE) provide Quality Standards which set out the priority areas for quality improvement. These all cover areas where there is variation in care, giving a set of statements to help us to improve quality and information on how to measure our progress. They enable us as a provider organisation to audit and produce governance reports demonstrating the quality of care. Although they are not mandatory, we use these to enable us to plan and deliver high quality care.

Health Education England's Quality Strategy states the importance of the quality of teaching, learning and assessments delivered, lying at the heart of our collective responsibility in the NHS

In the National Quality Board's *'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time'* it notes that key to high quality care for all, is our ability to deliver services that are sustainable and well-led.

The *Five Year Forward View* describes the need for a single, shared goal to maintain and improve quality, to improve health outcomes requires a focus on planning and delivering services which both improve quality and reduce avoidable costs. This is underpinned by three principles:

- *Right care* – doing the right thing, first time, in the right setting will ensure service users get the care that is right for them, avoiding unnecessary complication and longer stays in hospital and helping them recover as soon as possible
- *Minimising avoidable harm* – a relentless focus on quality, based on understanding the drivers and human factors involved in delivering high quality care, will reduce avoidable harm, prevent the unnecessary cost of treating that harm, and reduced costs associated with the litigation
- *Maximising the value of available resources* – providing high quality care to everyone who uses health and care services requires organisations and health economies to use their resources in the most efficient way for the benefit of their community – any waste has an opportunity cost in terms of care that could otherwise be provided.

Local Context

The Quality Strategy is informed by the National context (Appendix A) and the following were considered in the development of the strategy:

- The National Quality Board
- The NHS Long Term Plan
- The Care Quality Commission (CQC) 'Quality Improvement in Hospital Trusts'
- The CQC's Fundamental Standards
- The National Institute for Health and Care Excellence (NICE) Quality Standards
- Health Education England's Quality Strategy.
- Patient Experience Improvement Framework, NHS Improvements, 2018.

The local context was also considered in the development of this strategy. The Hertfordshire and west Essex Sustainability and Transformation Partnership's (STP) Clinical Strategy 'Integrated Care for a Healthier Future' is developed to focus on population health and place based care, and has the following aims:

- Set out its future health and wellbeing ambitions for people in Hertfordshire and west Essex, building on existing strategies
- Provide a framework for service user focused, clinically led and high achieving healthcare services

- Ensure a sustainable approach which addresses the health and wellbeing gap, the care and quality gap, affordability and efficiency gap
- Improve clinical outcomes
- Reduce unwarranted variation, ensure evidence based standardised approaches and to ensure full and effective clinical engagement in the design, development and delivery of its clinical strategy.

The STP's Clinical Strategy is currently out for consultation, with the implementation plan timescales to be confirmed.

The Trust's Carer Plans considers the case for supporting carers and the importance of their health and access to health services in its own right. Furthermore, promoting carers' health bringing health and other benefits to the person they care for.

Supporting documents

This strategy is also supported through:

- The Good to Great Strategy
- The Organisational Development Strategy. Our staff and staff teams are integral to delivering high quality services. This work is delivered through the organisational development strategy and the framework and approach to developing of sustainable high performing teams
- The Carer Plan (2019-2021) which specifically sets out the Trust's approach to carers' support
- Service Strategies
- Digital Strategy – That sets out our goal to improve our service users' health and well-being through the effective use of data and digital technology-enabled care to deliver Great Care and Great Outcomes – Together
- Continuous Quality Improvement Agenda – Our approach to create a culture and environment where we constantly learn, improve and innovate to deliver Great Care and Great Outcomes
- HPFT Equality Plan 2018 – 2022
- HPFT Carers Plan 2019 – 2021.

Appendix C Assurance and Compliance

The Trust governance structure will provide monitoring and assurance for this strategy. There are different operational levels of quality governance within the Trust:

- Board of Directors
- Assurance Committees (Integrated Governance Committee, Equality, Diversity and Inclusion Group)
- Executive Team
- Strategic Business Unit (SBU) or Corporate Governance meetings
- Department/speciality level
- All staff reporting on quality.

Quality Assurance by the Board is underpinned by a number of systems of control. These include

- The Board Assurance Framework (BAF) which provides a structure and process enabling organisations to focus on quality issues which may compromise the achievement of its most important strategic objectives, to map out the key controls in place to manage those objectives, to confirm the Board has gained sufficient assurance about the effectiveness of these controls and to enable the Board to confirm that its responsibilities are being discharged effectively. All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have evidence to support this Statement. The BAF brings this evidence together
- The designated assurance committees of the Trust Board are the Integrated Governance Committee and the Equality, Diversity and Inclusion Group. It is the responsibility of the assurance committees to report to the Trust Board any areas of concern relating to quality identified and gaps in assurance.

Equality Impact Assessment

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

Hertfordshire Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	6th June 2019	Agenda Item: 10
Subject:	Public Sector Equality Duty (PSED) compliance report and outcome of Equality Delivery System 2 (EDS2) Grading 2018/19	For Publication: Yes
Author:	James Holland, Inclusion & Engagement Team Manager	Approved by: Dr Jane Padmore, Director Quality & Safety
Presented by:	Dr Jane Padmore, Director Quality & Safety	

Purpose of the report:

The purpose of this report is to provide the Board with assurance of compliance with the Public Sector Equality Duty (PSED) for 18/19 as well as providing the outcome of the partial EDS2 grading during May 2019. Following Board approval this will be published on the Trust website

Action required:

The Board is asked to approve the report so that the Trust can publish its annual compliance as required by the PSED.

Summary and recommendations:

The Trust is required to comply with both the general duties and the specific duties of the PSED and is mandated to publish the results of exercises in relation to the EDS2. Trust compliance with the general duties is given in the form of some narrative regarding key pieces of project work, as detailed in this report. Following this, data is published on workforce and service users/carers as part of the Trust's compliance with the specific duties

The EDS2 reporting is given in the form of grades in comparison to our previous grading. All EDS2 grading is required to be completed by Trust stakeholders (rather than self – assessed) based on evidence supplied. The Trust is required to publish one or more equality objectives covering a four year period, in the context of the EDS2. However the Trust published its new Equality Plan in September 2018 which includes all targets and strategic objectives for the next four years. This is available online at https://www.hpft.nhs.uk/about-us/equality-and-diversity/our-equality-plan-2018-2022/

This report has provides an overview of the Trust work towards meeting the Public Sector Equality Duty with respect to both the general duties (in the form of narrative) and the specific duties (with respect to the trust equality plan and data in Appendix 1). Whilst there is work to be done, the Trust is able to show that it is linking its work into meeting the general duties and identifying areas for improvement

The past year has seen a number of successes for the Trust in relation to advancing the Equality, Diversity and Inclusion agenda, including events for NHS70 and Windrush, co-production of a new strategic plan for equalities and strengthening the Trust governance structure to equality, diversity and inclusion. However, there remain some challenges for the Trust, most notably in relation the Workforce Race Equality Standard and improving data quality across both employment and service provision. Targeted work in early 2019

has begun to yield results around some of this and the introduction of the Workforce Disability Equality Standard (WDES) will mean a need to consolidate learning for all NHS equality standards into one place to ensure due regard is paid to each.

Throughout 2019/20 there are a number of projects planned including the launch of visual campaigns for rainbow lanyards and NHS rainbow badges for staff, focus both on equality, diversity and inclusion across the Trust and, in the case of the badges, LGBT+ inclusion within frontline services

With respect to our partial review of EDS2 the result indicates that the trust has the right systems and processes in place and has good leadership. However there remain issues concerning the consistency of delivery and the quality of the demographic data that should inform improvement actions to ensure that all demographic groups are receiving equally good treatment from the Trust.

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

The programme of work supporting compliance with the PSED and EDS2 links to the following annual plan priorities for 2017/18:

Great Care, Great Outcomes

2. We will deliver a better experience of services and improved outcomes by delivering on our Quality and Service Development Strategy

Great People

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

Great Networks and Partnerships

We will be recognised as system leaders having successfully driven and delivered on key system priorities.

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

In the standard NHS contract, Equality Delivery System 2, NHS Workforce Race Equality Standard and NHS Accessible Information standard remain mandated for all provider organisations. This report indicates Trust compliance in implementing these areas, it acknowledges that this may now mean additional scrutiny through its relationships with commissioners.

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

This paper shows compliance with the PSED and the EDS2 which both contribute to meeting legal responsibilities under the Equality Act 2010. Service user and carer representatives were involved in the re-grade of the EDS2 alongside a range of other stakeholders during May 2019.

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

Compliance with key legal and contractual components re: equalities. Links to CQC Key Lines of Enquiry particularly in relation to safe and effective services.

Seen by the following committee(s) on date:

Equality, Diversity & Inclusion Group (EDIG) – 17/05/19 | Integrated Governance Committee – 22/5/19

Public Sector Equality Duty (PSED) compliance report and outcome of Equality Delivery System 2 Grading – 2018/19

1. Introduction/Executive Summary

1.1 The purpose of this report is to provide assurance of compliance with the Public Sector Equality Duty (PSED) for 2018/19 for Hertfordshire Partnership University NHS Foundation Trust (the Trust) as well as the outcome of a partial regrading that has taken place with stakeholders around the NHS Equality Delivery System 2 during May 2019.

1.2 The PSED requires the Trust to ensure that **ALL** of its functions are carried out in a way that does not disadvantage anyone from a protected group. This is part of the Trust's overall compliance with the Equality Act 2010.

1.3 The Equality Delivery System 2 Grading (EDS2) is an improvement tool used by NHS providers to focus on one or more areas/functions of compliance annually to track improvements to services and employment.

1.4 The Trust is required to comply with both the general duties and the specific duties of the PSED given the size of the organisation. The EDS2 is a mandated part of the NHS standard contract for providers.

1.5 Sections 2 and 3 provide an overview of PSED compliance followed by section 4 which provides an overview of EDS2 compliance.

1.6 A summary of past year's activities, that have contributed to both PSED and EDS2 compliance, included:

- Coproduction of new Trust Equality Plan 2019 – 2022
- Development of new senior governance Equality, Diversity and Inclusion Group (EDIG)
- Events focused on recognition of Race Equality in the workplace, LGBT+ equality within services and Carer Rights and strategy
- Coproduction of new Trust Carer Plan 2019 – 2021
- Compliance reporting for Public Sector Equality Duty
- Improving our approach to meeting the NHS Workforce Race Equality Standard (WRES)
- Data quality project looking at improving quality of demographic data, thereby supporting work to improve equity in outcome and experience
- Continued work with our staff disabled network and staff mental health network in supporting preparation for the NHS Workforce Disability Equality Standard (WDES)
- Completed development of new training package for front line staff on supporting gender identity within services
- Innovation work in relation to Spiritual Care through pilot work to deliver family sessions within inpatient services in partnership with clinical psychologist
- Staff Windrush Walk from St Albans Community Hub to Trust Head Office in Hatfield to promote race equality within the NHS and remember the impact of the Windrush generation on strengthening the NHS and delivering great care.

1.7 Challenges from the past year have included:

- Making improvements to the Trust's WRES scores and ensuring that the experiences of BME staff improve in relation to equality and diversity
- Continued focus on improving data quality across staff and service user/carer data
- Putting the new Equality Plan in motion and ensuring Trust wide engagement in strategic objectives. This has started well but there are a number of areas for development in 19/20.

1.8 Compliance with the general duty is given in the form of some narrative regarding key pieces of project work, as detailed in this report). Following this, data has been published on workforce as part of Trust compliance with the specific duties, as detailed in **appendix 1.**

1.9 Compliance with the EDS2 is given in the form of a partial regrading shown in comparison the Trust previous grading.

1.10 **Appendix 2** provides an overview of the Trust's requirements in relation to the Public Sector Equality Duty and requirements under the EDS2.

2. PSED - Summary of Key Performance Areas regarding General Duties

2.1 The general duty of the PSED requires the Trust, in relation to all protected groups[1], to ensure it is working to:

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it
- **Foster good relations** between people who share a protected characteristic and people who do not share it.

2.2 Overview/narrative to eliminate unlawful discrimination

2.1.1 *NHS Workforce Race Equality Standard (WRES)* - The Trust has continued implementation of their WRES programme focusing on identifying and addressing the inequalities within Trust workplaces. This year we are pleased to have Black, Asian and Minority Ethnic (BAME) staff representatives on both the national WRES experts programme and the national WRES front line group. The WRES data can be found on the public website.[2] We have also seen enhanced activity locally within services to proactively engage with BAME staff to understand their experiences of working in the Trust.

2.1.2 *New Equality Plan development* – The Trust began co-production of this in 17/18 and it completed in the past year with formal launch programme beginning in early 2019 focused on the strategic priorities of the plan. As part of this piece of work the Trust has established a senior governance committee for this agenda, the EDIG. The Equality Plan uses the person centred model for equality at its core and promotes improved awareness and understanding of intersectionality and removal of systemic barriers to inclusion.to changing service provision and developing a stronger quality.

2.2 Overview/narrative to advancing equality of opportunity

2.2.1 *Diversity Role Models* - The role models programme engages staff who are BME, LGBT, Women, Carers or have a Disability in being role models and to support people from similar backgrounds. This has now been expanded to include Mental Health role models and Spiritual care role models and is adding another layer of support for staff and helping staff identify allies[3] in the workforce.

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[1] Age, Disability, Gender identity/reassignment, Pregnancy and maternity (employment only), Race/Ethnicity, Religion/Beliefs, Sex (gender), Sexual orientation, Marriage & Civil Partnership (employment only)

[2] http://www.hpft.nhs.uk/about-us/equality-and-diversity/wres/

[3] Allies are broadly defined as people from a different background to a group they are speaking on behalf of. E.g. male allies supporting work around equality for women.

As part of the Trust work on its Bullying & Harassment plan, the Role Models programme will be absorbed into a new 'Dignity at Work champions' programme to increase the breadth of support available to all staff, whilst retaining some focus on the needs of different protected groups.

2.2.2 *Stonewall Workplace Equality Index* – For the second year running the Trust has seen a significant improvement in its placement in the Stonewall Workplace Equality Index. Whilst not achieving a top 100 placement in 2019, the Trust climbed a further 16 places in its ranking reflecting work that has taken place over the past year ranking the Trust at 113 out of 445 entrants.

2.2.3 *Staff Networks* – The Trust has six staff networks that provide support and a forum for discussion for the following groups; LGBT+ staff, Women, BAME staff, Disabled Staff, Staff Carers, Staff with Mental Health Issues. Most networks continue to meeting monthly and have been engaged with the design and delivery of a number of events and campaigns.

2.2.4 *Inclusive Revolution!* – This campaign was launched in January 2019 to encourage staff to look at the demography of service users and carers they are supporting and take proactive steps to improve data quality and initiate conversations about diversity and culture.

2.3 Overview/narrative to foster good relations

Our focus over the past year has been to use key events to bring a diverse range of people together to focus on a particular area of quality improvement. This has enabled both celebration of diversity and awareness around inequalities that require attention in order to remove barriers and further promote social inclusion. These have included:

2.3.1 *International Women's Day (IWD) Programme 2019* – This annual event brought staff together for a 'knowledge café' providing an opportunity to discuss actions for gender equality within the Trust. The event concluded with an overview presentation of the Trust gender pay gap and work taken place to narrow/eliminate this.

2.3.2 *LGBT History Month 2019* – As part of our annual promotion the Trust developed resources for staff and service users/carer clarifying the importance of LGBT+ rights and encourage staff, service users and carers to have conversations with staff around sexual orientation and gender identity to improve monitoring and quality of care.

2.3.3 *Carer Rights Day* – The Trust hosted a conference for carer rights day in November 2018. This included a mixture of carers, service users and staff hearing about topics including legal support for Lasting Power of Attorney, Information about the Triangle of Care and hearing from professionals involved in Carer Inclusive Practice projects within Learning Disability Services. There were also opportunities during the day to feed views into the development of the new Trust Carer Plan.

2.3.4 *Diversity & Leadership* - In October 2018, the Trust hosted its fourth local WRES annual workforce conference focused on 'enabling change through personal growth and empowerment'. The programme included inspirational stories from staff about their own journeys as well as through provoking presentations from NHS England about the challenges ahead in creating a fair and equal NHS.

2.3.5 *Hertfordshire Pride* – The Trust continued its annual presence at Hertfordshire Pride this year with stalls promoting Trust employment opportunities and the Hertfordshire Wellbeing Service. As an added extra for 2018, the HPFT staff choir were invited to perform which provided a wonderful opportunity for those who would not have usually attended a pride event to be front and centre in celebrating LGBT+ equality.

3. PSED - Specific Duties

3.1 Overview of requirements

3.1.1 The Trust is required to comply with the specific duties in the following ways:

- Publish information to demonstrate compliance with the general duty
- Publish data on the make-up of the workforce
- Publish data on those affected by Trust policies and procedures
- Publish one or more equality objectives.

3.1.2 *Publish information to demonstrate compliance with the general duty* – this report has been written and published to ensure compliance with this element of the duty.

3.1.3 *Publish data on the make-up of the workforce* – this is provided in **Appendix 1**

3.1.4 *Publish data on those affected by Trust policies and procedures* – this is provided in Appendix 1 (service user data).

3.1.5 *Publish one or more equality objectives spanning a four year period* – The Trust's Equality Plan was published in September 2018 detailing strategic objectives for the Trust over the next four years. The plan is available online at https://www.hpft.nhs.uk/about-us/equality-and-diversity/our-equality-plan-2018-2022/. The strategic objectives of the Equality Plan are:

1. People have equity of access
2. People have equity of outcomes
3. People's human rights are promoted
4. People have equally good experiences
5. The impact of the plan is monitored for effectiveness.

In addition to the above the plan includes focused work on improving understanding of intersectionality and the need to remove systemic barriers that can cause inequality.

3.2 Observations against our data

Appendix 1 details data for employment and for service provision by protected group. The following observations have been made from this along with our WRES data – available at http://www.hpft.nhs.uk/about-us/equality-and-diversity/nhs-workforce-race-equality-standard/:

3.2.1 There remain gaps in data quality for service users in relation to sexual orientation, disability and religion/belief. There has been some focused work on improving data quality since January 2019 and already the Trust is beginning to see improvements in data quality.

3.2.2 The Trust's Workforce Race Equality Standard (WRES) Data for 18/19 has showed some improvements in relation to workplace culture as reported through the 2018 staff survey for the Trust. However there remain challenges in improving equity for staff in relation to appointments following shortlisting and those entering the formal disciplinary processes. The introduction of pre-disciplinary panels and improvements in representation of diversity on interview panels are expected to see improvements in experiences over the first two quarters of 19/20.

3.2.3 There is a significant proportion of people identifying as bisexual applying for roles within the Trust (9.73% of all applicants). This is not currently mirrored across staff in post (1.51%) however current programmes of work to encourage staff to amend their staff records will hopefully reduce the proportion of data missing for staff records and provide a more equitable picture across compared datasets.

3.2.4 There are 23.74% of staff who have no data recorded on the disability field of their staff record. This is an area of focus for improvement given the launch of the NHS Workforce Disability Equality Standard (WDES) from 1st April 2019.

3.2.5 The Trust is currently only able to report gender as a binary choice (male/female). However work is taking place in early 19/20 to amend this on the Trust patient record system. This will not be possible at this stage with the Trust electronic staff record due to national restrictions within this system.

3.2.6 35% of employees are from an ethnic minority background (where those who did not state their ethnicity are removed from figures). This is not currently reflected evenly across the workforce which is a key evidence base for the WRES having been implemented. However over the past two years, the Trust has begun to see some movement in band 5 BME staff moving into band 6 roles (in line with national trends since the WRES was implemented).

4. EDS2 – partial regrading of activity

4.1 The EDS2 requires providers to select one or more EDS2 outcomes to re-assess on an annual basis.

4.2 EDS2 grades should be agreed by the Trust's 'local interests' (stakeholders) through the provision of range of evidence showing the Trust current position.

4.3 The EDS2 has four grading options:

- Red – Under-developed (I.e. no evidence of activity for protected groups)
- Amber – Developing (I.e. evidence of activity (often good) but not for all protected groups)
- Green – Developed (I.e. good evidence of activity for most protected groups)
- Purple – Excelling (I.e. good evidence of activity for all protected groups).

4.4 The Trust chose to re-grade ten outcomes as agreed with the Trust Equality, Diversity & Inclusion Group (EDIG).

4.5 **Table 1** shows the results of those EDS2 objectives that were regraded against the previous grading.

Goal	Outcome	January 2018	May 2019
1. Better health outcomes	1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	Not re-graded	Not re-graded
	1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways		
	1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.		
	1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	Not re-graded	
	1.5 Screening, vaccination and other health promotion services reach and benefit all local communities.		

Goal	Outcome	January 2018	May 2019
2. Improved patient access and experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds		
	2.2 People are informed and supported to be as involved as they wish to be in decisions about their care.		
	2.3 People report positive experiences of the NHS.		
	2.4 People's complaints about services are handled respectfully and efficiently.		
3. Empowered, engaged and well-supported staff	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.		
	3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.		
	3.3 Training and development opportunities are taken up and positively evaluated by all staff.		
	3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.		
	3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives.		
	3.6 Staff report positive experiences of their membership of the workforce.		
4. Inclusive leadership	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond		
	4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed.		
	4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.		

Table 1: HPFT EDS2 partial re-grading outcome (May 2019)

4.6 Observations from re-grading

There were 17 participants in the regrading process representing a mix of staff, service users, carers and partner agencies such as Mind, Guidepost Trust and Hertfordshire Equality Council. Overall four of the 10 areas were graded as developed with the other 6 as developing. Some key observations include:

- The strategies, policies, systems and processes in the Trust are good and well regarded
- Leadership commitment was recognised, hence the positive scoring of leadership.
- Unconscious bias training was positively recognised.
- Service users were generally more positive about the service that they received than non-service users

- However, a key message was that overall there was a sense that delivery was inconsistent
- Service users and carers were generally concerned about the individual patient health needs and how this was assessed. There was concern that there were issues around age, disability gender identity and carers where the feeling was that there was too much inconsistency and as such the view was that this was developing.
- There was a recurring concern that without good quality demographic data the Trust would not be best placed to take informed actions
- The diversity of engagement mechanisms was identified as a potential area of concern impacting on the view of the accessibility of information.
- The issue of access to reasonable adjustment for disabled staff was noted from the staff survey and was of concern
- There was a concern that the key to success is middle management and it was not sufficient to rely on the mandatory online Equality, Diversity, Inclusion (EDI) training and all recruiting managers should for example receive recruitment training.

4.7 EDS2 objectives

The following objectives have been identified to fit with the wider Trust Equality Action Plan for the coming year:

- Develop and implements plan to diversify engagement mechanisms such as carer council, service user council and youth council
- Improve the collection of demographic data particularly for sexual orientation and disability for staff and service users
- Identify and develop mechanisms to capture and report demographic data concerning the safety of service users and staff.
- Develop action plan emerging from gender pay gap reporting and put in place arrangements for ethnicity and disability pay gap monitoring and reporting
- Explore the rationale for the significant inequality identified with the workforce race equality standard results and identify solutions
- Identify and develop arrangements to monitor use of informal flexible working arrangements and identify any differential impact by demography.
- Review approach to reasonable adjustments to ensure that there is a consistent approach across the Trust
- Provide training and information on reasonable adjustments for all middle managers

5. Challenges & Opportunities for the coming year

5.1 A key challenge this year will be around improvement in WRES scores for staff appointments and staff experience of the formal disciplinary procedure.

5.2 Introduction of reverse mentoring programme to improve the opportunity for senior staff to be mentored by a more junior staff member in relation to improvement equality and inclusion.

5.3 Introduction of pre-disciplinary panels to screen those cases put forward for formal disciplinary to ensure appropriate and measured assessment of all circumstances.

5.4 Launch of rainbow lanyards and NHS rainbow badge scheme. The former focused on improving awareness and commitment from staff to equality, diversity and inclusion. The latter focused on staff and team commitment to creating safe spaces for LGBT people to disclose their sexual orientation and gender and receive specialist information/signposting for support.

5.5 The first full year of the Trust Equality, Diversity & Inclusion Plan will see more synergy between all NHS equality standards and significant improvements in data quality across the Trust. It is recognised by the Trust that improving data quality will help improve our understanding in relation to equitable access to services and employment.

5.6 Over the next year that will be more time and resource invested into the development of staff networks, both as physical spaces for support and virtual spaces for discussion and debate.

5.7 Continued targeted action planning to address the Trust gender pay gap through improving the experiences of women in the workforce, challenging inequality and learning from best practice across the health economy.

5.8 We will report for the first year on our Workforce Disability Equality Standard (WDES) data and spend time better understanding the experiences of disabled staff.

5.9 Our action plan for our overall carer plan will speak to the Trust equality plan in recognising carers as an associated group under the Equality Act 2010.

5.10 There will be and opportunity for the Trust to pilot EDS3 over the coming year, the third incarnation of the NHS Equality Delivery System.

6. Conclusion

6.1 This report has provided an overview of the Trust work towards meeting the Public Sector Equality Duty with respect to both the general duties (in the form of narrative) and the specific duties (with respect to the trust equality plan and data in Appendix 1).

6.2 Whilst there is work to be done, the Trust is able to show that it is linking its work into meeting the general duties and identifying areas for improvement.

6.3 The past year has seen a number of successes for the Trust in relation to advancing the Equality, Diversity and Inclusion agenda, including events for NHS70 and Windrush, co-production of a new strategic plan for equalities and strengthening the Trust governance structure to equality, diversity and inclusion.

6.4 However there remain some challenges for the Trust, most notably in relation the Workforce Race Equality Standard and improving data quality across both employment and service provision. Targeted work in early 2019 has begun to yield results around some of this and the introduction of the Workforce Disability Equality Standard (WDES) will mean a need to consolidate learning for all NHS equality standards into one place to ensure due regard is paid to each.

6.5 Throughout 19/20 there are a number of projects planned including the launch of visual campaigns for rainbow lanyards and NHS rainbow badges for staff, focus both on equality, diversity and inclusion across the Trust and, in the case of the badges, LGBT+ inclusion within frontline services.

6.6 With respect to our partial review of EDS2 the result indicates that the trust has the right systems and processes in place and has good leadership. However there remain issues concerning the consistency of delivery and the quality of the demographic data that should inform improvement actions to ensure that all demographic groups are receiving equally good treatment from the Trust.

7. Recommendations

It is recommended that this report is approved to proceed for Board approval so this can be published on the Trust website.

8. Contact

Any further information needed on the contents of this report can be obtained from the Trust Equality & Diversity Department within the Inclusion & Engagement Team on hpft.equality@nhs.net

Appendix 1 – Workforce & Service User/Carer Data

Data tables for staff and service user equalities data for 2018/19. The % listed in the tables relates the following numbers:

Applicants between 01/04/18 – 31/03/19	5108
Staff in Post at 31/03/19	4099
Leavers between 01/04/18 – 31/03/19	913
Staff a current Professional Development Plan (PDP)	2454
Service Users/Carers (open referrals during year)	51104

AGE

	Employed staff	Leavers	Current PDP
16-20	1.85%	1.10%	80.00%
21-25	9.49%	9.53%	92.86%
26-30	10.69%	13.36%	88.45%
31-35	12.22%	11.17%	88.54%
36-40	14.10%	10.41%	89.04%
41-45	14.10%	11.17%	91.99%
46-50	11.81%	9.53%	88.21%
51-55	7.27%	9.97%	92.00%
56-60	3.39%	10.19%	86.46%
61-65	0.51%	7.34%	90.91%
66-70	5.34%	2.96%	82.46%
71 & above	9.22%	3.29%	80.00%

	Applicants
Under 20	1.10%
20 - 24	16.54%
25 - 29	18.36%
30 - 34	13.35%
35 - 39	11.32%
40 - 44	10.02%
45 - 49	11.32%
50 - 54	8.99%
55 - 59	6.19%
60 - 64	1.20%
65+	0.31%
Not stated	0.51%

GENDER

	Applicants	Employed staff	Leavers	Current PDP	Service users
Female	74.5%	72.21%	71.74%	90.13%	54.2%
Male	25.4%	27.79%	28.26%	87.64%	45.7%
Not recorded	0.1%	-	-	-	0.1%

ETHNICITY

	Applicants	Employed staff	Leavers	Current PDP	Service users
A White - British	46.05%	50.26%	48.96%	90.01%	59.2%
B White - Irish	1.08%	2.54%	1.97%	96.30%	1.1%
C White - Any other White background	9.04%	6.68%	6.46%	90.06%	3.0%
D Mixed - White & Black Caribbean	1.02%	0.66%	0.66%	89.47%	0.8%
E Mixed - White & Black African	0.65%	0.41%	0.44%	100.00%	0.3%
F Mixed - White & Asian	0.10%	0.73%	0.99%	88.46%	0.4%
G Mixed - Any other mixed background	1.33%	0.68%	0.88%	100.00%	0.9%
H Asian or Asian British - Indian	7.40%	4.73%	3.83%	85.29%	0.7%
J Asian or Asian British - Pakistani	2.49%	1.34%	0.88%	85.19%	0.6%
K Asian or Asian British - Bangladeshi	1.16%	0.49%	0.66%	81.82%	0.2%
L Asian or Asian British - Any other Asian background	2.82%	3.98%	3.94%	93.27%	1.1%
M Black or Black British - Caribbean	2.06%	2.24%	2.41%	96.92%	0.5%
N Black or Black British - African	15.82%	11.66%	13.03%	87.41%	0.7%
P Black or Black British - Any other Black background	0.86%	2.00%	4.82%	78.26%	0.8%
R Chinese	0.74%	0.61%	0.55%	87.50%	0.1%
S Any Other Ethnic Group	2.86%	2.42%	1.42%	84.62%	0.7%
Z Not Stated	3.64%	8.56%	8.11%	84.76%	28.8%

SEXUAL ORIENTATION

	Applicants	Employed staff	Leavers	Current PDP	Service users
Gay or Lesbian	1.84%	0.98%	0.55%	93.10%	0.5%
Bisexual	9.73%	1.51%	1.53%	80.43%	0.4%
Heterosexual	83.89%	68.09%	64.95%	90.43%	34.2%
Refused	4.25%	21.86%	16.87%	88.68%	1.3%
Other	0.08%	0.02%	-	-	0.5%
Not recorded	0.22%	7.54%	16.10%	57.14%	63.1%

DISABILITY

	Applicants	Employed staff	Leavers	Current PDP	Service users
Yes	6.93%	4.07%	2.96%	90.15%	13.5%
No	92.82%	72.19%	69.99%	90.17%	3.4%
Not recorded	0.25%	23.74%	27.05%	86.53%	83.1%

RELIGION & BELIEF

	Applicants	Employed staff	Leavers	Current PDP	Service Users
Atheism	21.55%	11.34%	11.50%	92.63%	0.9%
Buddhism	0.10%	0.73%	1.20%	92.86%	0.1%
Christianity	47.63%	41.82%	40.74%	90.07%	15.1%
Hinduism	3.90%	3.15%	2.41%	81.54%	0.3%
Islam	6.17%	3.81%	3.72%	82.35%	0.9%
Jainism	0.06%	0.07%	-	100.00%	0.02%
Judaism	0.90%	0.85%	1.10%	88.89%	0.65%
Sikhism	0.88%	0.51%	0.77%	86.67%	0.08%
Other	8.18%	7.07%	5.26%	90.28%	3.74%
None	-	-	-	-	6.25%
Rather not say	9.51%	23.08%	17.09%	89.98%	0.8%
Not recorded	0.22%	7.56%	16.21%	55.56%	71.14%

MARRIAGE & CIVIL PARTNERSHIP

	Applicants	Employed staff	Leavers	Current PDP
Civil Partnership	2.41%	1.10%	0.88%	87.50%
Divorced	5.25%	7.12%	6.13%	88.73%
Legally Separated	0.84%	1.22%	0.77%	90.24%
Married	36.79%	51.89%	44.58%	89.55%
Single	47.43%	32.98%	40.74%	90.18%
Unknown	6.28%	4.54%	5.70%	83.48%
Widowed	0.70%	1.15%	1.20%	96.00%

Data is not reported here for service users as the protected characteristic of Marriage & Civil Partnership, as it applies to the Public Sector Equality Duty, refers only to employment.

Appendix 2 – Overview of Trust requirements re: Public Sector Equality Duty

In October 2010, the Equality Act 2010 came into effect. Prior to this time there had been over 100 pieces of legislation covering equalities protections and – with them – three associated public duties for race, gender and disability.

The Equality Act 2010 has brought with it a new – legal – public sector equality duty (PSED) requiring public bodies to declare their compliance with the duty on an annual basis. This means that HPFT must show compliance with both the general and specific duties of the PSED. This includes:

For the general duty showing how we have due regard to the need to:

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it
- **Foster good relations** between people who share a protected characteristic and people who do not share it.

Protected characteristics – in the context of the PSED – are defined as:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race – this includes ethnic or national origins, colour or nationality
- Religion or belief – this includes lack of belief
- Sex (gender)
- Sexual orientation

It also applies to marriage and civil partnership in respect of the requirement to have due regard to the need to eliminate discrimination.

For the specific duty HPFT must:

- Publish information to demonstrate compliance with the general duty
- Publish data on the make-up of the workforce
- Publish data on those affected by HPFT policies and procedures
- Publish one or more equality objectives.

This document outlines how HPFT is currently complying with the PSED and working at maintaining a level of excellence in equality & diversity. Much of our evidence of PSED compliance is detailed through Trust Equality Delivery System 2 (EDS2) approached.

The PSED is a legal framework which requires the Trust to be compliant across **ALL** functions in meeting the needs of those with a protected characteristic.

Appendix 3 – Evidence list used for EDS2 re-grading

The following evidence was provided to stakeholders in helping them to reach conclusions about EDS2 grades. This was supplemented with verbal feedback by staff members in response to queries or clarity sought are certain pieces of evidence,

EDS2 Goals 1 & 2 – Service Provision

- CQC - Service User Survey Report 2018
- HPFT Equality plan 2018-2022
- HPFT Equality, Inclusion & Human Rights Policy
- HPFT Accessible Information Policy
- NHS Annual Staff Survey 2018
- Equality Impact assessments
- FFT demographic data
- Adult Inpatient Services Operational Policy
- Adult Community Mental Health Services Policy
- Operational Policy
- Carer Practice Policy
- Sexual Orientation & Gender Identity: A Guide
- Young Carers Mental Health Booklet
- A helpful Guide to Transitions for Young People and their parents and carers
- Equality impact assessments/analysis
- Quality and Service Delivery Strategy (QSDS) (2017-22)
- Service User Council (SUC) Annual Report April 2018-March 2019
- HPFT Carers Plan 1919-21
- CAMHS youth council Annual Report - April 2018 – March 2019
- CAMHS Forest House Council Annual Report - April 2018 – March 2019
- Complaints and Service Experience Report Q4 2017-18
- Service User Council (SUC) Annual Report April 2018-March 2019
- Guide to Transition for Young people & their parents.
- Annual Plan for Peer Experience Listening

EDS2 Goals 3 & 4 – Workforce

- HPFT Equality plan 2018-2022
- HPFT Equality, Inclusion & Human Rights Policy
- HPFT Accessible Information Policy
- NHS Annual Staff Survey 2018
- Pulse Survey
- Harassment report
- Report to EDIG re Staff network
- Flexible Working policy
- Recruitment & Selection Policy
- Equal Opportunities Policy
- Capability Policy
- Absence Management Policy
- Family Leave Policy
- Grievance Procedure
- Harassment and Bullying
- Grievance Policy
- RESPECT statement

- Speak Up Policy
- Supervision Policy
- Stress Management Policy
- Staff Nurse Preceptorship Policy (Rotation Nurse Scheme)
- Shared Parental Leave Policy
- Staff Demographic Data
- Managers Guide for Supporting Staff with a Disability

Hertfordshire Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	6th June 2019	**Agenda Item:** 11
Subject:	2018/19 Safer Staffing Annual Report	**For Publication:** Yes
Author:	Jacky Vincent, Deputy Director of Nursing and Quality	**Approved by:** Jane Padmore, Executive Director of Nursing and Quality/ Chief Nurse
Presented by:	Jane Padmore, Executive Director of Nursing and Quality/ Chief Nurse	

Purpose of the report:

To provide the Board with an overview of Safer Staffing during the year, outlining the achievements and challenges; to also give assurance to the IGC in relation to Safer Staffing.

Action required:

To receive the report, discussing the content and agree its recommendations.

Summary and recommendations to the IGC:

This report provides the Board with detail of progress the Trust has made in relation to safer staffing. It also identifies the areas of challenge during the year as well as the achievements that have been made.

Relationship with the Business Plan & Assurance Framework:

This report speaks to and provides assurance in relation to clinical safety of service user and staff with regards to the safer staffing levels and establishments.

Summary of Implications for:

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

No Equality and Diversity and Public & Patient Involvement Implications

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

Safety KLOE for CQC

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

IGC – 22/5/19

as One

Our Values
Welcoming Kind Positive Respectful Professional

Executive Summary

Introduction
This report provides an overall summary of Safer Staffing during the year 2018/19. Safer Staffing has continued to be closely monitored and reveiwed on a daily, weekly and monthly basis through local and Trust wide forums, as appropriate.
The use of SafeCare and eRostering has increased significantly during the year, having a positive impact on how we monitor the safer staffing and also ensure that the skill mix and establishments on a shift by shift basis are enabling staff to provide safe and effective services.

Overview of 2018/19
During the year, we have seen an increased focus in the inpatient services with the use of SafeCare. Census checks are undertaken three times a day, detailing the safety of the staffing levels and whether staffing hours are short or in excess of hours for the forthcoming shift.
Daily SafeCare calls manage and monitor safe staffing within each of the Strategic Business Units (SBU), redeploying staff to another unit as appropriate as well as monitoring the bank and agency usage and service user acuity levels.
Furthermore, eRosters have been more clsoely scrutinised via weekly meetings, ensuring their effective utilisation and compliance.
The monthly Safer Staffing Group meeting was reviewed during the year with regards to membership, and governanace structure.

Agency usage showed a decline in the summer and also over the Christmas holiday period – at the lowest for the past 3 years, having a positive impact on the quality of services we provide with our regular staff, as well as financially.

In consideration of safer staffing levels during the year, the Care Hours per Patient Day (CHPPD) showed that there were many services which had used staffing above their establishment to meet the clinical needs and demands of the services. These were predominantly owing to the aucity levels and requiring prescibed increased levels of safe and supportive observations.

The first cohort of the Trainee Nurse Associates completed their training at the end of quarter 4. Reviews of the staffing establishments and completion of the Quality Impact Assessments have been undertaken by the Heads of Nursing.

The vacancy rates of the nursing staff remained a focus, with an increased concern on the number of Registered Nurses (RN) who can retire – particualrly in the Specialist Residential Servcies (SRS). The Heads of Nursing have continued to closely monitor this, supporting individuals and exploring options for them to remain in the workplace.

Prioities for 2019/20
The prioirities for the forthcoming year 2019/20, are to ensure the continual focus on the use of SafeCare and eRostering, as well as the process of agency approval.

The Heads of Nursing are all to be trained in the submission of the CHPPD to enable a greater understanding of the requirements and also a more detailed reflection of the staffing levels shown in the data.

The introduction of the TNAs into the staffing establishments will require a review of their impact and ensuring the upskilling of the nursing staff with whom they work as well as ensuring the skills from their training are fully appreciated and utilised in the service areas.

The success of the agency reduction needs to also remain a focus with the approval process fo requesting agency reinforced across the services and enabling a more SBU and Trust wide overview of support is ensured first prioir to using agency staff.

The eRostering scrutiny meetings have proven to be a success in the East and North SBU in particular; ensuring consistency in the meetings and their effectivenss in each of the SBUs will realise the benefits of the eRoster and safe staffing.
The wider implementation of SafeCare into all service areas and of eRostering into all staff groups is required and therefore a revew of the resource to enable this is required during the forthcoming year.

Conclusion
The year 2018/19 has seen successes with the use of SafeCare and eRostering in the inpatient services. An increased focus as enabled a reduction in agency at peak times of the year.
The Heads of Nursing have continued to monitor the staffing levels, enabling services to support eachother in order to run safe and effective services whilst being compliant with the safer staffing requirements, to ensure the Trust has the right staff, in the right place, with the right skills, at the right time.

Annual Safer Staffing Report 2018/19

1. Introduction

1.1 This report provides an overall summary of Safer Staffing during the year 2018/19. Safer Staffing has continued to be closely monitored and reveiwed on a daily, weekly and monthly basis through local and Trust wide forums, as appropriate.

1.2 The use of SafeCare and eRostering has increased significantly during the year, having a positive impact on how we monitor the safer staffing and also ensure that the skill mix and establishments on a shift by shift basis are enabling staff to provide safe and effective services.

2. Summary of key progress and challenges

2.1 SafeCare Census checks have been taking place three times a day (Sunday to Saturday) and submitted by the inpatient nursing staff (normally assigned/delegated to the Nurse in Charge) – within an hour's timeframe of the commencement of every shift.

2.2 These are monitored by the Team Leader and Matron regarding completion and referred to in the daily SafeCare calls (see below). A weekly report provided throughout the year details the overall weekly compliance for each inpatient service area, detailing the safety of the staffing levels on a shift by shift basis over the last week, showing whether staffing hours were short of in excess.

2.3 SafeCare calls have been held daily (Monday to Friday) within each of the SBUs, chaired by the Head of Nursing, a Service Line Lead or a 'duty' Matron. These calls have enabled the management and monitoring of safe staffing within the SBU and ensured consistency across the Trust on a daily basis (for the next 24 hours).

2.4 As an outcome of the daily SafeCare calls, staff have been redeployed to other inpatient service areas as appropriate. This has been more positively received as the year progressed with staff appreciating the support to each other's' service areas and the new skills and experiences they have acquired.

2.5 Bank and agency staffing levels have been continually monitored during the daily calls, challenging agency requests as appropriate. Furthermore, the calls have included the review of acuity levels with bed availability, admissions and discharges and staffing levels.

2.6 Agency usage showed a decline in the summer and also over the Christmas holiday period – at the lowest for the past 3 years. This has had a positive impact on the quality of services we provide with our regular staff, as well as financially.

2.7 The weekly eRoster Scrutiny meetings held within each of the SBUs are also chaired by the Head of Nursing or Service Line Leader. They have enabled and ensured the effective utilisation of the eRoster. Specifically, their completeness, finalisation, approval and sign off as well as their overall compliance of the eRoster Key Performance Indicators (KPI). These meetings have been joined by a Bank Bureau representative and the eRoster Manager as/when able.

2.8 The scrutiny meetings have realised a positive impact and improvement with the challenging of the rotas, the planned use of agency and the timely completion of the eRosters (12 weeks in advance).

2.9 During the year, the Trust's Safer Staffing Group meeting was reviewed with regards to the membership and the governance. As a result of increased scrutiny at a service area and SBU level, the Matrons and Team Leaders are no longer required to attend. Chaired by the Deputy Director of Nursing and Quality, the Heads of Nursing and Service Line Leaders jointly represent their SBUs with representation from finance, Human Resources (HR), eRostering and the Bank Bureau.

2.10 The Safer Staffing Group is responsible for overseeing staffing regarding effective utilisation of eRostering and SafeCare, bank and agency usage, staffing skill mix and establishments and now reports to the Trust Management Group (TMG).

2.11 In consideration of safer staffing levels during the year, the Care Hours per Patient Day (CHPPD) showed that there were many services which had used staffing above their establishment to meet the clinical needs and demands of the services. These were predominantly owing to the aucity levels and requiring prescibed increased levels of safe and supportive observations.

2.12 The first cohort of the Trainee Nurse Associates completed their training at the end of quarter 4. Reviews of the staffing establishments and completion of the Quality Impact Assessments have been undertaken by the Heads of Nursing.

2.13 The vacancy rates of the nursing staff remained a focus, with an increased concern on the number of Registered Nurses (RN) who can retire – particualrly in the Specialist Residential Servcies (SRS). The Heads of Nursing have continued to closely monitor this, supporting individuals and exploring options for them to remain in the workplace.

3. Priorities and recommendations for 2018/19

3.1 The prioirities and recommendations for the forthcoming year 2019/20, are:

- **To ensure the continual focus on the use of SafeCare and eRostering, as well as the process of agency approval.** We have seen a significant improvement in the declined use of agency at peak holdiay times in particular. However, a gradual increase in agency usage towards the end of the year in quarter 4 in some service areas has been noted.

An increase in focus and including the approval process for requesting agency reinforced across the services and enabling a more SBU and Trust wide overview of support is therefore required

- **To train the Heads of Nursing in the submission of the CHPPD.** This will enable a greater understanding of the requirements and also a more detailed reflection of the staffing levels shown in the data and improvement in the quarterly reports provided to the IGC and the Commissioners
- **To review the TNAs in the service areas.** The introduction of the TNAs into the staffing establishments will have a positive impact and ensuring the upskilling of the nursing staff with whom they work, as well as ensuring the skills from their training are fully appreciated and utilised in the service areas is therefore essential
- **To ensure the eRostering scrutiny meetings are consistent and have full attendance in all SBUs.** The meetings have proven to be a success in the East and North SBU in particular; ensuring consistency in the meetings and their effectivenss in each of the SBUs will realise the benefits of the eRoster and safe staffing
- **To implement the use of SafeCare into all service areas.** Currenlty used in inpatient services and some communtiy servcies, the wider use in all community service araes will enable the effective utilisation of staff. To enable this, an increased resource for training, support and monitoring will be required
- **To implement the use of eRostering into all staff groups.** Currently used for nursing staff and some Allied Health Professionals (AHP), increasing the use of eRostering across all staff gorups and service areas will require an increase in resource to support its implementation, support and monitoring.

4. Conclusion

4.1 This year has seen successes with the use of SafeCare and eRostering in the inpatient services. An increased focus as enabled a reduction in agency at peak times of the year.

4.2 The Heads of Nursing have continued to monitor the staffing levels, enabling services to support eachother in order to run safe and effective services whilst being compliant with the safer staffing requirements, to ensure the Trust has the right staff, in the right place, with the right skills, at the right time.

Appendix 1 – Quarter 4 Safer Staffing Report

Meeting Date:	22nd May 2019	**Agenda Item:**
Subject:	Quarter 4 Safer Staffing Report	**For Publication:**
Authors:	Heads of Nursing	**Approved by:** Jacky Vincent, Deputy Director of Nursing and Quality
Presented by:	Jacky Vincent	

Purpose of the report:

This report provides the IGC with the data for quarter 4 on nurse staffing for the Trust. In addition, the report provides information that sets the context for the published data including recruitment, retention and vacancies of nursing staff and cross referenced with patient safety data.
The purpose of this report is to provide information and assurance of the governance processes for rostering and ensuring the appropriate level and skill mix of nursing staff.

Action required:

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

Summary and recommendations to the Board:

The direct care nurse staffing data was analysed according to total hours worked per ward for RN and HCA, divided into day and night time hours and includes additional duties. Quarter 4 showed adequate staffing and shift cover in response to unexpected demand and levels of acuity and dependency on the wards.
There was no service with a fill rate below 80%. There was also more actual hours than planned used for both RNs and HCAs across many services. The CHPPD analysis showed that small standalone units with high acuity had high CHPPD. This is reflected when comparing the Trust with the national data.

Relationship with the Business Plan & Assurance Framework:

Adequacy of a balanced skill mix for nursing workforce has an impact on clinical outcomes, patient safety and experience.

Summary of Implications for:

Staffing – there is a need for regular review of staffing establishment

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

N/A

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

Potentially all of the above

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

None

Quarter 4 Safer Staffing Report 2018/19

1. Introduction

1.1 This report serves to provide the information and analysis of the quarter 4 nurse staffing data to enable the Integrated Governance Committee (IGC) to have assurance in relation to the nurse staffing in the Trust's inpatient services.

1.2 This report also provides supporting data in relation to vacancies.

2 Trust expectations in relation to inpatient nurse staffing levels

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

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

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

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

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

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

2.7 *SafeCare* is well embedded within all in-patient services with daily *SafeCare* calls held to ensure safe staffing and identifying any hotspots. This allows for effective use of our staffing resource across the Trust.

3 Summary of findings for quarter 4 nurse staffing data collection

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

3.2 Care Hours Per Patient Day (CHPPD) data submitted by the Trust, reflects the increased staffing utilised in many of the services as a result of increased acuity and also the stand alone units where CHPPD is high.

3.3 There were no services with a fill rate below 80% in Quarter 4 and there was adequate staffing in all in-patient services and many services have used staffing above their establishment to meet the clinical needs and demands of the services.

3.4 Wren ward and Lambourn Grove in the East and North Strategic Business Unit (SBU) both showed an increase in RNs and in HCAs for night shifts, owing to the level of prescribed safe and supportive observations (SASO).

3.5 In the West SBU, remedial environmental works were implemented from late January to the end of March 2019, particularly concentrated in Oak ward, where there were three service areas requiring additional staff for environmental observations during this period of time. Albany Lodge also had a high level of remedial works undertaken and across other service areas decorative works were completed requiring additional staff for environmental observations.

3.6 Also in the West SBU, Aston ward had a high number of vacancies, along with an ongoing investigation which has had an impact on the staffing. Oak ward's clinical acuity was also of particular note where two individual service users were awaiting an available bed in secure units, one individual requiring frequent seclusion or high level observations; with seclusion requiring two staff members for support - one with the individual and one observing the CCTV at all times.

3.7 In the Learning Disability and Forensic SBU, additional duties were used in all services in line with SafeCare and owing to the acuity levels. Dover ward, Astley Court, Warren Court and the Broadland Clinic have all had additional duties owing to levels of acuity and prescribed SASO, including seclusion and Long Term Segregation (LTS). The SBU have commenced Continuous Quality Improvement (CQI) projects on Dove ward and Warren Court specifically looking at the use of restrictive practice and also activities on evenings and at weekends.

3.8 The Specialist Residential Services (SRS), Hampden House and Gainsford House all in the Learning Disability and Forensic SBU had additional duties owing to the physical health needs of individual service users.

3.9 In North Essex, the overall CHPPD hours remained high in comparison to other services owing to acuity and increased SASO levels. Staffing levels on night shifts also increased by one in consideration of the acuity levels at Lexden as a standalone unit.

3.10 Nurses in charge of the shifts and the Team Leaders continue to review their nurse staffing level daily, on a shift by shift basis, in response to the changing clinical needs of services, following the clear process for escalation when staffing falls below the minimum safe level.

3.11 **Appendix 1** provides detailed data for each inpatient service for quarter 4.

3.12 *SafeCare* continues to be embedded within all in-patient services with daily *SafeCare* call and weekly e-roster scrutiny meetings, ensuring the effective use of staffing resource.

4 Vacancies

4.1 The Trust continues to have some challenges with recruitment in quarter 4 as detailed in **Table 1**.

SBU	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
Registered Nursing				
Learning Disability & Forensic	193.87	151.34	42.53	22
East & North	122.97	95.96	27.01	22
West	114.77	88.09	26.68	23
Total	**431.61**	**335.39**	**96.22**	**22**
Unregistered Nursing				
Learning Disability & Forensic	241.52	204.33	37.19	15
East & North	209.92	165.28	44.64	21
West	124.20	116.35	7.85	6
Total	**575.64**	**485.96**	**89.68**	**16**

Table 1

4.2 The Trust continues to work with the local universities ensuring that student nurses feel part of the Trust family at the start of their training and meeting senior nurse leaders during their training.

4.3 In quarter 4, the Heads of Nursing and Modern Matrons continued to meet with student nurses in their service areas per placement. Shadowing opportunities also continue to be offered to students to enable a greater understanding and appreciation of the Trust, feeling welcomed and included as a member of the workforce and also to gain greater insight into potential nurse career opportunities.

4.4 The 10 trainee Nursing Associates (TNA) from cohort 1 have completed their programme are commencing their employment in the SBUs prior to registering with the Nursing and Midwifery Council (NMC) in early quarter 1 2019/20. Cohort 2 with 9 TNA started in May 2018, cohort 3 started in September 2018 with 7 TNA and cohort 4 with 10 TNAs started on 21st December 2018. One of the two TNAs from cohort 1 in the West SBU has since resigned to relocate to her family

4.5 The Quality Impact Assessments (QIA) are being implemented with the Heads of Nursing and line managers to ensure that the skills acquired are being well utilised, whilst any limitations of the role are well known within the team.

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

4.7 A significant risk remains for the Trust regarding the profile of RNs who are able to retire (308), detailed in **table 2**. Work continues to support them and explore their options to remain in the workforce. Particular concern is within the SRS and the Learning Disability and Forensic SBU are looking at strategies to mitigate and manage this risk.

Area	55-59			60-64			65+		
	HCA	RN	Total	HCA	RN	Total	HCA	RN	Total
LD&F SBU	36	25	61	13	7	20	4	2	6
E&N SBU	32	10	42	16	11	27	3	3	6
West SBU	19	12	31	10	4	14	5	2	7
Total	**87**	**47**	**134**	**39**	**22**	**61**	**12**	7	**19**

Table 2

5 Conclusion

5.1 This report sets out to brief the IGC in relation to the quarter 4 position for safe nurse staffing within inpatient services. The report also includes community nursing staffing and the vacancy rate.

5.2 In addition, the report details the work the Trust is currently undertaking in order to run safe and effective services whilst being compliant with the safer staffing requirements, to ensure the Trust has the right staff, in the right place, with the right skills, at the right time.

5.3 *SafeCare* is embedded within all inpatient services with daily safe care call to ensure safe staffing and effective use of our staffing resources across the Trust.

5.4 The Trust continues to be involved in the development of the NHSI Mental Health Model Hospital initiative.

5.5 The IGC is asked to note this report and discuss any point of clarification.

Appendix 1 - Nurse Staffing fill rate data

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate	Cumulative count of s/u over the month at 23.59 each day	CHHPD RN	CHPPD HCA	Overall CHPPD
JANUARY 2019								
Learning Disability and Forensic SBU								
Gainsford House	88	162	85	129		3.6	3.3	6.6
Hampden House	96	207	102	134		3.9	3.0	7.3
Warren Court	94	116	95	117		5.1	8.7	13.8
4 Bowlers	99	106	100	100		4.1	5.5	9.6
Beech	136	87	100	103		3.8	4.5	8.3
Dove	132	106	113	138		3.6	7.8	11.4
SRS	84	111	97	100		2.7	10.5	13.2
Lexden	103	98	97	108		7.8	14.5	22.4
Astley Court	123	196	107	99		7.0	13.0	20.0
Broadland Clinic	111	92	95	95		3.1	8.8	12.2
The Beacon	98	101	95	110		2.6	2.1	4.7
West SBU								
Swift	99	156	97	213		4.3	6.1	10.4
Robin	102	130	97	168		2.3	4.7	7.0
Owl	115	156	100	197		2.3	5.2	7.5
Oak	102	178	100	160		5.6	13.7	19.2
Thumbswood	101	111	106	123		4.5	8.6	13.1
Albany Lodge	114	131	104	144		2.5	4.4	6.9
Aston	96	149	100	124		2.7	4.9	7.6
East and North SBU								
Victoria Court	97	100	98	109		1.8	6.0	7.8
Forest House	95	126	98	141		3.6	9.7	13.3
Wren	100	100	100	139		3.3	6.0	9.3
Lambourn Grove	106	103	105	106		2.1	6.4	8.5
Logandene	95	99	100	97		3.2	7.3	10.5
Seward Lodge	101	99	100	168		3.5	8.2	11.7
The Stewarts	93	124	100	100		4.5	5.9	10.4
Learning Disability and Forensic SBU								
Gainsford House	91	223	96	107		4.0	3.5	7.5
Hampden House	94	174	102	96		4.4	3.0	7.4
Warren Court	92	124	99	133		5.2	9.6	14.7
4 Bowlers Green	99	109	100	100		4.2	5.7	9.9
Beech	129	90	103	100		3.8	4.6	8.4
Dove	120	115	103	143		3.9	10.0	13.9
SRS	90	112	100	100		2.8	10.5	13.3
Lexden	96	100	102	99		15.9	27.1	43.0
Astley Court	98	182	104	102		5.9	12.6	18.5
Broadland Clinic	95	99	93	102		2.6	8.9	11.8
The Beacon	98	101	100	100		3.2	2.4	5.6
West SBU								
Swift	94	159	92	184		4.4	6.0	10.4
Robin	111	143	100	198		2.7	5.5	8.2
Owl	103	202	107	272		2.6	7.5	10.1
Oak	102	147	98	151		5.3	12.0	17.3
Thumbswood	131	99	103	111		7.7	12.5	20.2

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate	Cumulative count of s/u over the month at 23.59 each day	CHHPD RN	CHPPD HCA	Overall CHPPD
Albany Lodge	109	133	102	142		2.6	8.2	7.4
Aston	96	112	102	98		2.8	3.9	6.7
East and North SBU								
Victoria Court	90	107	100	149		1.7	7.0	8.7
Forest House	83	126	104	145		3.4	9.8	13.2
Wren	100	118	102	197		3.3	7.5	10.8
Lambourn Grove	111	107	109	121		2.2	6.7	8.9
Logandene	101	102	100	109		3.0	6.8	9.8
Seward Lodge	91	105	100	216		2.9	8.2	11.1
The Stewarts	98	101	100	100		4.8	3.7	8.5
MARCH 2019								
Learning Disability & Forensic SBU								
Gainsford House	94	139	101	93		4.8	2.8	7.6
Hampden House	96	165	100	100		4.4	3.0	7.4
Warren Court	95	114	100	115		5.1	8.2	13.3
4 Bowlers	95	94	100	100		4.0	5.1	9.1
Beech	133	97	101	104		4.1	5.1	9.2
Dove	127	114	110	140		3.8	9.1	12.9
SRS	94	112	100	100		2.9	10.5	13.4
Lexden	91	103	102	104		11.4	20.0	31.4
Astley Court	68	183	104	105		4.1	11.5	15.6
Broadland Clinic	109	86	98	102		2.7	7.6	10.3
The Beacon	101	95	98	103		3.1	2.3	5.4
West SBU								
Swift	107	156	99	221		4.5	6.1	10.6
Robin	114	145	100	205		2.7	5.6	8.3
Owl	108	181	102	255		2.6	7.1	9.8
Oak	115	220	102	188		5.6	15.2	20.8
Thumbswood	143	95	100	105		8.2	12.4	20.6
Albany Lodge	121	151	100	164		2.8	5.2	7.0
Aston	100	106	102	113		3.8	5.6	9.4
East and North SBU								
Victoria Court	96	106	100	124		1.8	6.3	8.1
Forest House	101	126	97	135		3.6	9.6	13.2
Wren	131	116	103	210		3.4	7.0	10.4
Lambourn Grove	120	111	102	130		2.2	7.3	9.5
Logandene	106	107	100	143		3.1	8.3	11.5
Seward Lodge	100	101	93	246		3.0	8.7	11.7

Appendix 2 - Vacancies breakdown by in-patient services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Learning Disability & Forensic SBU				
4 Bowlers Green	8.00	7.00	1.00	13
Beech Ward	14.20	14.00	0.20	1
Broadland Clinic	25.20	14.13	11.07	44
Dove Ward	11.00	10.00	1.00	9
Gainsford House	10.80	9.24	1.56	14
Hampden House	10.60	9.08	1.52	14
LPH Astley Court	11.00	10.00	1.00	9
Warren Court	28.00	20.60	7.40	26
NE Inpatient Unit	12.56	11.97	0.59	5
SRS Bungalows	18.00	10.00	8.00	44
The Beacon	11.31	7.76	3.55	31
Total	**160.67**	**123.78**	**36.89**	**23**
West SBU				
Albany Lodge	13.50	11.50	2.00	15
Aston Ward	15.00	8.82	6.18	41
Oak Ward	13.00	7.00	6.00	46
Owl Ward	11.00	9.64	1.36	12
Robin Ward	11.60	10.00	1.60	14
Swift Ward	18.00	16.00	2.00	11
Thumbswood	7.67	7.53	0.14	2
Total	**89.77**	**70.49**	**19.28**	**21**
East & North SBU				
Forest House	13.00	6.80	6.20	48
Lambourn Grove	11.20	9.30	1.90	17
Logandene	12.37	10.44	1.93	16
The Stewarts	11.13	2.00	9.13	82
Seward Lodge	12.00	10.80	1.20	10
Victoria Court	12.14	10.96	1.18	10
Wren	11.14	9.61	1.53	14
Total	**82.98**	**59.91**	**23.07**	**28**
Overall Total	**333.42**	**254.18**	**79.24**	**24**
NON-REGISTERED NURSING				
Learning Disability & Forensic SBU				
4 Bowlers Green	10.00	10.01	-0.01	0
Beech Ward	15.00	14.00	1.00	7
Broadland Clinic	43.60	38.10	5.50	13
Dove Ward	13.89	12.89	1.00	7
Gainsford House	5.40	5.40	0.00	0
Hampden House	5.00	5.00	0.00	0

LPH Astley Court	12.40	10.00	2.40	19
Warren Court	35.00	28.00	7.00	20
NE Inpatient Unit	20.53	15.96	4.57	22
SRS Bungalows	63.57	50.37	13.20	21
The Beacon	7.53	7.00	0.53	7
Total	**231.92**	**196.73**	**35.19**	**15**
West SBU				
Albany Lodge	19.00	17.60	1.40	7
Aston Ward	14.73	14.76	-0.03	0
Oak Ward	16.00	15.64	0.36	2
Owl Ward	13.53	14.53	-1.00	-7
Robin Ward	15.20	12.00	3.20	21
Swift Ward	13.90	12.04	1.86	13
Thumbswood	9.60	6.60	3.00	31
Total	**101.96**	**93.17**	**8.79**	**9**
East & North SBU				
Forest House	14.70	10.67	4.03	27
Lambourn Grove	36.86	29.97	6.89	19
Logandene	25.40	28.99	-3.59	-14
The Stewarts	22.69	1.00	21.69	96
Seward Lodge	22.13	18.77	3.36	15
Victoria Court	37.56	31.67	5.89	16
Wren	19.69	21.76	-2.07	-11
Total	**179.03**	**142.83**	**36.20**	**20**
Overall Total	**512.91**	**432.73**	**80.18**	**16**

Appendix 3 - Vacancies breakdown by Community Services

SBU/TEAM	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance	% Vacancy
REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	2.00	2.00	0.00	0
Continuing Care & Placement Team	8.64	6.60	2.04	24
Criminal Justice & Forensic	1.00	0.00	1.00	100
Criminal Justice Mental Health	2.00	2.00	0.00	0
LD SLDS A&T E/N Team	9.20	9.20	0.00	0
LD SLDS A&T West Team	10.36	7.76	2.60	25
Total	**33.20**	**27.56**	**5.64**	**17**
East & North SBU				
AMHCS Centenary & Jubilee	12.10	13.03	-0.93	-8
AMHCS Cygnet House	8.60	6.19	2.41	28
AMHCS Holly Lodge	4.04	4.00	0.04	1
AMHCS Saffron Ground	4.80	3.80	1.00	21
AMHCS Oxford House	2.00	0.00	2.00	100
AMHCS Rosanne House	8.45	9.03	-0.58	-7
Total	**39.99**	**36.05**	**3.94**	**10**
West SBU				
AMHCS NW Herts Dacorum	6.20	5.20	1.00	16
AMHCS NW Herts St Albans	6.20	3.20	3.00	48
AMHCS SW Herts	1.00	1.00	0.00	0
AMHCS SW Herts Borehamwood	6.00	4.00	2.00	33
AMHCS SW Herts Watford	5.60	4.20	1.40	25
Total	**25.00**	**17.60**	**7.40**	**30**
Overall Total	**98.19**	**81.21**	**16.98**	**17**
NON-REGISTERED NURSING				
Learning Disability & Forensic SBU				
Challenging Behaviour Team	2.00	2.00	0.00	0
Continuing Care & Placement Team	0.00	0.00	0.00	0
LD SLDS A&T E/N Team	4.00	2.00	2.00	50
LD SLDS A&T West Team	3.60	3.60	0.00	0
Total	**9.60**	**7.60**	**2.00**	**21**
East & North SBU				
AMHCS Centenary & Jubilee	8.34	5.64	2.70	32
AMHCS Cygnet House	6.75	4.51	2.24	33
AMHCS Holly Lodge	2.50	1.50	1.00	40
AMHCS Saffron Ground	3.80	3.80	0.00	0
AMHCS Oxford House	2.50	1.00	1.50	60
AMHCS Rosanne House	7.00	6.00	1.00	14

Total	**30.89**	**22.45**	**8.44**	**27**
West SBU				
AMHCS NW Herts Dacorum	5.49	6.29	-0.80	-15
AMHCS NW Herts St Albans	5.00	6.00	-1.00	-20
AMHCS SW Herts	4.00	2.60	1.40	35
AMHCS SW Herts Borehamwood	1.49	1.49	0.00	0
AMHCS SW Herts Watford	6.26	6.80	-0.54	-9
Total	**22.24**	**23.18**	**-0.94**	**-4**
Overall Total	**62.73**	**53.23**	**9.50**	**15**

Hertfordshire Partnership University
NHS Foundation Trust

Board Meeting

Meeting Date:	6th June 2019	Agenda Item: 12
Subject:	Infection Prevention and Control Annual Report	For Publication: Yes
Authors:	Debbie Pinkney, Consultant Nurse Infection Prevention and Control	Approved by: Jacky Vincent, Deputy Director of Nursing & Quality/DIPC
Presented by:	Jacky Vincent, Deputy Director of Nursing & Quality/DIPC	

Purpose of the report:

To give assurance to the Board in relation to Infection Prevention and Control requirements.

Action required:

To **Approve**: To formally agree the receipt of report and its recommendations and the Infection Prevention and Cleanliness Programme for 2019/20
For **Assurance**: To appraise the Board that controls and assurances are in place.

Summary and recommendations:

This report provides the detail of progress the Trust has made in relation to minimising the risks of healthcare associated infections. It also identifies the infection prevention and control priorities that the Trust is required to implement to ensure that the risk of service users, staff and visitors, acquiring a healthcare associated infection is kept to a minimum.

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

This report speaks to and provides assurance in relation to clinical safety of service user, staff and the wider public in relation to infection.

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

There are no overt financial implications.

Equality & Diversity and Public, service user and carer Involvement Implications:

No Equality and Diversity and Public & Patient Involvement Implications

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

Safety KLOE for CQC

Seen by the following committee(s) on date:

Infection Prevention and Control Committee on 29th April 2019
Integrated Governance Committee 22nd May 2019

DRAFT

Executive Summary

Introduction
The annual report gives an overview of the reporting year 2018/19 in relation to infection prevention and control and includes an overview of heathcare associated infection, the audit programme and results. It also demonstrates how the Trust has the relevant practices and procedures in place to ensure the early identification of service users and staff with infections. The report explains the accountability arrangements, audit, surveillance, education and training, policies and procedures relating to infection prevention and control.

Overview of 2018/19
The year has seen some key progress including low incidence of alert organisms, improvements in audit implementation and an increase in training compliance. There has also been an increase in an awareness of infection prevention and control as a result of promotional events.

The year has had some challenges, particularly in relation to concerns raised by the clinical staff regarding the service received by Interserve. Since the Estates Team re-structure, there has been closer working with the Estates Team/Interserve Managers/ Infection Prevention and Control Team and clinical staff and all are working together to ensure high standards of cleaning are consistently met. There has also been an increase in the number of infection prevention and control incidents being reported. These incidents are discussed and monitored at the quarterly Infection Prevention and Control Committee meetings. The Trust also did not meet the target for staff flu vaccinations. Lessons learned from this year's campaign have been taken forward and will be included within the planning of the campaign for 2019/20.

Prioities for 2019/20
2019/20 will continue to focus on developing and implementing a reporting procedure to monitor practices within the community setting. It will also continue to work towards achieving high standards of cleanliness across the organisation. A review of the service provision within the Infection Prevention and Control Team with the aim of ensuring sufficient resources, will take place following the Trust review of Corporate Services. Also, an increased focus on working with the Trust's Occupational Health provider and Human Resources in ensuring that the Trust meets the flu vaccination target. The "To dip or not to dip" campaign will be fully implemented within the Older Peoples services and this will run alongside a 90 day improvement initiative to reduce urinary tract infections. The Trust will also be reviewing the disposal of waste to ensure that the correct segregation of waste is being carried out.

Conclusion
The annual report on infection prevention and control 2018/19 demonstrates that there have been improvements in awareness raising, audits and training. There remain areas for improvement, in particular a need to focus on the flu campaign as well the service provison Trust wide regarding infection prevention and control.

1. Introduction

1.1 This report outlines the activities of Hertfordshire Partnership University NHS Foundation Trust (the Trust) relating to infection prevention and control (IPC) from April 2018 to March 2019.

1.2 The report will give an overview of the reported healthcare associated infections, the audit programme, training compliance and IPC incident reporting.

1.3 It demonstrates how the Trust has the relevant practices and procedures in place to ensure the early identification of service users and staff with infections. It also explains the accountability arrangements, audit, surveillance, education and training, policies and procedures relating to IPC.

2. Healthcare Associated Infections and Alert Organism Surveillance

2.1 **Standards.** The national profile identifying the reduction and control of the incidence of healthcare associated infections (HCAIs) has remained significant throughout 2018/19.

2.2 Following the launch of *The Health and Social Care Act*, 2008 (revised January 2015), the Trust is required to set out clear criteria by which managers of NHS organisations have to ensure that individuals are cared for in a clean environment and that the risk of acquiring HCAIs is kept as low as possible. **Appendix 1** identifies the ten criteria that the Trust is required to demonstrate compliance with.

2.3 The Trust incorporated the criteria into its Annual IPC Programme 2018/19, approved by the Trust IPC Committee (IPCC) and the Board. Progress of the programme has been monitored on a quarterly basis at the IPCC. The target was to fully complete 100% of the action points within each area.

2.4 **Table 1** identifies the overall compliance achieved. The actions that were partially/not completed mainly related to the level of cleaning within the in-patient and community areas and water safety. The actions that were either non-compliant or partially completed will be incorporated into the IPC Programme for 2019/20.

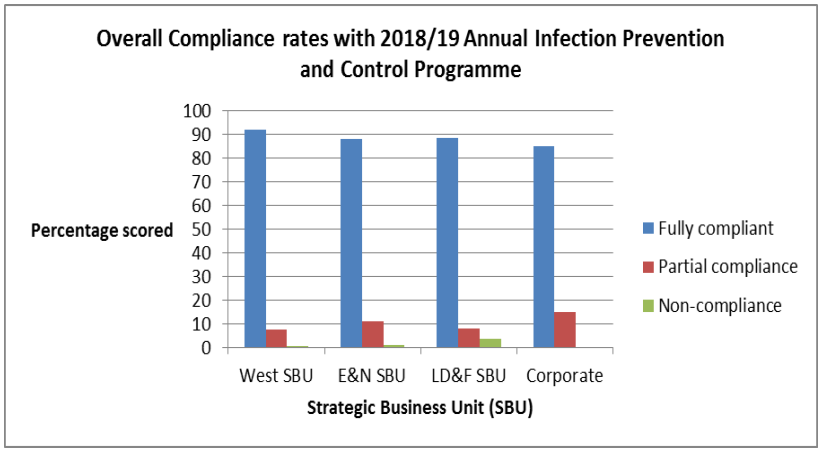

Table 1

2.5 The role of Director of Infection Prevention and Control (DIPC) has been designated to the Deputy Director of Nursing and Quality. The DIPC oversees the implementation of the IPC Programme and ensures that the roles and responsibilities regarding the actions identified within the IPC programme are addressed.

2.6 **Incidents.** Monthly data has been collected on the incidence of Meticillin resistant *Staphylococcus aureus* (MRSA), Meticillin sensitive *Staphylococcus aureus* (MSSA), E-coli bacteraemia and *Clostridium difficlie*. In previous years, the Trust has reported low incidence of alert organism surveillance. Consequently, the Trust was not set a target to reach relating to alert organism reporting, from the Trust's Clinical Commission Groups (CCG).

2.7 There were no reported cases of MSSA or E-coli bacteraemia; this is the same as the previous year. There have been 2 reported cases of MRSA colonisation/infection (not bacteraemia). This is the same number of reported cases in the previous year.

2.8 There has been 1 reported case of *Clostridium difficile,* with a service user at The Beacon. This is the same number of reported cases from the previous year. The service user was transferred to West Herts Hospital Trust (WHHT) when staff became concerned regarding the physical condition. Service user was treated appropriated and there were no further reports of cross contamination. A lessons learned note was developed and distributed to all clinical areas. Key learning points included:-

- Staff to collect stool specimens (type 5- 7 using Bristol Stool Chart) within 24 hours of an infection being suspected
- Infection prevention control training compliance on each unit to reach the minimum standard of 92%
- Cleaning audits to be completed jointly by Interserve staff and unit staff and to reach a minimum of 95% each month
- All service users reporting with symptoms of type 5-7 stools to be commenced on a Bristol stool chart and the Trust food and fluid chart
- All service user equipment to be included within the weekly cleaning schedules and for a minimum of 95% to be recorded. Clinell wipes to be used to provide assurance that cleaning has taken place according to the Trust decontamination policy
- Environment and equipment to be cleaned, with a chlorine based product for any service users diagnosed or suspected with *Clostridium difficile*
- An alert to be placed on PARIS for all confirmed cases of *Clostridium difficile*.

2.9 There have been 3 reported cases of service users being transferred from WHHT to a Trust unit, with Carbapenamase producing Enterobacteriacaea (CPE) policy. These were not related in terms of time and space; this is an increase of 3 from the previous year. Staff implemented the risk assessment identified in the national guidance and the Trust (CPE) policy.

2.10 There have been 3 reported cases of Type A influenza. All reports were not related in terms of time and space. The Trust is currently reviewing the

use of Filtering Facepiece (FFP3) masks, in line with Health Safety Executive guidance.

2.11 There has been 1 reported case of Meningitis in a staff member. The staff member was admitted and treated in one of the acute general hospitals; no further transmission was reported.

2.12 All cases were investigated by the IPC Team (IPCT) and opportunities for learning were identified from each incident. No trend or common themes were identified across these incidents. In addition to the above, other alert organism/condition surveillance has been collated.

2.13 A post infection review form has been developed and trialled following a number of reports of periods of increase in incidence. This form will identify the details of the incident and any learning lessons which will then be cascaded to the Strategic Business Units (SBU).

3. Assurance

3.1 The IPCC oversees the quality assurance for this area of work. During the year, the Care Quality Committee (CQC) inspected the Trust, undertaking a core and a well led inspection as well as Mental Health Act (MHA) assessments throughout the year. At the time of the report the Trust awaits the outcome of the inspection; however, no major IPC concerns were identified during these visits with staff reported to be implementing appropriate hand hygiene practices.

3.2 Audits are used to ensure quality assurance regarding the IPC practice within the Trust against the expected practice and standards. Following an audit, areas for development are identified and action plans are put in place. These are held within the SBU quality meetings and report into the IPCC.

3.3 The following audits have been undertaken:

- **Environmental audits.** The appointment of the IPC Healthcare Assistant (HCA) ensured a more joined up approach between the inpatient and community units and IPC. Support was provided to the link practitioners to ensure the quality and consistency of the completion of the audits. Several common themes in the areas for improvement were identified:
    - Areas appearing cluttered and untidy, including the clinic rooms
    - Lack of storage space leading to inappropriate storage of equipment
    - Stickers not being used that identify when cleaning has taken place
    - Cleaning of equipment schedules not available
    - Sharps containers not being assembled or labelled correctly
    - Inconsistent audit scores from the unit staff and the IPCT.

  The majority of these issues were addressed at the time of the audit being undertaken which improved standards immediately
- **Hand hygiene audits.** These audits were implemented on a 1-3 monthly basis. No major concerns were identified regarding the hand hygiene procedure. Many of the units have been consistently scoring 100%. Cross auditing of staff working in the same SBUs will be commenced in 2019, to review if this scoring is an accurate reflection of what is actually occurring in practice. Hand hygiene audits will also commence in the community sites in 2019
- **Essential steps IPC audits**. No major concerns have been raised regarding the use of personal protective equipment

- **Mattress audits.** Generally, the mattresses being used within the Trust are of good quality. Those mattresses which did fail the audit were replaced immediately
- **Antibiotics prescribing audit 2019.** This audit measured the Trust performance against 6 standards, as detailed in **Appendix 2.** The audit was completed in February 2019.
  The analysis identified the following areas of good practice:
  - Completion of the allergy status – standard achieved
  - Local and Trust guidelines were followed when prescribing for inpatients in the majority of cases – standard partially achieved – 85%
  - Appropriate total duration of treatment - unless a clear indication is present antibiotic therapy should be stopped after 5-7 days – standard partially achieved – 88% (7 out of 9 charts).

  The analysis also identified the following areas for improvement:
  - The indication for the use of the antibiotic should be noted on the prescription chart as well as in the service users' medical records – 45% (9 charts out of 20)
  - The anticipated course length or review date should be clearly documented in the service users' medical records and on the prescription chart – 47% (8 charts out of 17)
  - Evidence of a clinical review should take place at least 48-72 hours after initiating an antibiotic – 27% (3 charts out of 11)
  - The community mental health teams need to consider carefully when prescribing antibiotics for community service users and where possible these service users should be referred to their GP.

4. Policies and Practice

4.1. IPC policies have been reviewed and updated. No major or significant changes have needed to be made. They continue to be compliant with the national guidance.

4.2. A new policy has been written in relation to Respiratory Tract Infections. This was written to provide guidance to staff regarding the risks associated with respiratory tract infections, including influenza. This policy is to be used in conjunction with the Trust's Business Contingency plan during an outbreak of influenza.

4.3. Since 1st October 2018, the Estates and Facilities service launched a centralised service function which supports both Hertfordshire Community NHS Trust (HCT) and the Trust. This joint venture has resulted in the restructuring of the Estates department and has included the appointment of 18 new members of staff taking up specific roles within a new management team structure. The team are working to a strategic plan to deliver a first class estates support services.

4.4. In total, 134 deep cleans/terminal cleans have been implemented.

4.5. It is a requirement under Section 34 of the Environmental Protection Act that waste producers complete annual pre acceptance waste audits to provide assurance that waste is segregated, handled, packaged and disposed of in accordance with HTM 07-01 (Safe Management of Healthcare Wastes). An initial audit has identified that clinical waste is not being segregated correctly or

consigned according to description; thus most waste is being consigned as "Infectious" waste where, in fact, the majority of waste would fall into the description and category of "Offensive" waste. Estates have appointed an independent auditor to complete the 2019 pre acceptance waste audits of which the results will be used to explore the appropriate waste segregation option and ensure compliance with legislation.

4.6. The "To dip or not to dip" campaign is currently in the process of being rolled out in the Trust's Mental Health Services for Older People. This campaign has been implemented across Hertfordshire within the Residential/Nursing Homes and consists of using a specific tool to diagnose individuals with urinary tract infections rather than using urine dip stick testing which are not accurate within the over 65s.

4.7. The Antimicrobial Stewardship Policy was updated in June 2018 to be in line with the "Start Smart then Focus" principles and to promote the eLearning available to staff on the prudent use of antibiotics.

5. Education and Training and Awareness raising

5.1. In April 2017, the IPC training was updated to comply with the East of England streamlining programme. As a result, all Trust staff were required to be compliant with either level 1 or level 2 training; during the transition period, the training compliance levels dropped. At the end of quarter 4, the overall compliance was recorded at 95**%** for level 1 and 95% for level 2. This is an increase in the overall compliance rates reported at the end of quarter 4 in 2018, which were recorded at 83**%** for level 1 and 82% for level 2.

5.2. IPC link practitioners are also offered additional training and development opportunities. These sessions are implemented 6 monthly. These sessions included sepsis training by the Sepsis Lead Nurse at East and North Acute Trust and cleaning as well as Patient Led Assessment of the Care Environment (PLACE) issues by the Estates and Facilities Team. These study days were well attended and positive and enjoyable feedback was received from both sessions.

5.3. This year the profile of IPC and the IPCT have continued to be raised. This has resulted in closer working relationships between the Community Clinical Nurse Leads and the IPCT.

5.4. The Trust used national awareness weeks to promote this work further including 2018 International Infection Prevention and Awareness week. During this week, IPC was promoted in many of the units and staff worked with service users and carers in promoting the importance of IPC. The World Antibiotic Awareness week was also celebrated with key points being communicated by the Trust's Communications Team and also the Pharmacy Team.

6. Incidents

6.1. 151 IPC incidents were reported on Datix and to the IPCT. This is an increase in the number that was reported during 2017/18, which was reported at 90. The increase is likely to be due to an increase in incidents involving issues relating to cleaning and clinical waste collection and also staff awareness of

what incidents should be reported. All incidents were followed up by the IPCT and discussed at the quarterly IPCC where any lessons learnt are shared.

6.2. The incidents related to:

- Accidental Inoculation Injuries (bites, scratches, splashes, needlestick)
- Suspected/confirmed outbreaks of infection
- Periods of Increase in incidence of infection
- Failure to carry out Trust policies
- Poor environmental cleaning
- Suspected/confirmed communicable/notifiable/reportable infection
- Equipment failure.

6.3 There were no significant trends identified regarding the time and place of the incident being reported.

6.4 The number of sharps injuries being reported involving a used needle remains low. This has been supported by the Trust complying with the EU Directive involving safer needle devises.

7. Legionella

7.1 Following the HCT and Trust Estates and Facilities merger, the Water Safety Group (WSG) was re-structured. The initial WSG meeting was held on 4th October 2018. The Terms of Reference for this group was reviewed and updated.

7.2 Water Risk Assessments carried out for the Trust's Estates portfolio take into account all aspects of the hot and cold water systems. All identified issues and risks are monitored with tasks issued and recorded. All tasks are fully auditable through the Interserve Computer Aided Facilities Management System (CAFM). *Lakeside Water* undertakes the bi-annual Water Risk Assessments in-line with *BS8580*, which is an on-going process.

8. Flu campaign

8.1. The overall total of staff uptake was recorded at 51.9% (national target of 70%). This was despite the Trust implementing an extensive flu campaign, including early training of additional peer vaccinators, early provision and distribution of equipment, regular communications of key messages from the executive team and the employment of a temporary agency nurse who visited the units on site to offer staff the vaccine.

8.2 The planning for 2019/20 campaign will commence in quarter 1. Included in this campaign will be identification of several case studies from a number of young people who isolated Influenza and required admission into the Intensive Care Units at the local acute general hospitals. The 2019/20 will be driven by the SBU teams so that the monitoring of the administration of the vaccine can be investigated at local level.

9. Summary of key progress and challenges

9.1 Key progress noted over the year includes:

- The incidence of alert organisms remains low

- An improvement in audit implementation due to the input of the IPC HCA. Actions plans developed and implemented post audit and improvements monitored at the quarterly IPCC meetings
- IPC policies updated and reviewed in line with the Trust format and national guidance
- An increase in training compliance levels – reporting at 95% for level 1 and 95% for level 2, at the end of quarter 4
- An increase in IPC awareness at several promotional events including International IPC Awareness week and European antibiotic awareness week.

9.2 Key Challenges noted over the year includes:

- Ongoing concerns in relation to the service received by Interserve. Through the new Estates re-structuring and joint working with Interserve and the IPCC members, this will continue to be monitored. Modern Matrons will also focus on ensuring that the environment is clean, safe and fit for purpose
- The Trust did not meet the set target for staff flu vaccinations. Lessons learned from this year's campaign will be taken forward and will be included within the planning of the campaign for 2019/20
- There were a number of areas within the Trust which could be considered as "Augmented Care" as service users may be admitted into the Trust with leg ulcers, burns and bedsores. These service users should have a specific Pseudomonas risk assessments implemented addressing necessary preventative actions and routine water sampling being carried out. This situation is currently being reviewed by the IPCC
- 151 IPC incidents reported via Datix and the IPCT.

10. Priorities for 2019/20

10.1. Following the review of 2018/19 performance and the national priorities, the priorities have been set for 2019/20. The IPC Programme has been approved at the IPCC.

10.2. The IPC Annual Work Plan will be discussed and approved, on behalf of the Board, by the Integrated Governance Committee (IGC). The key areas of work for the coming year are:

- Develop and implement a procedure to monitor IPC practices within the community setting
- Monitor and improve the standard of cleanliness from Interserve
- Review staff resources within the IPCT as part of the Corporate Services Review, to ensure sufficient resources available to secure the effective prevention and control of infection
- Work with the Trust's Occupational Health provider, Human Resources and clinicians to ensure that the Trust meet the flu vaccination target
- Manage and monitor the use of anti-microbial prescribing
- Develop and implement "the to dip or not to dip" campaign within the Mental Health Services for Older People
- Enhance the current IPC audits – both in the inpatient and community setting
- Enhance the cleaning schedules template
- Work with the CCGs to develop and implement the 90 day UTI improvement tool
- Review of waste collection in line with national guidance

- Update the terminology of the type of clean that is currently being implemented across the Trust, to ensure staff are aware of what cleans to request and what this entails
- Implement the IPC Programme 2019/20, which is for Board approval.

11. Conclusion

11.1 There have been challenges faced within all NHS organisations and the Trust has continued to make progress in the prevention and control of HCAIs.

11.2 The Trust continues to have high standards in IPC owing to strong working relationships between the IPCT, the Director of Infection Prevention and Control (DIPC) and Deputy Director of Nursing and Quality, the Heads of Nursing, Matrons and the clinical nurse leads. Also the IPC link practitioners, Occupational Health and the Facilities and Estates departments.

11.3 This report has set out the work that has been undertaken during 2018/19. The target was to fully complete 100% of the action points identified in the 2018/19 IPC programme; those actions which were either not completed or partially completed will be incorporated into the IPC priority schedule for 2019/20.

11.4 The IPCT will continue to work to maintain high standards, improving service user safety and the quality of services within the Trust in IPC.

Appendix 1

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs of staff in relation to infection.

Appendix 2

Standard Number	Criteria
Standard 1	The allergy status of the patient must be ascertained and documented on the prescription drug before any antibiotic is prescribed. Allergy box completed and signed and dated.
Standard 2	The indication for the use of the antibiotic should be noted on the **prescription chart as well as in the service users' medical records.** *
Standard 3	a) Appropriateness / Adherence to Local and Trust guidelines. b) Expert advice from medical microbiologist if not adhering to guidelines
Standard 4	The anticipated course length or review date should be clearly documented in the service users' medical records **and** on the prescription chart.
Standard 5	Appropriate total duration of treatment - unless a clear indication is present antibiotic therapy should be stopped after 5-7 days
Standard 6	a) Was there evidence of a clinical review of antibiotic use at 48-72 hours? b) Was the outcome of review recorded?

Hertfordshire Partnership University
NHS Foundation Trust

INFECTION PREVENTION AND CLEANLINESS PROGRAMME

April 2019- March 2020

1. Background

1.1 Hertfordshire Partnership University NHS Foundation Trust (the Trust) is committed to protect all service users, employees and other individuals who may be at risk of acquiring a healthcare associated infection (HCAI).

1.2 It is crucial that staff implement excellent infection prevention, cleanliness and prudent antimicrobial practices to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone.

1.3 Good management and organisation processes are vital to make sure that high standards of infection prevention and control are set up and maintained.

1.4 As with previous years, this year's annual Infection Prevention and Cleanliness Programme is mapped on the criteria that is specified in the Health and Social Care Act, 2008 - Code of Practice for health and adult social care on the prevention and control of HCAIs. This Code of Practice was up-dated in January 2015 and this Annual Programme reflects the changes identified within the reviewed Code.

1.5 The Code of Practice sets out the 10 criteria against which the Care Quality Commission (CQC) will judge the Trust on how it meets the fundamental standards of quality and safety regarding "assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated" (Health and Social Care Act, 2008, reviewed 2015).

2. Board Statement

2.1 The Board is fully committed towards minimising the risks of infection and monitors the progress of the infection prevention and control programme on a quarterly basis.

3. Purpose

3.1 The Infection Prevention and Cleanliness annual programme will:

- Set objectives that meet the needs of the organisation and ensure the safety of service users, health care workers and the public
- Identify priorities for action
- Provide evidence that relevant policies have been implemented
- Report progress against the objectives of the programme in the Director of Infection Prevention and Control's (DIPC) annual report.

4. Objectives

- To ensure compliance with the 10 criteria as highlighted within the Health and Social Care Act, 2008, revised 2015. See table 1 overleaf.

Compliance criteria	What the Trust has to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs of staff in relation to infection.

Table 1

- To ensure that the incidence of alert organisms/ conditions remain low. This includes rates of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia, Meticillin sensitive *Staphylococcus aureus* bacteraemia (MSSA), E-*coli* bacteraemia, *Klebsiella* bacteraemia, *Pseudomonas aeruginosa* bacteraemia and *Clostridium difficile*
- To ensure that all Trust staff acknowledge the importance of their role in terms of Infection Prevention and Control (IPC)
- To ensure staff understand the legal requirements of the Code of Practice
- To maintain high standards of communication between all individuals within the Trust. This includes 'Board to ward' correspondence, professionals working within different teams/ establishments, service users – staff
- To provide an effective on-going training programme to ensure that staff are aware of the necessary infection prevention and control procedures required to keep the risk of infection to a minimum
- To provide staff with up-to-date IPC policies and procedures
- To enhance the on-going programme of audit to monitor compliance with IPC policies and procedures

- To provide the appropriate information to all the relevant Committee members and local Strategic Business Units (SBUs) on the progress of the programme
- To report the progress of the programme within the annual infection prevention and control report
- To monitor the appropriate prescribing of anti-biotic usage.

5. Infection Prevention & Control Arrangements

5.1 The Trust has a designated Director of Infection Prevention and Control (DIPC) who is accountable directly to the Chief Executive Officer (CEO) and the Board. The role of DIPC is being undertaken by the Deputy Director of Nursing and Quality. The Trust has a designated Non-Executive Director responsible for IPC. The Trust also has a fully functional IPC Committee that meet on a quarterly basis. Membership consists of both nursing and medical expertise including a Consultant Microbiologist and Consultant in Communicable Disease Control (Public Health Consultant). The Trust employs a Consultant Nurse – IPC, who works part time and a full time IPC Support Worker. Both are accountable to the Deputy Director of Nursing and Quality (DDN&Q). The Infection Prevention and Control Nursing Team is to be reviewed in 2019-2020 as part of the Trust Corporate Review.

5.2 Service level agreements (SLAs) continue with:-

- West Hertfordshire Hospital Trust
- Norfolk and Norwich Microbiology

These agreements ensure that Trust staff can have further access for IPC advice via the IPC Nurses, Infection Control Doctors and microbiology staff working within these establishments.

5.3 The Trust Contracts Team and the Trust IPC Team continue to work towards a Trust wide service specification to ensure that the provision of services providing IPC is consistent across the whole organisation.

5.4 Progress of the SLAs will be monitored on a six monthly basis by the DDN&Q /Consultant Nurse – Infection Prevention and Control (CN – IPC) and the Contracts Manager and with the appropriate personnel within the service providers.

6. Key Priorities

6.1 As already stated, the 2019/20 IPC Cleanliness Programme identifies all ten of the criteria that are required to be achieved. However, the Trust has highlighted certain key priorities which are also to be implemented.

6.2 All of the actions stated within the key priorities have been included within the action plan (please refer to appendix 1). The action plan also identifies the *responsibilities of key personnel*, for each individual action.

- **Alert Organism / Condition Surveillance (Criteria 1)**
  - Trust IPC nurses to be informed of any new MRSA/ MSSA isolates, E-*coli* bacteraemia, *Clostridium difficile,* Carbapenem resistant organisms (CRO's), Acinetobacter, extended spectrum beta-lactamase (ESBLs) and other antibiotic resistant bacteria
  - Trust IPC nurses to maintain a database on alert organisms/conditions. The database will include information on the incidence of MRSA, MSSA, ESBLs, E-*coli, Klebsiella, Pseudomonas auruginosa* bacteraemia and *Clostridium difficile*
  - Modern Matrons (MM) to provide a quarterly, written report to the IPC team and Heads of Nursing (HoN) which identifies the incidence of all alert organisms/conditions that have been isolated within their units.
  - Post Infection Reviews and/or root cause analysis to be completed on any new MRSA bacteraemia, MSSA bacteraemia/*Clostridium difficile* cases/ Carbapenemase Producing Enterobacteriaceae (CPE) / suspected outbreak/ period of increase in incidence
  - To implement a post infection review form which has been developed which will identify any lessons learned following the reporting of any suspected or confirmed outbreaks of infection or periods of increase in incidence of infections
  - To report all confirmed cases of MRSA bacteraemia, MSSA bacteraemia, *Clostridium difficile* infection, Carbapenemase Producing Enterobacteriaceae to Public Health England and to the Clinical Commissioning Group by the next working day
  - Quarterly reporting of surveillance statistics to the Trust's IPC Committee and the Board via the Strategic Performance Report
  - All alert organism/condition surveillance information to be included in the annual report.

  Action by: IPC team, MMs, Laboratory staff

- **Assessing and reducing the risks of infection (Criteria 1)**
  - To ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
  - Staff to routinely complete the Risk Assessment Form regarding Healthcare Associated Infections – on all admissions/transfers into and out of Trust units. MMs to report on the frequency of use of the form on a quarterly basis, within the MM action plan update report
  - Discuss incident analysis and learning in local practice governance forums.
  - IPC nurses/ Occupational Health/ Health and Safety managers to follow up on any relevant actions regarding the management of IPC incidents
  - Lessons learned follow up to be implemented on all suspected or confirmed outbreak situations and periods of increase in incidence of infections
  - To monitor and review the IPC Risk Register on a quarterly basis and to report at the IPC Committee.
  - To implement the "Dip or not to dip" campaign that has been launched within the Hertfordshire Nursing and Residential Homes
  - Water Safety Steering Group to be reviewed to include new members of staff who have joined the Trust.

- Water Safety Steering Group to monitor all Trust sites and ensure that compliance is met with the Health and Safety Executive (HSE) guidance regarding water systems.
- To complete the Water Safety Plans which will require clinical input and clinical assessments.
- Report the progress of the Water Safety Steering group at the IPC Committee and the Health Safety and Security meetings.
- Legionella training to be provided to the Modern Matron and Team Leaders.
- Deputy Director of Nursing and for Quality (DDN&Q), HoN and IPC nurses to monitor the practices and procedures of staff by implementing unannounced visits to the units.

Action by: IPC team, MMs, All staff, Patient Safety Groups, Estates and Energy Team

- **Management and Monitoring Arrangements (Criteria 1)**

The Board should ensure that the Trust: -

- Demonstrate compliance and assurance with the Code, thus maintaining low infection rates and ensuring quality is central to care delivery. The Board are to receive quarterly reports on IPC matters from the IPC team via the Strategic Performance Report. The Board members should be assured that the appropriate systems are in place to minimise the risk of infection
- Has an agreement that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks
- Provides strategic leadership for effective delivery and management of patient safety in relation to infection prevention and control
- Have sufficient resources available to secure the effective prevention and control of infection. These should include the implementation of IPC and cleanliness programme, infection prevention and cleanliness infrastructure and the ability to detect and report infections
- The IPC nursing team to be reviewed to ensure sufficient resources are available.

Action by: *CEO, DIPC, DDN&Q, Board Members, Consultant Nurse-IPC, Estates and Energy Manager*

- **Audit (Criteria 1)**
  - IPC nurses to implement a minimum of 5 Infection Prevention Society environmental audits per annum
  - In-patient IPC link persons to work with the MMs and implement regular IPC audits within their workplace. These include 6 monthly environmental audits and mattress audits, 1-3 monthly Essential Steps to Safe Clean Care and hand hygiene audits. Three times weekly flushing of the water system is also required. Environmental audit tool to be completed every 6 months within all community sites
  - Community Clinical Nurse Lead to oversee the completion of 6 monthly environmental audits within the Community Hubs.
  - To ensure that a minimum overall percentage score is above 85% on the environmental audit tool. If the score is below this, immediate actions must be implemented to improve the score and the audit repeated within 4-6 weeks

- To ensure the appropriate action plans are developed and implemented post all infection prevention & control audits
- Patient and Environment Monitoring Officer to complete Patient-Led Assessments of the Care Environment (PLACE) assessments and to implement the relevant follow up regarding a poor assessment
- MM to complete the weekly walkabout IPC checklist
- MMs to ensure that the monthly cleaning audits are completed working in collaboration with Interserve Supervisors. Poor cleaning standards are to be reported to the Interserve help desk and these should be actioned in a timely manner
- IPC nurses to review the brief walkabout checklist
- IPC to develop a template checklist to improve the overall appearance of clinical rooms
- IPC to review the Essential Steps to Safe Clean Care audit tool

Action by: IPCNs, ICLPs, MMs, Monitoring Officers

- **Hand Hygiene (Criteria 2)**
  - To ensure staff complete the hand hygiene audit tools and to ensure that compliance is above 95%
  - All staff to complete two yearly mandatory training, which includes hand hygiene
  - All staff carrying out direct service user contact to be provided with and to wear individual alcohol hand toggles to ensure that alcohol hand gel is available at the point of care
  - To encourage hand hygiene amongst visitors entering/leaving the units.
  - To replace the detergent wall mounted dispenser at all entrances/exit to HPFT sites

  Action by: IPCT, MMs, Infection Prevention & Control Link Persons, Estates Team

- **Clean and Appropriate Environment for Health Care (Criteria 2)**
  - IPC issues to be taken into consideration at the planning and design stage of all refurbishments/new builds
  - Lead personnel to check that units are kept clean and are maintained in good physical repair and condition
  - All cleaning concerns to be reported to the Interserve help desk
  - Cleaning standards and auditing arrangements to be implemented as per the NHS cleaning standards
  - Head of Facilities/Estates to monitor the SLA agreement with Interserve and to report the findings to the Board and IPCC
  - MMs to implement and monitor the responsibilities for cleaning within their areas - including the correct decontamination of equipment and furniture
  - Maintain public confidence and service user involvement. Service users and visitors must be provided with the appropriate information regarding healthcare associated infection and be encouraged to participate in the appropriate hand hygiene procedures.

Action by: the Facilities Department, MM, Unit Managers, SBU managers, IPC Committee members.

- **Appropriate Anti Biotic Usage (Criteria 3)**

- To manage and monitor the use of antimicrobials

- SLA to include access to timely microbiological diagnosis, susceptibility

testing and reporting of results, preferably within 24 hours. Prescribers to have access to a suitably qualified individual who can advise on appropriate choice of antimicrobial therapy

- All prescribers to receive induction and training in prudent antibiotic use
- Display anti biotic awareness materials during anti-biotic awareness week
- To encourage staff to download and make reference to the antimicrobial app on their mobile 'phone.
- Medicines management team to carry out an annual audit regarding anti biotic prescribing.

Action by: Pharmacy Team

- **Training (Criteria 6)**
  - Planned programme of training to be implemented
  - All staff who delivers direct service user contact must attend a minimum of two yearly level 2 IPC training via the national e –learning programme or the completion of the workbook and assessment. During a suspected/confirmed outbreak of infection or an increase in incidence of a specific infection, training will need to be implemented at the time of the incident being reported
  - All non-clinical staff to complete level 1 infection prevention and control training via the national e learning programme
  - All **new** Trust staff will need to meet the East of England streamlining IPC training
  - IPC link persons to provide feedback from the training sessions to their colleagues working on their unit
  - Database regarding compliance to be reported by the learning and development department.
  - To liaise with the link practitioners to celebrate the achievements that has been made during the International IPC and Awareness Week.
  - To continue implementing the training action plan to ensure that IPC training compliance is maintained at a minimum of 92%
  - Modern Matrons to monitor the training compliance within their areas and to report the rates within the quarterly Heads of Nursing reports which are discussed at the IPCC and local SBU meetings.

  Action by: IPC nurse, IPC Link Person, MM, HoN, Learning and Development Team

- **Policies (Criteria 9)**
  - To ensure that all IPC policies are in date and all new/reviewed policies to be written following the new Trust Format
  - To ensure that all staff are aware of the IPC policies and how to access them

- **Healthcare Workers (Criteria 10)**
  - All staff must have access to Occupation Health services
  - A record to be kept of all relevant immunisations
  - All staff to acknowledge their importance of their role in terms of IPC
  - All staff must have access to the IPC team to ensure adequate communications are available
  - Trust and Occupational Health to provide annual seasonal influenza programme for staff in line with Department of Health guidance

- The Human Resources department to monitor that the Occupational Health service provides adequate management of exposure to healthcare associated infections and to provide regular reports to ensure that the appropriate documentation is available.

Action by: Human resources, Occupational Health, Trust staff, Communications Department.

Appendix 1

Criteria 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other user may pose to them.

Criteria 1 – Objectives 1 to 31

Appropriate Management and Monitoring Arrangements

		Action to be taken by :
1.	Board level agreement that outlines its collective responsibility for minimising the risks of infection. This to be noted in Board minutes.	DIPC
2.	Implementation of infection prevention and control programme which has been submitted and discussed at Board level.	DIPD, CN- IPC
3.	3 monthly progress reports to be written by the Infection Prevention & Control (IPC) Nurses to be submitted to the Board.	DIPC, CN - IPC
4.	Comprehensive 3 monthly progress reports to be written by the Modern Matrons and Heads of Nursing and discussed at the IPCC and local SBU Meetings.	MM, HoN
5	Yearly infection prevention and cleanliness programme to be developed, implemented and the progress reported.	IPCC
6.	To assure the Board that the appropriate systems are in place to minimise the risk of infection.	IPCC
7.	Effective infection prevention & control infrastructure which has the ability to detect and report infections	All staff, IPCC
8	MRSA, MSSA, E coli, *Klebsiella, Pseudomonas aeruginosa* bacteraemia, Clostridium difficile, CPE incidence to be reviewed and reported	IPCT
9.	To report all bacteraemia cases, CPE, *Clostridium difficile* infection, to the Health Protection England and CCG by the next working day.	CEO, IPCT
10.	To ensure that all HPFT staff whose normal duties are directly or indirectly concerned with providing care receive suitable and sufficient information on, and training and supervision in, the measures required to prevent and control the risks of infection	IPCT, MM, HoN, Learning and Development
11.	Implementation of a programme of audit to ensure that key policies and practices are being implemented.	IPCT, MM, Link Practitioner's
12	Hand hygiene compliance to be reported and maintained at a minimum of 95%	IPCLP, HoN, MM, IPCT, IPCC
13.	Environmental infection prevention and control compliance to be reported and maintained at a minimum of 85%	IPCLP, HoN, MM, IPCT, IPCC

14	MM to complete the weekly walkabout IPC checklist	MM
15	MMs to ensure that the monthly cleaning audits are completed working in collaboration with Interserve Supervisors. Poor cleaning standards are to be reported to the Interserve help desk and these should be actioned in a timely manner	MM, Team Leader, HoN, IPCT
16	To review, develop and implement the Essential Steps to Safe Clean Care	IPCT
17	IPC Nurses to implement a minimum of 5 environmental audits – concentrating on high risk areas and the community hubs.	IPCN
18	HPFT to have a designated Director of Infection Prevention and Control (DIPC) who is responsible for the organisations Infection Prevention & Control team. The DIPC is accountable directly to the CEO.	CEO
19	HPFT to have a designated decontamination lead.	DIPC/Head of Operations – Estates and Facilities
20	HPFT to have a water safety group and a water safety plan in place which is to be regularly monitored.	Water Safety Group
21	To complete the Water Safety Plans which will require clinical input and clinical assessments.	Water Safety Group
22	Water Safety Steering Group to be reviewed to include new members of staff who have joined the Trust.	Water Safety Group
23	Report the progress of the Water Safety Steering group at the IPC Committee and the Health Safety and Security meetings.	Water Safety Group
24	Water Safety Steering Group to monitor all Trust sites and ensure that compliance is met with the Health and Safety Executive (HSE) guidance regarding water systems.	Water Safety Group
25	Legionella training to be provided to the Modern Matron and Team Leaders.	Estates Manager
26	To ensure that sufficient resources are available to secure the effective prevention and control of infection.	DIPC, HoN, Board Members
27	To develop and implement the dip or not to dip campaign within the Older People's services	IPCT
28	To develop, agree and monitor a Trust wide IPC service specification	DDN&Q, Contracts Manager, CN- IPC, Service Providers
29.	Implementation of unannounced visits by the Deputy Director of Nursing and Quality, HoN and Consultant Nurse – Infection Prevention and Control (CN IPC)	DDN&Q, HoN, CN - IPC
30	To monitor and review the IPC Risk Register on a quarterly basis and to report at the IPCC.	Safer Care Team, IPCC members
31	To develop a Trustwide template to identify the requirements of the clinical/treatment room	IPCT

Criteria 1 – Objective 32 to 40		
Risk Assessment • To ensure that a suitable and sufficient assessment is made regarding the risks to service users in receipt of health care with respect to HCAI • Staff to identify and implement the steps that need to be taken to reduce or control the risks		
		Action to be taken by :
32	Staff to implement the guidance set out in the A-Z of infections policy and the risk assessment for healthcare associated infections - transfer and discharge guidance.	All HPFT Staff
33	To ensure that staff record the infection risks on the Alert system on PARIS	Unit staff, MM, HoN
34	Ensure the appropriate screening mechanisms are being implemented	All HPFT Staff
35	Root cause analysis and PIR to be completed on all new isolates of MRSA bacteraemia, MSSA bacteraemia, *Clostridium difficile*, suspected/confirmed outbreaks of infection. All to be reported at an SI.	All HPFT Staff, IPCT, MM
36	All new isolates of MRSA bacteraemia, MSSA bacteraemia, *Clostridium difficile*, notifiable diseases, suspected/confirmed outbreaks of infection / periods of increase in incidence to be reported via datix	All HPFT Staff
37	Staff to record accurately the steps that they have taken to reduce or control the risks of infection	All HPFT Staff
38	Staff to routinely use the Bristol Stool Chart when assessing the bowel movement of service users, including monitoring the frequency of the bowel movement.	All HPFT staff
39	Staff to accurately report the food and fluid input on all service users with a known/suspected infection.	All HPFT staff
40	Staff to monitor vital observations regularly if an infection is suspected / confirmed. If there are signs of deterioration/infection suspected /sepsis medical attention is sought immediately	All clinical staff

Criteria 1 – Objective 41 to 48		
Implementing an Appropriate Assurance Framework • Demonstrate that infection prevention and control is an integral part of clinical and Corporate Governance		
		Action to be taken by :
41	Regular presentations from the DIPC to the Board which includes trend analysis for infections, antimicrobial resistance and antimicrobial prescribing and compliance with audit	DIPC, Chief Pharmacist

	programmes	
42	Quarterly reports to the Board via the Strategic Performance Reports identifying compliance with the Code. Data to be collected via the Modern Matrons reports, HoN reports, incident reports etc.	DIPC, IPCT, MM,HoN
43	Review of statistics on incidence of alert organisms (MRSA, MSSA, *Clostridium difficile*) and conditions, outbreaks and Serious Incidents	IPCT, DIPC
44	Review monthly cleaning scores and PLACE scores. Monthly cleaning scores to be reported via the Trust Quality Schedule	Head of Operations – Estates and Facilities, Monitoring Team
45	Evidence of appropriate actions taken to deal with infection occurrences, including post infection reviews or root cause analysis reports.	All HPFT Staff, MM, HoN
46	To implement the post infection review form that has been developed which will identify any lessons learned following the reporting of any suspected or confirmed outbreaks of infection or periods of increase in incidence of infections	IPCT, Safer care Team
47	Review incident analysis and learning in the relevant practice governance meetings	All HPFT Staff, MM, HoN
48	Collate and monitor the audit scores on a quarterly basis. Scores to be in included within the individual SBU infection prevention and control reports. Hand hygiene audit scores to be reported via the Trust Quality Schedule.	IPCLP, IPCN, MM, HoN
Criteria 1 – Objective 49 to 53		
Infection Prevention and Cleaning Infrastructure		
		Action to be taken by :
49	To have an IPCT consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention and cleanliness), other healthcare workers and appropriate administrative and analytical support, estates and facilities management and adequate information technology	Board
50	Quarterly Infection Prevention & Control Committee Meetings	IPCC
51	Ensure a Trust wide Service Specification is written, agreed and signed for by any external services required by HPFT	Human Resources, IPCT, Contracts Team, Procurement Team
52	Monitor progress of the SLAs	IPCT, Contracts Team, Service Providers
53	To have 24 hour access to a nominated qualified Infection Prevention and Control Doctor.	IPCT, Contract Team, Service Providers

Criteria 1 – Objective 54 to 55		
Appropriate Planning of Service User Movement		
		Action to be taken by :
54	Provide evidence of the implementation of the risk assessment regarding health care associated infection -transfer and discharge guidance.	All HPFT Staff
55	Ensure appropriate communication between professionals from different units/ healthcare establishments regarding a service user's infection status, in relation to referrals, admissions, transfers, discharges and movements.	All HPFT Staff

Criteria 2 ***Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of HCAI***		
Criteria 2 – Objectives 1		
There are policies for the environment that make provision for liaison between the members of the IPC team and the persons with overall responsibility for facilities management.		
		Action to be taken by :
1	The following policies to be available for all HPFT staff:- • Cleaning services • Building and refurbishment, including air-handling systems • Waste management • Laundry arrangements for the correct classification and sorting of used and infected linen • Planned preventative maintenance • Pest control • Management of drinkable and non-drinkable water supplies • Minimising the risk of Legionella and other water supply and building related infections e.g. *Pseudomonas aeruginosa* and aspergillus by adhering to national guidance • Food services, including food hygiene and food brought into the care setting by service users, staff and visitors	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer

Criteria 2 ***Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of HCAI***		
Criteria 2 – Objective 2 to 15		
Cleaning Services		
		Action to be taken by :
2	Allocation of a clear definition of specific roles and responsibilities for cleaning to be written	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer, Contract Managers, Modern Matrons, Site Managers.
3	All cleaning routines to be clear, aged, signed and displayed on the IPC notice board (within staff areas only).	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer, Contract Managers Modern Matrons, Site Managers.
4	All units/sites to have sufficient resources dedicated to keeping the environment clean and fit for purpose	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer
5.	The IPCT to be consulted regarding any cleaning protocols when internal or external contracts are being prepared	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer
6	Staff to be aware of how additional cleaning can be requested – both routinely and urgently	HPFT staff, Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer, Modern Matrons, Site managers, On Call Managers
7.	The Trust Monitoring Manager involves the Deputy Director of Nursing and Quality, Heads of Nursing, Modern Matrons and the IPCT in all aspects of cleaning services, from contract negotiation and service planning to delivery at ward and clinical level.	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer,

Criteria 2 ***Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of HCAI***		
		DDN&Q, HoN, MM, IPCT
8	MM to have personal responsibility and accountability for maintaining a safe and clean care environment	HoN, MM
9	Person in charge of a unit to have direct responsibility for ensuring that cleanliness standards are maintained throughout the shift.	HoN, MM
10	All lapses in cleaning procedures to be reported as a complaint to the Interserve help desk.	All staff
11	The Trust to ensure that all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition	All staff
12	The cleaning arrangements to detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning responsibility and frequency is available on request	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer
13	The Trust to ensure there is adequate provision of suitable hand washing facilities and antimicrobial hand rubs.	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer, IPCT
14	To replace the detergent wall mounted dispenser at all entrances/exit to HPFT sites	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer
15	To have appropriate provisions of linen and laundry, including the storage and supply of this equipment.	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer, IPCT

Criteria 2 – Objective 16 to 22	
Decontamination • Delivery of a safe and clean environment. • All parts of the premises in which it provides health care are suitable for the purpose, are kept clean and are maintained in good physical repair and condition.	
	Action to be taken by :

Criteria 2 ***Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of HCAI***		
16	The DIPC and the Head of Facilities and Maintenance to continue with the role of environmental cleaning and Decontamination Lead	DDN&Q, Head of Operations – Estates and Facilities
17	The Trust to have the following decontamination policies available and in-date:- • Decontamination of the environment and equipment • Decontamination of linen and laundry	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer IPCN
18	Single use items to be used, were possible	All HPFT staff, procurement group, medical devices group
19	To ensure that staff are trained in cleaning and decontamination processes and hold appropriate competences for their role	All HPFT staff, IPCT, MM, HoN, Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer
20	To have effective arrangements in place for the appropriate cleaning of equipment that is used at the point of care, for example hoists, beds and commodes – these should be incorporated within appropriate cleaning, disinfection and decontamination policies	All HPFT staff
21	To review the written documentation of the different types of deep cleans that are implemented	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer
22	IPC nurses to develop a Trustwide template form to record the decontamination of equipment	IPCN

Criteria 2 – Objective 23 to 27		
Decontamination • There is adequate provision of suitable hand wash facilities and antibacterial hand rubs.		
23	Staff carrying out direct patient contact to be provided with and to wear individual alcohol gel toggles.	MMs, Service Line Lead, Health Safety and Security Team, Community and in-patient Staff, Medical Representative of IPCC
24	Staff to manage the risks associated with the use and storage of alcohol based hand gel	Health Safety and Security Team, IPCT,

Criteria 2 ***Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of HCAI***		
		MM, Ward Manager, Service Line Lead, direct patient care staff
25	Staff to implement the generic risk assessment regarding the use of alcohol hand products.	Health Safety and Security Team, IPCT, MM, Ward Manager, Service Line Lead, direct patient care staff
26	Implementation of hand hygiene audits to ensure all staff complies with the Hand Hygiene Policy. Compliance rates should be a minimum of 95%	All HPFT staff
27	Hand hygiene posters and alcohol gel posters are clearly displayed in the unit.	MM, IPCLP, Site Manager

Criteria 3 ***Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance***		
Criteria 3 – Objective 1 to 7		
		Action to be taken by :
1	To manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic	Pharmacy Team, IPCC, Medical/nurse prescribers
2	To implement and monitor the Trust's antimicrobial and stewardship policy drawing on Start Smart Then Focus	Pharmacy Team
3	SLA to include access to timely microbiological diagnosis, susceptibility testing and reporting of results, preferably within 24 hours. Prescribers to have access to a suitably qualified individual who can advise on appropriate choice of antimicrobial therapy	IPCT, Contracts Team, Service Providers
4	Staff to be encouraged to download and make reference to the antimicrobial app on their mobile phone	Pharmacy Team, IPCC
5	All prescribers to receive induction and training in prudent antibiotic use	Pharmacy Team, IPCC
6	Display and celebrate anti biotic awareness materials during anti biotic awareness week.	Pharmacy Team, IPCC
7	To implement an annual anti biotic prescribing audit	Pharmacy Team, IPCC

Criteria 4 ***Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.***		
Criteria 4 – Objective 1 to 11		
The Trust must ensure that:- • Accurate information is communicated in an appropriate and timely manner; • This information facilitates the provision of optimum care, minimising the risk of inappropriate management and further transmission of infection • Where possible, information accompanies the service user		
		Action to be taken by :
1	**Information available must include:** • Contact details of the infection prevention & control nurses • Infection prevention & control team poster • Ten criteria identified in the Health and Social Care Act 2008 • Infection prevention and control patient leaflet • Most recent infection control audit scores • Poster encouraging visitors to wash their hands on entering and exiting the unit • Sepsis poster from the UK sepsis Trust • Chain of infection	IPCN, MM, IPCLP
2	All posters to be reviewed and up-dated	IPCN, Communications Dept.
3	General principles on the prevention and control of infection identified within the Trust Management of infection prevention and control policy to be available	MM, HoN
4	The roles and responsibilities of particular individuals such as carers, relatives and advocates in the prevention and control of infection, to support them when visiting service users	IPCLP,MM, Ward Manager
5	The importance of appropriate use of antibiotics is adopted.	All clinical HPFT staff
6	Supporting service users' awareness and involvement in the safe provision of care	All HPFT staff
7	Encouraging compliance with Trust Policy regarding visiting	All HPFT staff
8	Staff /visitors/carers reporting failures of hygiene and cleanliness to the help desk.	All HPFT staff
9	Encourage compliance by visitors with hand washing and visiting restrictions	All HPFT staff
10	Explanation of incident/outbreak management	IPCT, MM, Team Leader
11	To liaise with the patient advice and liaison services regarding all aspects relating to patient information	IPCC

Criteria 5 ***Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people***		
Criteria 5 – Objective 1 to 10		
Responsibility for infection prevention and control		
		Action to be taken by :
1	Provide accurate information in an appropriate manner.	IPCC, ALL HPFT STAFF, Communications Department
2	Complete the transfer and discharge form when transferring/discharging service users.	ALL HPFT STAFF, MM, Team Leader
3	Staff to implement an appropriate risk assessment regarding a suspected/confirmed infection	ALL HPFT STAFF,MM, Team Leader
4	Staff to record any confirmed infection on the Alert section on PARIS	ALL Clinical Staff
5	Staff to carry out regular vital observations on all service users if an infection is suspected /confirmed and to report and act on any abnormalities	All Clinical Staff
6	Provide relevant information across organisational boundaries taking into account service user confidentiality.	ALL HPFT STAFF
7	Inform the local health protection unit and CCG of any outbreaks or serious incidents relating to infection in a timely manner.	IPCT, HoN, Risk Manager
8	All staff across the organisation should demonstrate their responsibility for infection prevention and cleanliness	ALL HPFT STAFF
9	All relevant care pathways to be implemented	ALL HPFT STAFF carrying out direct patient care
10	All service users with a suspected/confirmed urinary tract infection to be reported to the IPCT. All catheter associated urinary tract infections to be reported via the safety thermometer reporting system and to the IPCT.	All Clinical Staff

Criteria 6 ***Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection***		
Criteria 6 – Objective 1 to 6		
The Trust must ensure its staff, contractors and others involved in the provision of health care, co-operate as necessary, to enable the Trust to meet its obligations under this Code.		
		Action to be taken by :
1	All staff to be aware and to conform to the obligations under the Health and Social Care Act, 2008, revised 2015**.**	All HPFT staff
2	Education and training to be implemented during the induction programme and staff updates to be provided	IPCNs, MMs, Infection Prevention and Control Link Persons
3	Level 1 training to be implemented via e-learning for all non-clinical staff. Level 2 training to be implemented via e-learning or via the workbook and assessment for all clinical staff.	All HPFT staff, Learning and Development Department
4	Infection prevention and control to be included and discussed in all job descriptions, personal development plan or annual appraisal	HR, MM, Service Line Lead, HoN
5	Contractors working in service user areas to be aware of any of any issues with regard to infection prevention and cleanliness and obtain “permission to work”	Head of Operations – Estates and Facilities, Services Manager, Environment and Monitoring Officer, MM, Unit/Site Manager
6	Staff to be trained and to demonstrate proficiency before being allowed to undertake specific skills/procedures independently e.g. aseptic technique, PEG feeding, urinary catheter care.	IPCN, Modern Matron, Team Leader, Learning and Development Dept, HoN.

Criteria 7 ***Provide or secure adequate isolation facilities***		
Criteria 7 – Objective 1 to 3		
Adequate isolation precautions to prevent or minimise the spread of HCAI.		
		Action to be taken by :
1	Staff to refer to the a-z of infections policy for information regarding isolation/exclusion	All HPFT staff
2	Risk assessments to be implemented following a suspected/ confirmed infection risk. Staff to implement appropriate infection prevention and control procedure to reduce the risk of transmission.	All HPFT staff
3	HPFT to provide or secure facilities to physically separate the service user from other residents in an appropriate safe manner (co-hort nursing), should this be necessary to minimise the spread of infection.	Board members, All HPFT staff carrying out direct patient care, IPCNs, DDN&Q, Service Line Lead.

Criteria 8 ***Secure adequate access to laboratory support***		
Criteria 8 – Objective 1 to 3		
Appropriate protocols are in place regarding the investigation and surveillance of HCAI and the appropriate procedure for the examination of specimens		
		Action to be taken by :
1	Ensure Service level agreements (SLA) are written, agreed and signed for which includes the approval microbiology service.	IPCC, Human resources, SLA microbiology departments, Contracts Team. Procurement Team
2	SLA to ensure that the laboratories that are used to provide a microbiology service in connection with arrangements for infection prevention and cleanliness have in place appropriate protocols and that they operate according to the standards required by the relevant national accreditation bodies.	IPCC, Human resources, SLA microbiology departments, Contracts Team
3	Protocols should include: • a microbiology laboratory policy for investigation and surveillance of antimicrobial resistance and healthcare associated infections; and • standard laboratory operating procedures for the examination of specimens; • timely reporting	IPCC, Human resources, SLA microbiology departments, Contracts Team

Criteria 9 **Have and adhere to policies designed for the individual's care and provider organisations, that will help to prevent and control infections**		
Criteria 9 – Objective 1 to 3		
The Trust must have the appropriate core polices in place. There must be a rolling programme of audit, revision and update.		
		Action to be taken by :
1	All staff to be aware and implement guidance laid out in **all** Infection Prevention & Control policies	All HPFT staff
2.	Policies must be easily accessible to staff	Communications dept, ICLPs, Site Managers
3	All infection prevention & control polices to be monitored and reviewed every two /three years	IPCC

Criteria 10 ***Providers have a system in place to manage the occupational health needs of staff in relation to infection***		
Criteria 10 – Objective 1 to 14		
Occupational Health Services		
		Action to be taken by :
1	All staff to have access to the Trust Occupational Health Service	HR
2	Occupational health to follow Trust policies and national guidance on the prevention and management of communicable infections in care workers are available	PAM Occupational Health
3	Decisions on offering immunisation should be made on the basis of a local risk assessment as described in *Immunisation against infectious disease* ('The Green Book').	PAM Occupational Health , HR
4	Risk-based screening for communicable diseases and assessment of immunity to infection after a conditional offer of employment and ongoing health surveillance	PAM Occupational Health , HR
5	Having arrangements in place for regularly reviewing the immunisation status of care workers and providing vaccinations to staff as necessary in line with *Immunisation against infectious disease*	PAM Occupational Health , HR
6	To ensure compliance with the seasonal flu campaign and monitor the progress at the IPCC.	PAM Occupational Health , HR
7	The implementation of a risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids	PAM OH, Unit Manager
8	Management of occupational exposure to infection, including a consultation 24 hour needlestick injury helpline service.	PAM Occupational Health Team, HR
9	Assist in the management of exposure to HCAI	All staff, PAM Occupational Health , HR
10	Records to be maintained regarding all relevant immunisations	PAM OH
11	Having arrangements for identifying and managing healthcare staff infected with hepatitis B or C or HIV and advising about fitness for work and monitoring as necessary, in line with Department of Health guidance	PAM Occupational Health , HR
12	Liaising with the *UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses* when advice is needed on procedures that may be carried out by BBV-infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed	PAM Occupational Health , HR

Criteria 10 ***Providers have a system in place to manage the occupational health needs of staff in relation to infection***		
13	Records to be maintained on all accidental inoculation injuries reported to the Occupational Health provider.	PAM OH, Health Safety and Security Team
14	Staff to refer to the staff health policy regarding IP&C	All HPFT staff

ABREVIATIONS

MRSA	Meticillin resistant *Staphylococcus aureus*
MSSA	Meticillin sensitive *Staphylococcus aureus*
CDAD	*Clostridium difficile* Associated Disease
CPE	Carbapenamase Producing Enterobacteriaceae
HCAI	Healthcare Associated Infection
HIV	Human Immuno deficiency virus
HPFT	Hertfordshire Partnership University NHS Foundation Trust
DIPC	Director of Infection Prevention and Control
DDN&Q	Deputy Director of Nursing and Quality
IPCN	Infection Prevention and Control Nurse
IPCC	Infection Prevention and Control Committee
ICNA	Infection control nurses association
MM	Modern Matron
IPCLP	Infection Prevention and Control Link Person
OHA	Occupational Health Advisor
SLA	Service Level Agreement
WHHT	West Hertfordshire Hospital Trust
E&N	East and North Hospital Trust
HR	Human Resources
CN-IPC	Consultant Nurse – Infection prevention and control
HoN	Head of Nursing.

Hertfordshire Partnership University
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Trust Board

Meeting Date:	6th June 2019	**Agenda Item:** 13
Subject:	Complaints and Service Experience Annual Report 2018-2019, including Q4 reporting	**For Publication:**
Author:	Mary Stephenson, Complaints and Service Experience Manager	**Approved by:** Sandra Brookes Executive Director of Service Delivery and Service User Experience
Presented by:	Sandra Brookes Executive Director of Service Delivery and Service User Experience	

Purpose of the report:

This report provides the Board with an overview on compliments, PALS contacts, complaints and responses to experience questionnaires, including Having Your Say questionnaires in the year 2018/19. It provides assurance about how the Trust learns from complaints and other service experience information.
It identifies themes and learning over the last twelve months.
The report also includes quarter 4 reporting in appendix 1

Action required:

The Committee is requested:

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

Summary and recommendations:

The Complaints and Service Experience Annual Report for 2018-19 provides an overview of complaints, compliments and service experience performance during the year. The Information provided is analysed to identify themes, trends and learning for the Trust. The report contains elements of learning that the Trust has undertaken in response to the complaints and other feedback as well as more detailed information on complaints received.

The report highlights the importance of services receiving feedback on the care and services they provide. It also provides a summary and any identified themes of the issues that are being raised in both compliments and complaints.

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

The report related to the following strategic objectives:

- Deliver safe and effective services
- 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. Mandatory Friends and Family Test monthly submission to NHS England.

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 the 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

IGC – 22/5/2019

Executive Summary

Introduction

Delivering a great service user and carer experience is a priority for the Trust. This report seeks to provide assurance on how the Trust's complaints and Patient Advice and Liaison Service (PALS) contacts are managed effectively to ensure responses are responsive and robust.

The report also highlights compliments received and other systems for comments, complements and concerns through the 'Having Your Say' platform. The aim is to triangulate the data in a way that provides a clear picture of the reported experiences of our service users and their carers.

This report provides evidence of learning from complaints and provides details of priorities for 2019/2020.

Overview of the 2018/19 report

- PALS contacts across the Trust increased by 2%. Corporate 247, West SBU 379, East and North 204, and Learning Disabilities & Forensic 42%. 46% of the corporate PALS contacts related to sign posting enquiries and concerns unrelated to HPFT.

- The number of complaints in 2018/19 has increased by 38% compared to a drop of 22% the previous year.

- The number of complaints acknowledged within 3 working days is 98%.

- The number responded to within 25 workings days is 78%; an 8% decrease from 2018/19 – reflecting the emerging level of complexity of the complaints received.

- Our Friends and Family Score remained the same as 2017/18 at 87% saying they would recommend the Trust; 5% would not.

- 6640 Having Your Say forms were returned.

- 7 Ombudsman investigations were opened and 7 were closed all with no further action for the Trust.

The Trust was rated as good by the Care Quality Commission (CQC) in 2018 with positive comments about the way complaints are managed within the Trust and the level of information and support available to service users and carers who may wish to raise a complaint or concern.

Key priorities for 2019/20

Due to staff shortages, the PALS and Complaints team were unable to complete a number of the items in the programme for 2018-19 and these have been rolled over into the 2019-20 programme.

- A number of ½ day training sessions have been arranged for staff new to the role of investigating complaints with particular emphasis robust investigations and documentation.

- We aim to update the e-learning complaints training for frontline staff so it is compatible with Discovery.

- We will continue to promote learning from complaints, comments and compliments as part of overall learning from service user and carer feedback in particular those related to changes brought about by the redesign of services.

- We will continue to encourage the use of the new ipads in six community hubs. Use will continue to be monitored, with a three month evaluation at the end of May 2019.

- Single Point of Access (SPA) will be supported to develop a new SMS text survey to increase the amount of feedback received from service users.

- Stories to the Board will continue throughout 2019-20. The Board will also be asked to consider how they reflect on the stories they have heard in the previous 12 months.

- The National Community Mental Health Survey will be repeated in 2019-20.

- Peer Experience listening projects to be undertaken in 2019-20 are: Safety on Units and listening post incident at the Broadland Clinic.

- The Inclusion & Engagement Team will support a co-produced observation project in 2019-20, to help the Trust to understand peoples' feelings about safety in older peoples' inpatient services; there will be a co-produced observation project in 2019-2020 using CQI methodology.

- The Involvement and Experience Plan is being launched to reinforce the Trust's commitment to quality.

Conclusion

During 2018-19 the Trust received 871 PALS contacts, a 2% increase on the number of contacts received in 2017-18. There were 285 formal complaints, a 38% increase compared to the previous year. First responses were sent out for 78% of the complaints within 25 working days.

In 2018-19 7 complaints files were requested by the Parliamentary and Health Service Ombudsman (PHSO)/Local Government Ombudsman. Five decisions were returned during the year the year, 3 not upheld and 2 not investigated.

There were 6,647 pieces of Having Your Say and FFT feedback received in 2018-19; this was a decrease in feedback of 0.2% compared to 2017-18. The FFT score remained consistent at 87%.

The introduction of new technology in our community hubs is ensuring that we are offering service users and carers the opportunity to give feedback in different ways.

Teams continue to be encouraged to share all feedback in team meetings for an overall view of the experience.

The Care Quality Commission report for 2018 rated the Trust as good with positive comments about the Trust's complaints process.

Hertfordshire Partnership University
NHS Foundation Trust

Meeting Date:	6th June 2019	Agenda Item: 13
Subject:	Complaints and Service Experience Report **Q4** 2018-19	For Publication:
Author:	Mary Stephenson, Complaints and Service Experience Manager	Approved by: Sandra Brookes Executive Director of Service Delivery and Service User Experience
Presented by:	Sandra Brookes Executive Director of Service Delivery and Service User Experience	

Purpose of the report:

This report provides the Board with information on compliments, PALS contacts, complaints and responses to experience questionnaires, including Having Your Say questionnaires, received during Quarter 4 2018/19.
It provides assurance about how the Trust learns from complaints and other service experience information.

Action required:

The Committee is 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 4 2018/19.

Data is drawn from Having Your Say (including Friends and Family Test), formal complaints, Patient Advice and Liaison Service (PALS) contacts, compliments and other methods of feedback used across services (for example: PULSE, mutual expectation meetings, advocacy reporting). Information is provided over time to help identify themes, trends and learning for the Trust. The report contains elements of learning that the Trust has undertaken in response to the complaints and other feedback as well as more detailed information on complaints received.

1,546 pieces of feedback (not including PALS, compliments or complaints) were received in the quarter.

During the quarter we received 82 formal complaints, 224 PALS contacts and 408 compliments. The Ombudsmen returned 2 decisions – both from PHSO as not being investigated and no further action from the Trust. This represents an increase in complaints, compliments and PALS concerns.

The report highlights the importance of services receiving feedback on the care and services they provide. It also provides a summary and any identified themes of the issues that are being raised in both compliments and complaints.

The Board are asked to note the activity from service user/carer feedback, Complaints and PALS and the responding actions to address this.

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

The report related to the following strategic objectives:

- Deliver safe and effective services
- 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.

Mandatory Friends and Family Test monthly submission to NHS England.

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 the 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

IGC – 22/5/2019

Hertfordshire Partnership University
NHS Foundation Trust

Complaints and Service Experience Annual Report 2018-2019

1. Introduction

1.1 This section reviews the compliments, Patient Advice and Liaison Service (PALS) contacts, complaints and service user and carer feedback (Having Your Say (HYS) / Friends and Family Test (FFT) received by the Trust for the period 1 April 2018 to 31 March 2019.

1.2 This report provides evidence of learning from complaints in section 5.83 and section 9 provides details of priorities for 2019/2020.

1.3 Table 1 provides a statistical overview of compliments, complaints, PALS contacts and Having Your Say (HYS) responses for 2018-19.

Table 1: Overview of service experience contacts received during 2018/19

	Q1	Q2	Q3	Q4	Total
PALS contacts received	240	212	196	223	**871**
Compliments received	443	378	342	408	**1571**
Complaints received	72	67	64	82	**285**
Service User 'Having Your Say' completed	1594	1312	1124	1142	**5172**
Carer 'Having your Say completed	345	328	391	404	**1468**
% Friends and Family Test service users would recommend	85	85	88	88	**87**
Complaints fully upheld at year end	8	17	7	7	**39**
Complaints partly upheld at year end	24	26	21	22	**93**
Complaints not upheld at year end	34	20	26	20	**100**
Complaints files requested by PHSO /LGO	2	0	4	1	**7**
% of complaints acknowledged within 3 working days	99	97	98	96	**98**
% of complaints with a first response within 25 working days (90% target)	72	75	86	79	**78**

Note:
33 complaints are awaiting a formal response at the time of preparing the report, this includes complaints suspended because the service user is unwell, complaints subject to serious incident reviews, or for meetings with the complainant.

2. KEY RESPONSIBILITIES AND REPORTING FRAMEWORK

2.1 The Chief Executive has overall responsibility for the management of complaints in the Trust. The Executive Director for Service Delivery and Service User Experience has executive responsibility for overseeing monitoring and reporting procedures.

2.2 During the year the Complaints and Service Experience Manager provided quarterly reports to the Involvement and Engagement Group (IEG), Integrated Governance Committee, the Trust Board, Hertfordshire Clinical Commissioning Groups and the Integrated Health and Care Commissioning Team.

2.3 Copies of the annual report are provided to the Clinical Commissioning Groups, HealthWatch Hertfordshire, POhWER, Commissioners, Hertfordshire County Council Health and Community Services.

3. COMPLIMENTS

3.1 The Trust values compliments as they indicate an appreciation of the quality of the services that staff provide and which people often go out of their way to give. Services are asked to send copies of all service users and carer related compliments to the PALS and Complaints Team for logging so that they can be shared with staff using HPFT News – People Focus. We recognise that the many verbal compliments made direct to frontline staff are not recorded.

3.2 During the year, 1571 compliments were forwarded to the PALS and Complaints team compared to 1989 in 2017-2018. This is 21% decrease. The figures for 2018-2019 are shown in Table 2. In part the reduction can be accounted for by more stringent quality assessment of feedback from Friends and Family Test.

Table 2: Number of compliments forwarded by Strategic Business Unit

Strategic Business Unit	2018/19
Corporate Services	3
East & North Hertfordshire Strategic Business Unit	450
Learning Disabilities & Forensic Strategic Business Unit	362
West Hertfordshire Strategic Business Unit	956
Totals:	1571

3.3 The PALS and Complaints team raises awareness of the importance of sending copies of all compliments to the team for inclusion in HPFT News, during training and induction of new staff.

3.4 Relatively few compliments explicitly mention any of the Trust Values; however, most compliments mention good or great care indicating that our staff are demonstrating the Trust values in their work.

4. PATIENT ADVICE AND LIAISON SERVICE (PALS)

4.1 PALS recorded 872 contacts during 2018-2019 compared to 858 during 2017-2018. This is a 2% increase on last year's figures. Table 3 provides a breakdown of the contacts by Strategic Business Unit.

Table 3: PALS contacts by Strategic Business Unit

Strategic Business Unit	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Corporate Services	70	57	54	66	247
East and North Hertfordshire	49	46	49	60	204
Learning Disabilities & Forensic	12	14	8	8	42
West Hertfordshire	108	95	86	90	379
Totals:	239	212	197	224	871

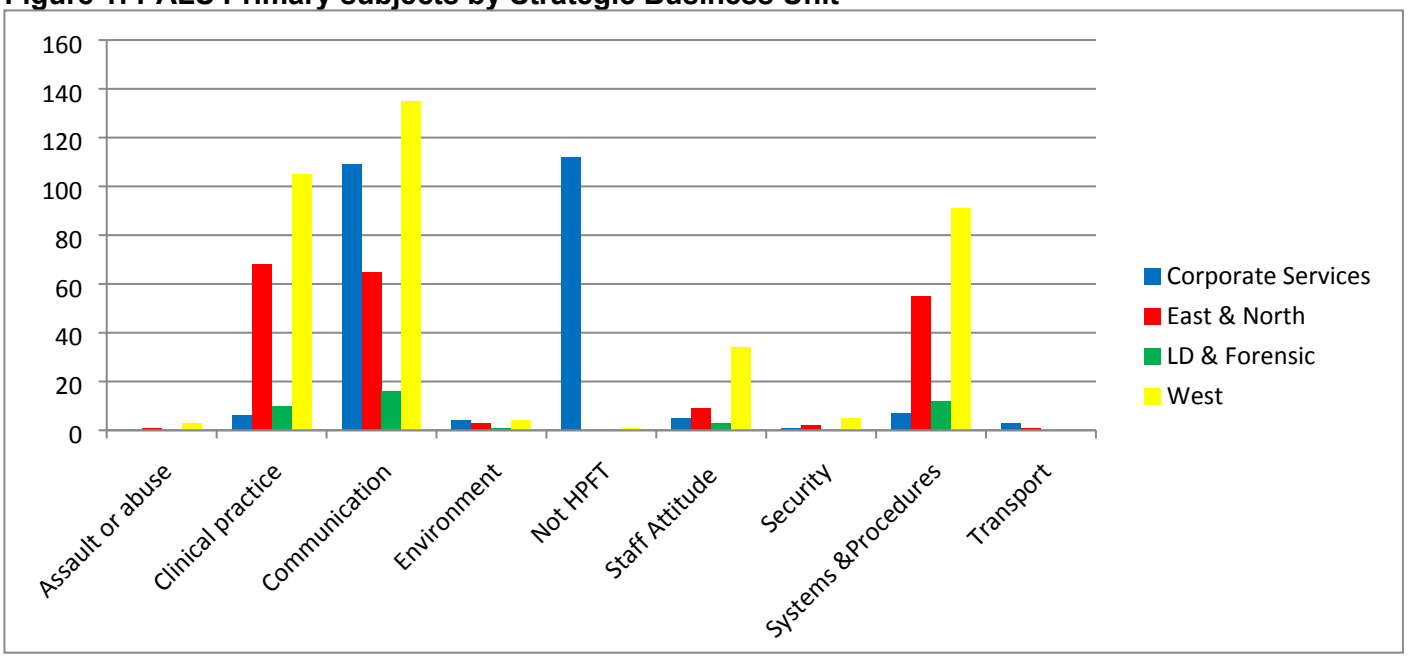
Table 4 PALS contacts by Strategic Business Unit and Type

Strategic Business Unit	Advice	Enquiry	Feedback	Informal complaint	Issue for resolution	Not HPFT	Other	Total
Corporate Services	11	83	22	2	15	114	0	247
East & North Herts	8	38	37	21	99	1	0	204
LD & Forensic	1	8	11	8	13	1	0	42
West Herts	12	66	189	65	145	0	1	378
Totals:	32	195	159	96	272	116	1	871

4.2 Primary subjects by Strategic Business Unit

Figure 1 shows the primary subject of complaints received by each Strategic Business Unit

Figure 1: PALS Primary subjects by Strategic Business Unit



4.2.1 Clinical Practice (189 contacts) – the subsubject for 134 (71%) of contacts about clinical practice related to the care provided to the service user. The rest were divided between 12 other sub-subjects, including care planning, assessment and treatment, diagnosis, adminsitration of drugs and medicines, failure to prescribe and poor treatment technique.

4.2.2 Communication (324 contacts) – 168 (52%) of contacts about communication were requests for information. Of the other issues 18% were about commuication breakdown, 17% provided feedback (including through NHS website), 6% were requests to forward information to services and 6 were about telephone access.

4.2.3 Systems and Procedures (165 contacts) - 63 (38%) of contacts were about access to treatment, 16% about discharge, the other contacts fell into 25 other sub-categories.

4.2.4 113 (13%) of contacts were not about our services, information was provided about the correct service and, where appropriate, consent was obtained to forward them to the correct service.

5. COMPLAINTS

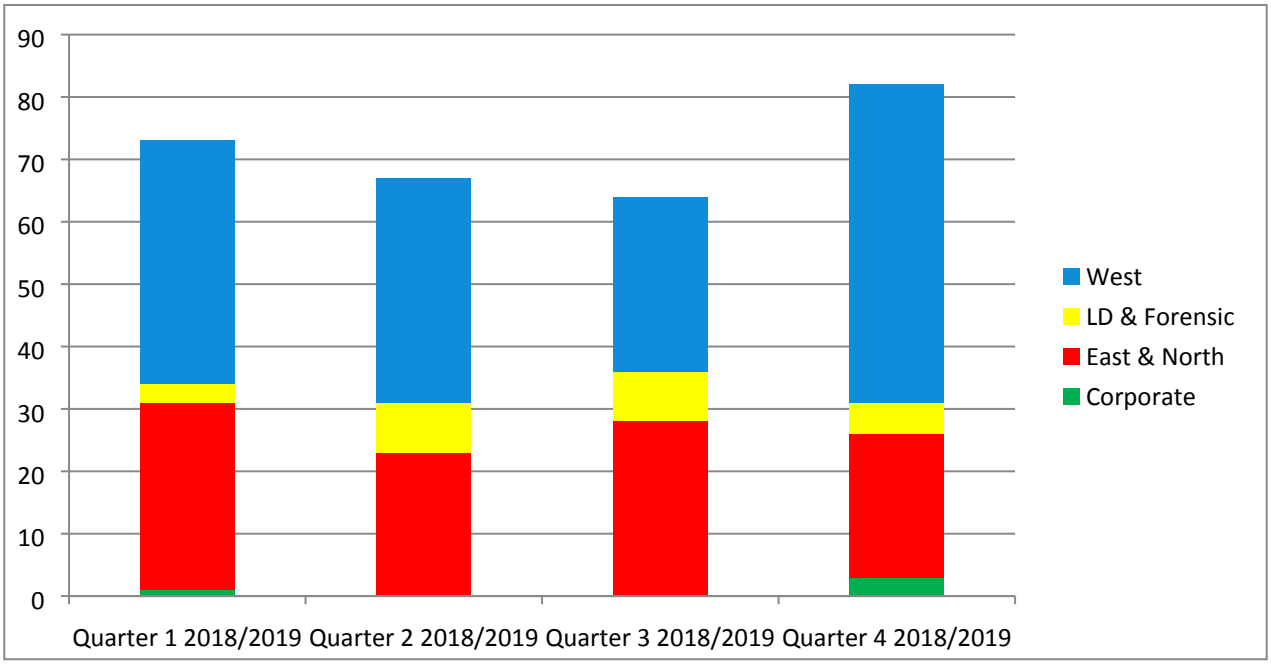
5.1 Complaints received

5.1.1 The Trust received 285 complaints about its services during the year compared to 206 received in 2017-18. This is a 38% increase. This followed a large drop (22%) from 252 compared to 2016-17. It is not clear why there is such a variation year on year, but the change does indicate that people are able to access the complaints procedure when needed. The increase in complaints is also mirrored by an increase in PALS contacts. Table 5 and Figure 2 show the number of complaints for each Strategic Business Unit for each quarter for 2017-18.

Table 5: The breakdown of complaints for 2018-19 is as follows:

Strategic Business Unit	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Corporate Services	1	0	0	3	4
East & North Hertfordshire	30	23	28	23	104
Learning Disabilities & Forensic	3	8	8	5	24
West Hertfordshire	38	36	28	51	153
Totals:	**72**	**67**	**64**	**82**	**285**

Figure 2: Number of complaints by Strategic Business Unit for each quarter in 2018-19



5.1.2 The team continues to raise the profile of the Complaints, PALS and Service Experience services to ensure that service users, carers and other visitors to the Trust feel able to raise their concerns, confident that they will be investigated and responded to in a fair and open way.

5.1.3 Many clinical services send information about making complaints out with first appointment letters.

5.1.4 Service users, their carers and relatives are encouraged to raise concerns with the care staff at the time they arise. On the inpatient units this is facilitated by the modern matrons who meet with inpatients during a weekly surgery and weekly residents meetings. An independent advocate also attends each ward regularly to enable service users to raise concerns.

5.1.5 The Trust recognises that many people are more comfortable putting a complaint or concern in writing or speaking to someone not involved in the service user's direct care and 'Making Comments, Compliments and Complaints' leaflets are available at all Trust sites and are included in the inpatient admission packs. As well as providing information about the complaints process, the leaflets give contact details and there is a freepost form. The leaflets have been updated in light of recent changes to Data Protection legislation.

5.1.6 People are able to comment, compliment or complain through the Trust website.

5.1.5 Service users and carers are able to use Having Your Say forms to give comments or compliments or raise concerns. If service users wish their feedback to be raised as a formal complaint they are advised to contact the complaints team. Where a person has not indicated that they wish their comments to be managed through the formal complaint process the comments provided on Having Your Say forms are sent to the services so they can act upon them. All feedback is available to view on the MES (Membership Engagement Service) dashboard and teams are expected to update their "you said, we will" poster every 3 months.

5.1.6 Service users and carers can also post comments on the NHS Website but as these are anonymous, and may not identify the service, it is difficult to respond effectively.

5.2 Acknowledgement times

The Trust has a target of acknowledging all complaints within 3 working days of receipt into the organisation. Table 6 shows the percentage of complaints acknowledged within that time. The team aspires to meet this target and has shown a small improvement compared to last year. It is hoped that now the team has a full establishment of staff the 100% target will be met later in 2019-2020.

Table 6: percentage of complaints acknowledged and responded to within timescale

	2017-2018	2018-2019
Total number complaints	206	285
Percentage acknowledged within 3 working days	96%	98%
Percentage first responded to within 25 working days	86%	78%

5.3 Response times

The Trust target is for 90% of complaints to have a first response within 25 working days. Table 6 shows the percentage of complaints first responded to within 25 working days in 2018-19 compared to 2017-18. During 2018-2019 78% of complaints were first responded to within 25 working days. One of the reasons for the drop in first response rate compared to the 2017-18, is the higher number of very complex complaints involving more than one organisation or more than one Trust service. Complex complaints often take longer to investigate and respond to, especially when other organisations are involved. It is our practice to contact the complainant to explain why a complaint response has been delayed.

5.4 Methods used to make complaints

Table 7 shows the methods complainants used to make their complaints. While a large number of complaints were sent as letters (with or without comment cards), or email, others were made by telephone or were forwarded by other organisations.

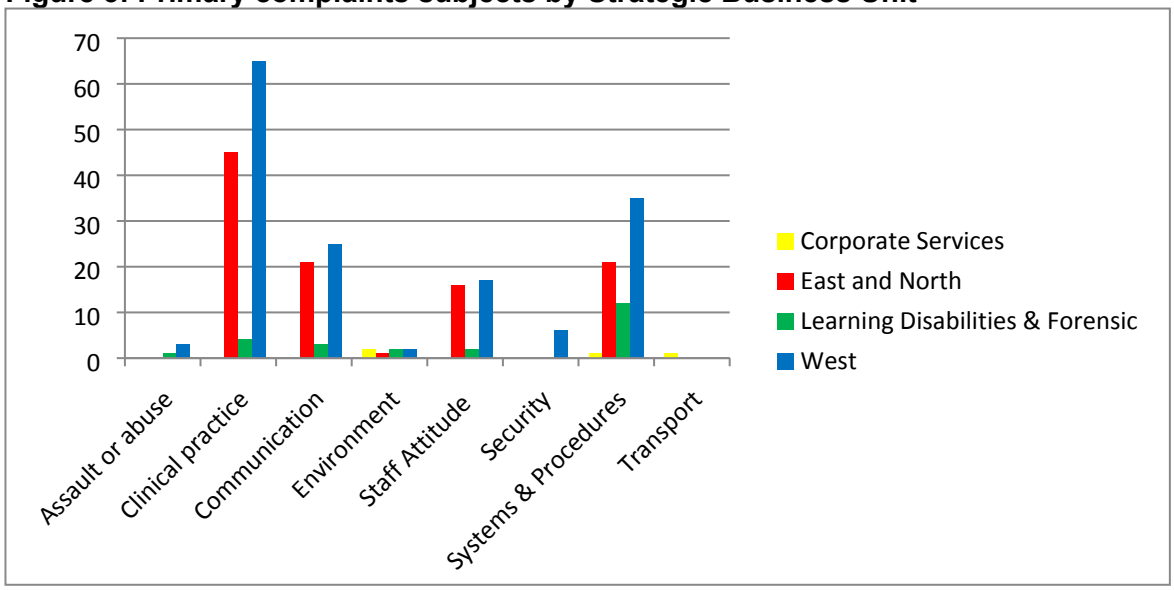
Table 7: Complaints by Strategic Business Unit and method received during 2017-2018

Strategic Business Unit	Comment card	Care Quality Commission	CCG	E-mail	Having Your Say Form	Letter	In Person	By Telephone	Trust's Website	Total
Corporate Services	1	0	0	1	0	2	0	0	0	4
East & North Hertfordshire	4	0	2	40	1	36	3	6	12	104
Learning Disabilities & Forensic	3	1	2	11	0	5	0	1	1	24
West Hertfordshire	16	3	0	51	1	52	2	10	17	153
Totals:	24	4	4	103	2	95	5	17	31	285

5.5 Main complaints issues

5.5.1 Figure 3 shows the proportion of complaints for each service area in each of the main subject categories during 2018-19. As in previous years the primary issue for most complaints is clinical practice closely followed by complaints about the Trust's systems and procedures. Our investigations continue to show that many of these complaints might have been avoided if communication with service users, their carers and relatives had been more effective.

Figure 3: Primary complaints subjects by Strategic Business Unit



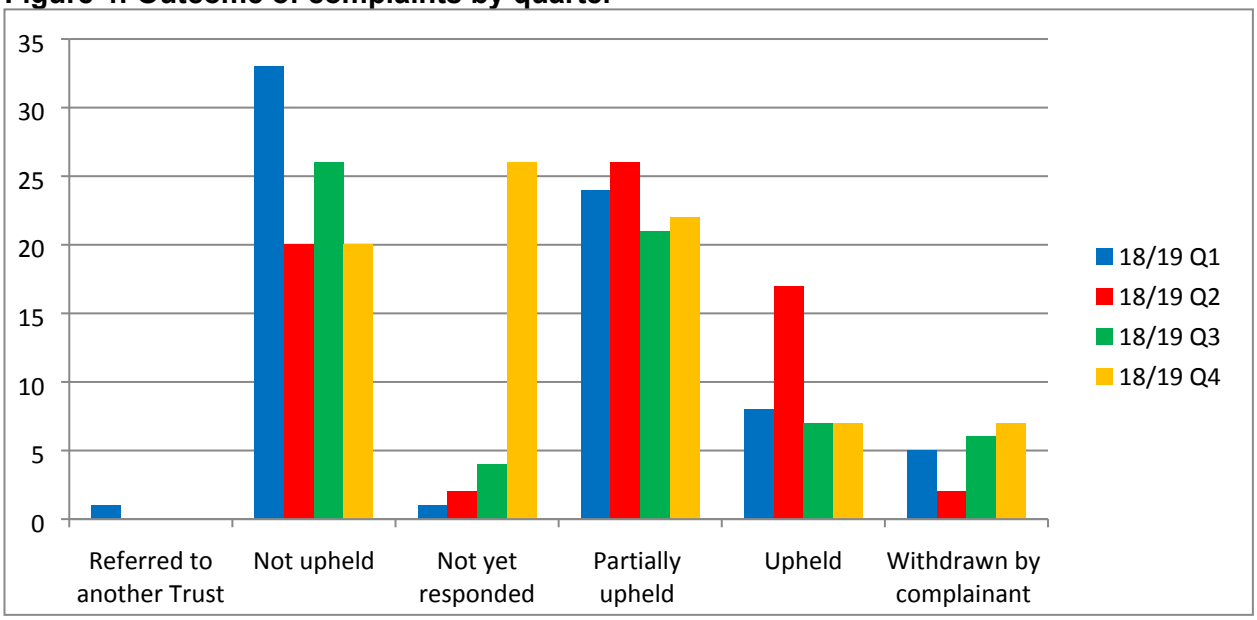
5.5.2 Appendix 1 provides a breakdown of complaints by primary subject and sub-subject for each Strategic Business Unit. Overall there were 4 complaints of alleged abuse, two patient to patient physical, and two staff to patient physical, one of which was about the use of the respect technique. It is standard procedure to refer cases of alleged abuse to Safeguarding.

- Of the 114 complaints with clinical practice as the main issue: 51 were about general care, 24 were about assessment and treatment, 13 about care planning and 10 about diagnosis.
- There were 35 complaints where staff attitude was the main issue, 10 complaints related to a breakdown in the staff to service user relationship, 9 were about staff being rude either face to face or on the telephone and 6 were about the indifferent attitude to carers/service users.

- Of the 69 complaints about systems and procedures, 17 were about access to treatment and 12 were about alleged breach of confidentiality.
- There were 49 complaints where communication was the main issue, 21 concerned a communication breakdown with service users, 19 were about communication breakdown with relatives, and 3 each were about a communication breakdown between professionals and sharing of information/record keeping.

5.5.3 The Trust takes all complaints very seriously and a thorough and proportionate investigation is carried out, whatever the circumstances, in accordance with national guidelines and local best practice. Figure 4 shows the outcome of the complaints that have been responded to. There is one complaint carried forward from Q1 and 2 from Q2 due to either the service user remaining very unwell and lacking the mental capacity to have an appropriate discussion about their concerns or because the complaint is also the subject of a serious incident investigation.

Figure 4: Outcome of complaints by quarter



5.5.4 Most complaints were resolved at a first response stage and, where staff speak with the complainant early in the complaints resolution process, complaints are often resolved quickly and successfully. In complex cases meetings are also held with the complainants. The PALS and Complaints team works closely with staff involved in investigations and quality assure the content of responses to ensure that all issues are addressed appropriately. Staff are also requested to complete an action plan when appropriate. Complaints are monitored through the Trust's Practice Governance procedures to ensure that lessons are learned and our services are improved.

5.5.5 If a complainant is unhappy with the written response, we offer to meet with them in order to resolve any outstanding concerns. This is usually successful, as meetings enable both staff and complainants to discuss and clarify issues and sometimes new information can be provided, which enables the complaint to be resolved to the complainants satisfaction.

5.6 Teams with five or more complaints raised against them

5.6.1 The Trust is based on many sites in Hertfordshire, and manages Learning Disability and Forensic services in Buckinghamshire, Norfolk and North Essex and IAPT services in mid Essex, north east Essex and west Essex and Hertfordshire, as well as secondary and

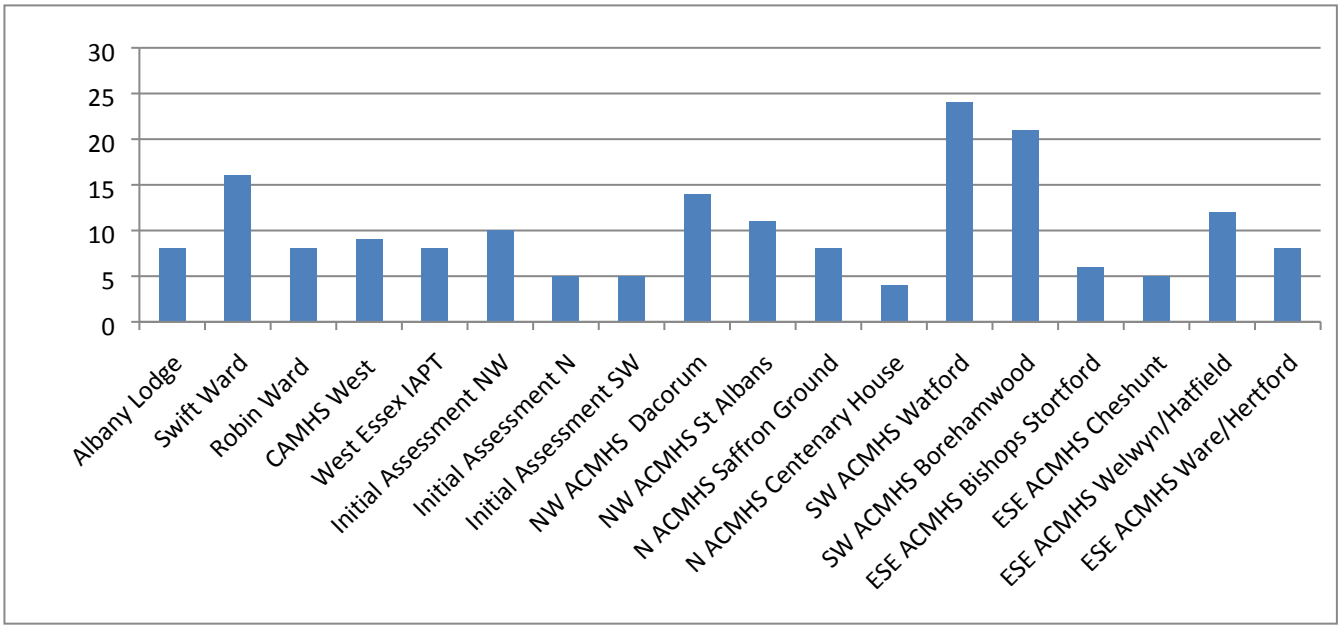
tertiary Child and Adolescent Mental Health Services, Specialist Mental Health Services for Older People and Adult Mental Health Services within Hertfordshire.

5.6.2 Figure 5 shows the teams which were involved in five or more complaints in 2018-19, which accounted for 182 (64%) of complaints received by the Trust.

5.6.3 Overall, 135 (48%) complaints came from community services , which is to be expected as community services see the highest numbers of service users with 35 sub-subjects. The primary subject for 72 of the complaints was clinical practice with 32 complaints about patient care, 16 about assessment and treatment and 10 about diagnosis. There were 27 complaints about systems and procedures with 7 each about breach of confidentiality and access to treatment and 3 about direct payments. The primary subject for 19 complaints was around communication with 13 about communication breakdown with service users. Of the 17 complaints were the primary subject was about staff attitudes 7 were about patient relationship and 3 were about rudeness on the telephone.

5.6.4 As in previous years, South West Adult Community Services has the highest number of complaints. 49 (36%) of the 135 complaints related to South West, 27 about clinical practice, 12 about systems and procedures, 7 about communication and 3 about staff attitude. However, North West Adult Community Services had 35 complaints, 17 about clinical practice, 7 about communication, 6 about staff attitude and 5 about systems and procedures. Adult Community Services for West SBU have been subject to as deep dive in the past, with recommendations relating to managing appointments and customer training for reception staff being implemented. A further deep dive will be undertaken to determine what factors have caused the further increase in complaints in this SBU.

Figure 5: Graph showing number of complaints by team with 5 or more complaints



5.6.5 Swift ward is an acute admission ward where services users are admitted for assessment and normally remain on the ward for a maximum of 72 hours before transferring to a treatment ward or returning to relevant community services. There were 16 complaints for Swift ward covering 2 different sub-subjects. 6 complaints were about clinical practice (3 about general care, 2 about care planning and 1 about clinical decisions), there were 3 complaints about systems and procedures (1 each about confidentiality breach, discharge and service cutbacks). 2 complaints were about patient belongings going missing, 2 complaints were about the environment, two complaints were about staff attitude and 1 was about a communication breakdown with relatives.

5.6.6 Focus on South West Community Mental Health Services

The service has two main hubs, The Civic Offices in Borehamwood, and Colne House in Watford.

There were 21 complaints about services provided from Borehamwood, of these three complaints were from one complainant and two from another. The complaints were about a number of different issues and staff. One complaint was upheld, 10 were partly upheld, 5 were not upheld, and 3 complaints were withdrawn at the request of the complainants. Two complaints remain under investigation.

There were 24 complaints about Adult Community Mental Health Services provided from Watford, no single issues or themes have been identified within the complaints. The service continues to experience staffing problems with a high number of bank and agency staff supporting service users, which may be impacting on the experiences of service users and their families. Four complaints were upheld, 8 were partly upheld, 7 were not upheld and 4 complaints remain under investigation.

5.7 Joint complaints

During the year 11 joint complaints with other organisations including Hertfordshire County Council's Adult Community Services and other NHS services were received.

5.8 Independent reviews

5.8.1 Ombudsman reviews
If a complainant is unhappy with the Trust's response they can ask the Parliamentary and Health Service Ombudsman (PHSO), or the Local Government Ombudsman (LGO) to carry out a review of the complaint and how it has been handled. Complaints that sit with both the PHSO and LGO are reviewed by a joint working team managed through the LGO office. At the year end, the Trust was awaiting 6 decisions from the Ombudsmen.

5.8.2 Files requested and decisions received
Between April 2017 and March 2018, the Trust received 7 requests for files/records from the Ombudsmen and 5 decisions were returned all requiring no further action from the Trust. More detail is provided in Appendix B.

5.9 Learning from complaints

A key part of the complaints process is to identify areas of improvement and to develop and carry out an action plan to ensure that lessons are learnt. Some examples of changes made as a result of receiving a complaint are provided below:

5.9.1 Improved access to activities in evenings and at weekends (Acute Inpatient Services)
Following complaints and other feedback from service users on our acute inpatient wards a number of new activities have been introduced which are available in the evening and at weekends. These include table tennis for Older peoples services, come dine with me nights for service users and their loved ones, walking activities and a variety of other activities. In addition, Albany Lodge now provides additional psychological input and support that includes families and carers.

5.9.2 S117 prescription charge exemption (Adult Community Services)
Following a complaint and a query from different quadrants about the eligibility of service users (subject S117) for free prescriptions it was found that many staff were unaware of service users required citeria for an exemption through the government scheme, the Trust must meet the cost of prescribed medication to treat their mental disorder. The S117 policy has been updated to include instructions on how to purchase a Prescription

Prepayment Certificate for affected service users and a learning note was shared with staff.

5.9.3 Clinical Care

Following complaints in older people's services and one particular complaint that is now a serious incident, the Trust is refocusing it's care of the deteriorating patient by rolling out a new training programme for the National Early Warning System2 (NEWS). Having also taken learning from external intelligence it is adopting the handover escalation framework SBAR (Situation, Background, Assessment, and Recommendation).

5.9.4 Comments about CQC report 2018

The CQC commented on good practice relating to complaints handling in the 2018 report. Comments included:

'Most patients told us they knew how to complain. Staff encouraged patients to raise concerns in weekly community meetings and supported by staff to identify their own solutions. Staff knew how to record and escalate complaints.'

'Managers investigated local complaints in a timely way and involved patients to feedback learning from complaints'.

'Clinical leads had oversight of safeguarding and incident reporting and shared lessons learnt. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.'

'Staff knew how to deal with complaints and advise patients how to make complaints. Patients were able to give feedback about their care, and staff supported them to raise a complaint about any aspect of their care. Staff received many compliments from patients about how staff treated them.'

6. COMMUNICATIONS AND INFORMATION

6.1 The PALS and Complaints team uses various Trust publications such as HPFT News and the HPFT intranet (TrustSpace) to inform staff of changes made to services following complaint investigations. The team works closely with the Safer Care Team and Practice Governance Leads to ensure learning from complaints and incidents is shared Trust wide to improve practice. The Trust website provides information to enquirers about how to make a compliment, comment or complaint and provides an e-form for people to use, if they wish.

6.2 Service users and carers also comment through the NHS Website and Care Opinion. The Trust will always try to identify which service is involved and ensure comments are shared with them. If the person has identified themselves, direct contact is made. During the year there were 7 compliments and 36 adverse comments. Adverse anonymous comments are recorded as PALS feedback. It is believed that a number of the adverse comments about one of the IAPT services were by the same individual.

6.3 Complaints training is mandatory for all frontline staff to ensure that they are aware that the Trust takes complaints seriously and how they should be managed. The complaints e-training continues to be well used and the team also provides taught sessions in individual units when needed.

6.4 A handbook for frontline staff, relevant policies and template letters are available on the Trust's internal website TrustSpace. The policy and copies of the leaflets are available on TrustSpace.

6.5 During the year specific training continued to be provided to those responsible for investigating and responding to complaints with the aim of improving the quality of responses and increasing customer satisfaction.

7 HAVING YOUR SAY (HYS) AND FRIENDS AND FAMILY TEST (FFT)

7.1 The main method of obtaining feedback from our service users and carers is by asking them to complete Having Your Say forms and Friends and Family Test postcards, these are available as paper and electronic forms. Some teams have questionnaires specific to their teams, for example, Forest House and Single Point of Access (SPA) where a telephone survey is used. In March ipads were introduced to six community hub sites and staff are encouraging service users and carers to give feedback through these devices to increase real-time feedback, the use of technology and reduce paper.

7.2 Over the last year we have received 6,634 pieces of feedback through HYS and FFT, a decrease in feedback of 0.2% compared to 2017-18. The FFT score remained the same at 87%. We continue to receive high volumes of feedback from CAMHS and some Wellbeing teams. The response numbers have increased in some adult community hubs following the introduction of meet and greet volunteers who are supporting individuals to give feedback.

7.3 This year has seen qualitative feedback from CHI-ESQ outcome surveys contributing to the FFT feedback on MES, which has increased the richness of the data and enables the CAMHS teams to have a better understanding of the way the people they care for experience their services.

7.4 Analysis of the free text comments tells us that we receive positive feedback on the emotional and physical support and the helpfulness of the service. “Safety” and “waiting” continue to score less well.

8 PROGRAMME FOR 2019-2020

8.1 The PALS and Complaints team, due to the increased workload have yet to complete a number of the items in the programme for 2018-19 and these have been rolled over into the 2019-20 programme.

8.2 We aim to continue the training programme for investigating managers with particular emphasis on ensuring investigations are robust and properly documented, ensuring that staff within new services coming under HPFT management are offered training.

8.3 We will review and amend the Complaints Policy and Procedure and the PALS Policy and Procedure in line with changes in legislation and Department of Health Guidelines.

8.4 We aim to update the e-learning complaints training for frontline staff.

8.5 We will continue to work with teams to improve the communication with complainants at an early stage of the complaints process, in line with recommended practice.

8.6 We will continue to develop strong evidence of good complaints investigations and learning from complaints and implementation of actions arising from complaints.

8.7 We will continue to promote learning from complaints, comments and compliments as part of overall learning from service user and carer feedback in particular those related to changes brought about by the redesign of services.

8.8 We will be reviewing our Acute Community Having Your Say survey which will follow the review of the crisis services. The survey will be co-produced to ensure the questions are meaningful and reflect crisis care priorities.

8.9 We will continue to encourage the use of the new ipads in six community hubs. Their use will continue to be monitored, with a three month evaluation at the end of May 2019. Q1 will see a targeted advertising campaign regarding the use of ipads encouraging service users and carers to use them rather than paper surveys. The experience team will also identify a baseline response rate taken from the discharge rate of service users in community services. Meet and greet volunteers will continue to promote the use of ipads and the experience team will set up a monthly phone call with community team leads to review the quantity and quality of the data.

8.10 We will support SPA to develop a new SMS text survey to increase the amount of feedback received from the service.

8.11 Teams will continue to be encouraged to bring their experience data to team meetings for discussion each month and to produce their "you said, we will" poster each quarter.

8.12 The programme of stories to the Board will continue throughout 2019-20. The Board will also be asked to consider how they reflect on the stories they have heard in the previous 12 months.

8.13 The annual National Community Mental Health Survey will be repeated in 2019-20.

8.14 Peer Experience listening projects to be undertaken in 2019-20 are: Safety on Units and listening post incident at the Broadland Clinic.

8.15 Reporting of the "feeling safe" scores for our inpatient HYS survey continues. Monitoring of the qualitative feedback continues to give local services clarity around feeling safe; this will also feed into the Peer Experience Listening safety project.

8.16 The team will continue to support the mealtime experience project with ongoing work around nursing culture at mealtimes.

8.17 In order to understand peoples' feelings about safety in older peoples' inpatient services, there will be a co-produced observation project in 2019-2020. Currently in the planning stages, the project will use CQI methodology and, although led by the SBU, will be supported by the Inclusion and Engagement Team.

8.18 The Involvement and Experience Plan is being launched to reinforce the Trust's commitment to quality.

9 KEY OPPORTUNITES and CHALLENGES FOR THE COMING YEAR

9.1 Efficiency of processes to manage an increasing complex workload, including increased numbers of PALS contacts, compliments forwarded to the PALS and Complaints Team, and complaints, which are also increasing in complexity.

9.2 Ensuring complaints are acknowledged within three working days while managing an increasing workload.

9.3 In an increasingly challenging environment ensure that services are supported to provide consistently high quality investigations and responses to complaints and work to ensure

that PALS contacts, including informal complaints are managed in a timely way to prevent them from being escalated to formal complaints.

9.4 To ensure adequate succession planning for the upcoming retirement of the two full-time members of staff in the PALS and Complaints team.

9.5 The use of new technology to improve efficiency and quality of the service.

9.6 Encouraging community teams to use the new technology in hub sites.

9.7 The introduction of the new Experience and Involvement plan

10 CONCLUSION

During 2018-19 the Trust received 871 PALS contacts, a 2% increase on the number of contacts received in 2017-18. There were 285 formal complaints, a 38% increase compared to the previous year. First responses were sent out for 78% of the complaints within 25 working days.

In 2018-19 7 complaints files were requested by the Parliamentary and Health Service Ombudsman (PHSO)/Local Government Ombudsman. Five decisions were returned during the year the year, 3 not upheld and 2 not investigated.

There were 6,647 pieces of Having Your Say and FFT feedback received in 2018-19; this was a decrease in feedback of 0.2% compared to 2017-18. The FFT score remained consistent at 87%.

The introduction of new technology in our community hubs is ensuring that we are offering service users and carers the opportunity to give feedback in different ways.

Teams continue to be encouraged to share all feedback in team meetings for an overall view of the experience.

The Care Quality Commission report for 2018 rated the Trust as good with positive comments about the Trust's complaints process.

Appendix A – Complaints subjects and sub-subjects by Strategic Business Unit

	Corporate	East & North	LD & Forensic	West	Total
Assault or abuse	**0**	**0**	**1**	**3**	**4**
Staff to patient physical	0	0	0	1	1
Patient to patient physical	0	0	1	1	2
RESPECT Technique	0	0	0	1	1
Clinical practice	**0**	**45**	**4**	**65**	**114**
Care	0	19	0	32	51
Care planning	0	3	1	9	13
Diagnosis	0	6	0	4	10
Administration of Drugs and medicines	0	2	0	1	3
Failure to follow procedures	0	1	0	0	1
Failure to prescribe	0	2	0	1	3
Incorrect dosage	0	1	0	1	2
Incorrect medicine	0	0	0	1	1
Poor treatment technique	0	1	0	0	1
Clinical decisions	0	3	0	2	5
Assessment and Treatment	0	7	3	14	24
Communication	**0**	**21**	**3**	**25**	**49**
Communication breakdown with patient	0	7	2	12	21
Communication breakdown with relatives	0	12	0	7	19
Communication between professionals	0	0	0	3	3
Telephone access	0	0	1	1	2
Service information inadequate	0	0	0	1	1
Sharing of Information/Record Keeping	0	2	0	1	3
Environment	**2**	**1**	**2**	**2**	**7**
Food and Catering	2	0	1	0	3
Noise pollution	0	0	0	1	1
Disability discrimination	0	1	1	0	2
Health and Safety issues	0	0	0	1	1
Staff Attitude	**0**	**16**	**1**	**17**	**35**
Inappropriate behaviour	0	0	1	3	4
Inappropriate language	0	0	0	2	2
Rude face to face	0	2	0	2	4
Rude on telephone	0	3	0	2	5
Patient Relationship	0	3	1	6	10
Communication with relatives/carers	0	2	0	2	4
Indifferent attitude to carer/SU	0	6	0	0	6
Security	**0**	**0**	**0**	**6**	**6**
Patients belongings	0	0	0	6	6
Systems and Procedures)	**1**	**21**	**11**	**35**	**69**
Access Admission	0	0	0	1	1
Access Appointment Cancellation OPD	0	1	0	0	1
Access Appointment Delay OPD	0	1	0	0	1
Access to Health Records	1	0	0	0	1
Administration Inefficiency	0	2	0	0	2

Change of Ward	0	0	0	1	1
Confidentiality Breach	0	3	1	8	12
Discharge	0	1	0	2	3
Follow up	0	0	0	1	1
Mental Health Act Detention	0	1	0	3	4
Record Keeping	0	0	1	2	3
Referral Delayed	0	1	0	0	1
Resettlement	0	0	2	0	2
Transfer of care	0	0	0	2	2
Waiting Lists	0	1	0	0	1
Access to treatment	0	2	7	8	17
Policy Decisions of Trust	0	1	0	0	1
Service Cutbacks	0	0	0	1	1
Patient's monies	0	0	0	1	1
Continuity of care	0	1	0	2	3
Continuing Care Funding	0	2	1	0	3
Direct payments	0	2	0	1	3
Safeguarding	0	2	0	0	2
Carers Assessment	0	0	0	1	1
Discrimination	0	0	0	1	1
Transport	**1**	**0**	**0**	**0**	**1**
Failure to arrive	1	0	0	0	1
Totals:	4	104	24	153	285

Appendix B: Decisions made by the Ombudsmen

Complaint reference	Main issues and local resolution	Ombudsman's recommendations
C3018 Adult Community Services	A service user made a number of complaints over a 5 year period about his personal budget, and poor care and treatment. Despite considerable efforts to resolve his concerns he continued to remain unhappy and asked the Ombudsmen to review his case.	**Not upheld** No fault found in the way the personal budget was assessed or managed. No fault in the way care plans were followed, support for physical health or in considering requests for change of care coordinator. No further action.
C3045 Older People's Services	Complaint from service user's daughter mainly about an independent supported housing provider, and how they dealt with her complaint. Concerns around the way the Trust managed a request for a safeguarding referral. The Trust responded to the issue related to the safeguarding. The complainant remained unhappy about responses from all parties involved.	**Not upheld** The LGO did not uphold the complaint about the Trust and there was no further action
C2915 CAMHS	A service user's father complained about the service user's treatment and also the way staff treated him. The service user refused consent to respond and the Trust provided a limited response. The complainant went to the PHSO, who gained consent from the service user and asked HPFT to respond. Consent was verified and a full response provided. The Complainat remained unhappy and asked the PHSO to investigate.	**Not upheld** The PHSO did not uphold any aspect of the complaint and considered that the Trust acted appropriately and proportionately in difficult circumstances
C3008 Adult community Services	First received and responded to in 2017. A service user complained about their diagnosis and treatment. The complaint was partly upheld due to delays in ensuring concerns were passed to the complaints team. Additional psychological support was offered with senior psychologist. Service user approached the PHSO in late 2018.	**Not investigated** The PHSO decided not to investigate as the complaint was deemed to be out of time. No further action for the Trust.
C3266 Adult Community Services	A service user complained about the Flexible Assertive Community Treatment team entering his home; being coerced into taking medication against his wishes and his detention. The complaint was not upheld as the service user was demonstrably unwell at the time.	**Not investigated** After reviewing the Trust records the PHSO decided not to investigate this complaint as they were satisfied that the investigation and response were appropriate. There was no further action for the Trust.

Hertfordshire Partnership University
NHS Foundation Trust

Meeting Date:	May 22nd 2019	Agenda Item: 26
Subject:	Complaints and Service Experience Report Q4 2018-19	For Publication:
Author:	Mary Stephenson, Complaints and Service Experience Manager	Approved by: Sandra Brookes Executive Director of Service Delivery and Service User Experience
Presented by:	Carolyn Fowler, Deputy Director Safer Care and Standards	

Purpose of the report:

This report provides information on compliments, PALS contacts, complaints and responses to experience questionnaires, including Having Your Say questionnaires, received during Quarter 4 2018/19.
It provides assurance about how the Trust learns from complaints and other service experience information.

Action required:

The Committee is 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 4 2018/19.

Data is drawn from Having Your Say (including Friends and Family Test), formal complaints, Patient Advice and Liaison Service (PALS) contacts, compliments and other methods of feedback used across services (for example: PULSE, mutual expectation meetings, advocacy reporting). Information is provided over time to help identify themes, trends and learning for the Trust. The report contains elements of learning that the Trust has undertaken in response to the complaints and other feedback as well as more detailed information on complaints received.

1,546 pieces of feedback (not including PALS, compliments or complaints) were received in the quarter.

During the quarter we received 82 formal complaints, 224 PALS contacts and 408 compliments. The Ombudsmen returned 2 decisions – both from PHSO as not being investigated and no further action from the Trust. This represents an increase in complaints, compliments and PALS concerns.

The report highlights the importance of services receiving feedback on the care and services they provide. It also provides a summary and any identified themes of the issues that are being raised in both compliments and complaints.

IGC are asked to note the activity from service user/carer feedback, Complaints and PALS and the responding actions to address this.

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

The report related to the following strategic objectives:

- Deliver safe and effective services
- 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.

Mandatory Friends and Family Test monthly submission to NHS England.

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 the 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

None

Appendix 1

Service Experience Report – Q4, 2018-19

Service Users & Carers	**88%**	→
Staff	**77%**	↓

When we get it right… *

"She cared, she listened and she helped change my life."

When we don't get it right…+

"…I had to chase you and you just said, sorry we forgot that we should have phoned …"

*Comment was reflective of positive comments given about care and support.

+Comment was reflective of negative comments about communication.

1. Summary

- This report provides an overview of what people have said about the quality of HPFT services during Quarter 4, 2018-19.
- Data is drawn from Having Your Say (HYS) (including Friends and Family Test), formal complaints, PALS contacts, compliments and other methods of feedback used across services (for example: PULSE, mutual expectation meetings, advocacy reporting).
- 1,546 pieces of feedback (not including PALS, compliments or complaints) were received in the quarter.
- During the quarter we received 82 formal complaints, 224 PALS contacts and 408 compliments. The Ombudsmen returned 2 decisions, with no requirement for investigation or further action from the Trust.

2. Important messages

2.1 What was good about service quality?

- A 30% increase in HYS responses from adult acute services.
- CATT, Mental Health Liaison (formerly RAID), ADTU and Wellbeing services maintained high levels of satisfaction, continuing to be above target and higher than other service areas.
- Mid Essex IAPT services maintained a high FFT score at 100% compared to 97% in Q3.
- The number and variety of activities across the rehabilitation services appears to be increasing.
- Feedback from older peoples' services and Adult Community East and South East locality continues to increase month on month.
- Holly Lodge had a 16% increase in service users saying staff are kind and caring.
- There was an increase in the number of compliments forwarded by the units to the PALS and Complaints Team.

- Increases in satisfaction across many questions in older people's services (see table 1).

2.2 What was not good about service quality?

- Although the feeling safe score rose this quarter to 79%, it is still below target of 80%.
- SPA satisfaction has fallen and responses to the telephone survey remain low.
- There is a consistent decrease quarter on quarter for LD&F SBU.
- Overall satisfaction for the North East Essex IAPT service was 53% citing lack of communication and waiting lists as a reason for low scores.
- Decrease in responses from forensic inpatient services and West Essex IAPT.
- FFT score for rehabilitation services was 55% compared to 54% in the previous quarter.
- No feedback received from Forest House.
- Feedback from Adult Community north locality remains very low (20).
- The primary subject for most complaints was Clinical Practice

2.3 What are the most significant changes when compared with the previous quarter?

- A 30% increase in HYS responses from adult acute services.
- Increase in service users at Gainsford House saying activities helped towards their recovery.
- The drop in satisfaction for IAPT North East Essex, from 88% in Q3 to 53% in Q4.
- A 28% increase in the number of complaints compared to Q3.

3 Understanding feedback by service area

3.1 Table 1: Key observations from Q4 2018-19 by service

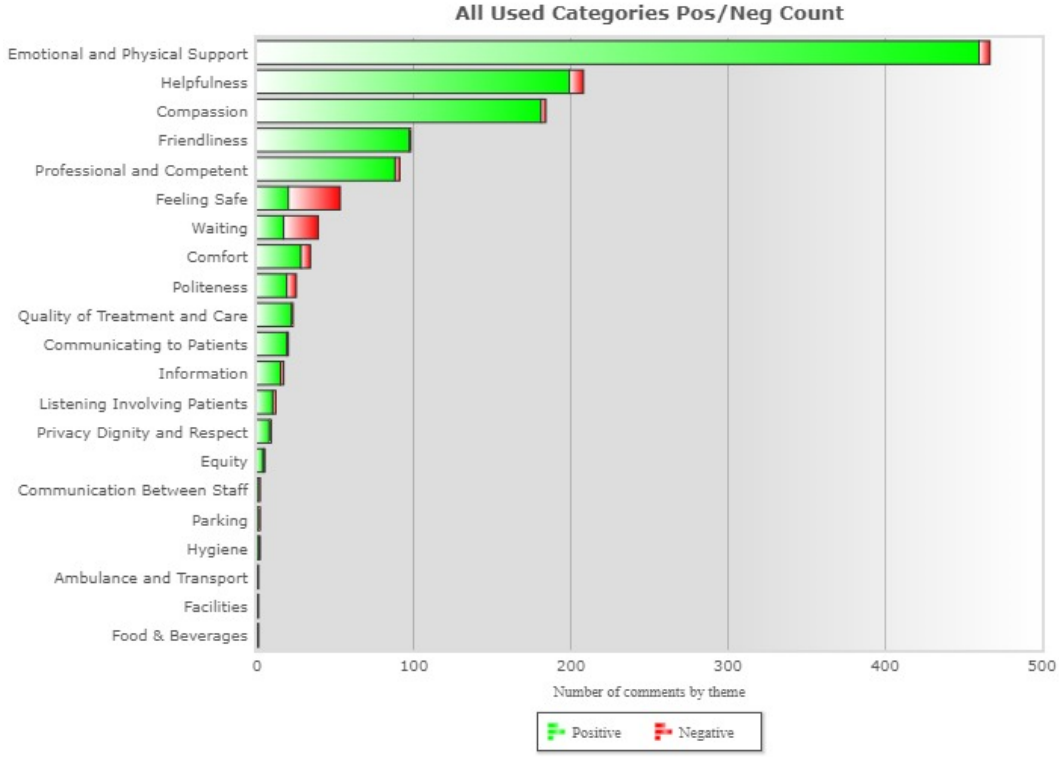
	Pieces of feedback received (HYS, PALS, Compliments)		**Formal complaints**	**Key observations**
Adult community	HYS		38	• 16% increase in satisfaction for Holly Lodge. • Low numbers of responses from north locality
	PALS	63		
	Comps	38		
Adult Acute	HYS	325	18	• 82% FFT score • A 30% increase in responses compared to Q3 • 79% of service users reported feeling safe on the unit, an increase compared to Q3 (75%), however below the 80% target.
	PALS	36		
	Comps	39		
Adult Rehabilitation	HYS	21	0	• FFT score 55% • Feeling safe score 83%
	PALS	0		
	Comps	4		
CAMHS community	HYS	375	8	• FFT score 90% • High level of positive comments regarding care, treatment and support.
	PALS	21		
	Comps	54		
CAMHS Inpatient	HYS	0	1	• There was no HYS feedback from Forest House in Q4.
	PALS	1		
	Comps	8		
Essex IAPT	HYS	108	3	• FFT score 92% • 87 responses from Mid Essex – 100% score • North East Essex scored 53% (20 responses) - comments about lack of communication and waiting lists. • West Essex 1 response.
	PALS	7		
	Comps	68		

	Pieces of feedback received (HYS, PALS, Compliments)		Formal complaints	Key observations
Forensic Community	HYS	0	0	
	PALS	0		
	Comps	1		
Forensic Inpatient	HYS	9	0	• FFT score 67% • A decrease in responses from 40 in Q3.
	PALS	0		
	Comps	9		
Learning Disability Community	HYS		0	• FFT score 93% • 26 responses were received from Bucks services. • 2 responses were received from Herts LD Community services
	PALS	0		
	Comps	28		
Learning Disability Inpatient	HYS	8	1	• FFT score 88% • Feeling safe score 86% • Although a low number of responses, this is an increase compared to Q3 (2).
	PALS	0		
	Comps	13		
Bed Management and Placement	HYS	0	1	
	PALS	1		
	COMPS	0		
Older People's Community	HYS	176	1	• FFT score 94% • 41% increase in service users saying we talk about support with physical health. • 23% increase in service users saying the service understands how mental health affects their life. • 16% increase in those saying they knew who to contact for support. • 20% increase in those saying they knew how to get support and advice at a time of crisis.
	PALS	6		
	Comps	24		
Older People's Inpatient	HYS	22	6	• FFT score 95% • Positive comments given about "helpful" services.
	PALS	4		
	Comps	19		
SPA	HYS	28	0	• 74% FFT score • Satisfaction has fallen for all questions.
	PALS	3		
	Comps	1		
Wellbeing Services	HYS	183	1	• FFT score 92% • A 28% decrease in responses.
	PALS	16		
	Comps	101		
Corporate Services	PALS	65	4	•
	Comps	2		

4. Comments from Having Your Say

4.1 Graph 1 shows all comments mapped against categories, green for positive and red for negative. From the graph below we can see that the majority of comments are given about emotional and physical support and these were positive. The highest proportion of negative comments was about safety and waiting however, this was a small number of comments compared to the total qualitative feedback received.

4.2 Graph 1 Categories of comments



4.3 Emotional Word Cloud showing all emotions commented on - green for positive emotions and red for negative. The larger the emotion the more often words were attributed to it.

5. Methods of receiving feedback

Feedback is gathered in a number of ways and added to our Having Your Say feedback, which gives us a rich source of information about peoples' experiences. In addition we gather feedback though complaints, compliments and PALS contacts.

- Acute Mutual Expectation meetings are held weekly on the adult acute inpatient wards to give service users time to talk about their experiences, make suggestions and raise concerns.

- Board stories (see appendices for overview of actions arising from stories)
- Peer Experience Listening - there were no Peer Experience Listening projects this quarter.
- Advocacy
- Compliments from service users and carers
- Feedback and concerns raised with PALS
- Formal complaints

5.1 Table 2: Summary of issues and feedback from the above sources in Q4.

Issue	Service
The gardening project, walking group and games nights are popular. Yoga was not so popular, as people had to pay for it.	4 Bowlers Green
The paint fumes on female corridor due to redecorating. Also causing difficulties with access to clothes due to having them packed away. Hot drinking tap is not working. Service users don't know how to use their safes. Searches have been explained and a list of prohibited items is now displayed. Recreational worker posters have now been filled and a list of activities is on the noticeboard.	Albany Lodge
Sometimes it can be noisy which the staff are aware of and helping to reduce as much as possible. Service users feel safe and staff take time to explain what this means for people.	Astley Court
Art, Maths, English, IT, Life Skills, Tearing, Sticking and Drawing are enjoyed. Would like more magazines, books, craft items and board games. Would like to have 2 walks per day. Have enjoyed baking, smoothie making and would like more cooking sessions. Staff to support with the internet and computer.	
There were some maintenance issues with toilets which were reported. Would like more clocks on the walls.	
Service user keen to do a GCSE and the education team are supporting this. Have requested ipad to help with this.	
In March service users commented that the food was not good, and they were encouraged to attend the food meeting to discuss.	
Food around the world event each month, service users are learning about backgrounds and food of some of the staff on the wards. "Dignity in Care" day was also celebrated with tea and cakes and discussion about dignity.	Broadland Clinic
For service users who do not have S17 leave there are sessions available at the Wherries every day. Service users have asked for physical activities and staff have offered to lead this. Sporting events in the park.	
Recovery college courses continue with a course called "Townography".	
The "golden ticket" brunch scheme has started with nominations for service users for achievements and sticking to mutual expectations. The winner receives a big breakfast.	
Advocacy with Opening Doors: • 229 sessions of education and training where service users were involved. • 62 people who have moved on got in touch for self-referrals • 48 people worked face to face with Opening Doors trainers • 468 contacts were made regarding health issues, social care issues, welfare/benefits issues and other issues.	
Experts by experience from the COG group interested in being part of interview panels.	Bucks
COG North group cancelled due to the upstairs venue not being accessible for all.	
All service users feel safe because staff protect them. Service users know their care plans but sometimes don't understand their medication.	Dove Ward
"All About Me" books have recently been updated with ways the staff can support service users. Service users enjoy art therapy as it helps them to express how they feel and help with recovery. They would like to do more cooking and their	

own laundry. Would like more home visits. Would like more skittles, cricket and basketball and smoothie sessions.	
Would like more comfy chairs in the communal area. They like the big TV and the lounge is cosy.	
The bedrooms are nice and service users like having a shower in the morning, the beds are comfortable.	
Advocacy: At the weekly drop-in sessions, new services users were supported to understand their rights as formal or informal patients. A service user was supported to prepare for their ward round, noting down key points they want to discuss. Advocate also facilitated communication between service users and professionals. No major concerns were raised.	Forest House
Future activity suggestions: bowling, cinema, music appreciation, pool tournament, table tennis, 10 pin bowling. Wi-Fi has now been installed. Would like to plant flowers and get a table and chairs for the garden.	Gainsford House
Food is often too hot. Debit cards have arrived on unit and service users will be able to part self-cater.	
Go-kart racing trip to London. 2 new walking groups. Suggestions for a BBQ and bowling.	Hampden House
Would like croissants for breakfast. Food is going missing; cupboards with locks will be available shortly.	
1:1 activities have increased as there are enough staff to take service users out. There are also only 3 service users currently on the unit.	Lexden
Activity boxes are now on the unit.	
Some dissatisfaction with food, being investigated.	
Suggestions for a gardening group, badminton. Community out and about group. Issues with Wi-Fi being sorted.	The Beacon
The houses are being renamed and service users have decided they will be tree themed.	Warren Court
DVD ban for 18+ films is being looked into.	
New board games are on order.	
Food issues – the catering manager is going to meet with service users.	
The food is good and service users are thankful that staff encourage them to drink more water.	Wren Ward

6. What actions will the teams take following their feedback?

Teams are required to look at their feedback monthly within their team meetings. Quarterly they are required to produce a "you said, we will" poster incorporating all their feedback

6.1 Having Your Say – "you said, we will".
29 "you said we will" posters were received from services; this is a response rate of 37%.

6.2 Table 3 shows the actions by services which had the highest impact on scores compared to the previous quarter.

6.3 Table 3: examples of action taken in response to feedback

Action set in previous quarter	Service	Satisfaction increase
On the first day a member of staff will always try to make you feel comfortable, we will welcome you, show you around the unit and explain the purpose of ADTU.	ADTU The Orchards	20%
Searches have been explained and a list of prohibited items has been put up on the noticeboard. There are 2 new recreational workers in post.	Albany Lodge	47%

We will discuss with you in the residents meeting and morning brief to find out activities you would like to do. (see table 2)	Gainsford House	50%
We will ensure a smooth handover between services and provide you with clear information on your transition.	Holly Lodge	16%
The score for "staff being kind and caring" increased. The team arranged more structured daytime activities for the service users with our OT and recreational worker and have dedicated planning time with timetables taking into account the service users ideas and preferences.	Oak Unit	19%
The score for "staff being kind and caring" increased. Staff made sure that all new staff introduced themselves on the ward and joined in with activities when possible.	Robin Ward	18%
Due to ongoing issues, the team monitored the room and water temperatures and reported any problems to estates. The team continued to encourage mums to attend music therapy, baby massage and protected time to talk to the doctors and nurses.	Thumbswood	100% **score maintained**

7. Annual Plan updates

7.1 Mealtime Experience Project

- The two specific areas of focus were reiterated to the inpatient teams prior to the CQC visit to ensure that the correct menus were being displayed each day on the wards and to ensure that Interserve staff are adhering to policy and wearing the correct protective clothing when serving food.

7.2 Increase quantities and methods of feedback

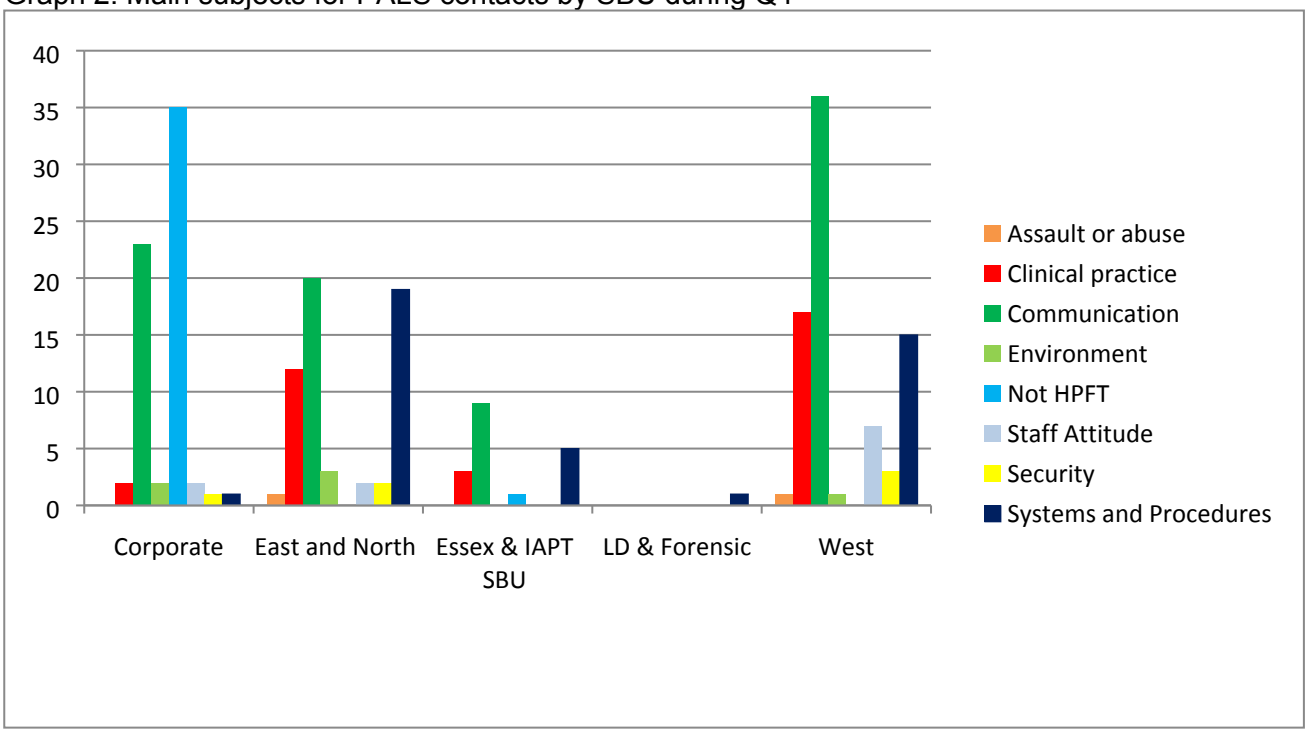
- New technology in the community hubs has now been deployed with ipads being installed in six community hubs trust wide. Reception staff have been trained and are being supported to use the ipads. Responses are being monitored and any issues or concerns are being logged by reception teams in order to evaluate the project. 21 surveys were completed through ipads in March 2019, 70% of the total responses from the hubs were completed on the ipads.
- Teams are continuing to be encouraged to use online survey links as opposed to paper surveys.

7.3 Feeling safe

- The feeling safe score for Acute 24/7 services rose compared to the previous quarter, 79% in Q4 compared to 75% in Q3, however this is below the 80% target.
- In acute services: Aston Ward, Oak Unit and Robin Ward all scored below the target for feeling safe. In particular, those wards scoring particularly low were Aston Ward (50%) and Oak Unit (63%). Thumbswood scored 100% with three responses and Swift Ward scored 89% with 37 responses.
- LD&F inpatient services saw an increase in service users feeling safe from 75% in Q3 to 86% in Q4 (based on 29 responses).
- Hampden House (75%) scored below target; however, Astley Court (86%) and Warren Court (88%) saw an increase in satisfaction compared to the previous quarter.

8. PALS Contacts

8.1 Graph 2: Main subjects for PALS contacts by SBU during Q4



8.2 Observations:

- There were 224 Patient Advice and Liaison Service (PALS) contacts during the quarter, an 14% increase compared to Q3
- 4 PALS contacts became formal complaints
- 24 contacts were informal complaints
- 32 contacts were about non-HPFT services
- Of the 88 contacts with the main subject as communication, 47 were requests for information, 15 were about poor communication, 17 were feedback (6 through the NHS website see 8.2.1 and Appendix 3 for more detail), 5 were requests to forward information to services, 2 were about telephone access to services, and 1 was about sharing information/record keeping.
- Of the 34 contacts about clinical practice, 24 were about care, 5 about assessment and treatment, 2 about care planning, and 1 each about failure to prescribe, incorrect medication and poor treatment technique.
- 4 of the 11 contacts about staff attitude were about patient relationship.
- 22 of the 41 contacts about systems and procedures were about access to treatment and 6 were about discharge.

8.3 NHS website/Care Opinion

8.3.1 Feedback received through NHS website and Care Opinion is recorded as a PALS contact because it is anonymous

8.3.2 Where the service is identified, or identifiable, the comments on NHS website are shared with them so appropriate action can be taken. If it is possible to identify the service user their concerns are discussed and addressed with them. Otherwise commentators are asked to contact the PALS and complaints team so their concerns can be looked into and addressed were appropriately.

8.3.3 During Q4, 6 negative comments and 4 compliments were posted.

8.3.4 Appendix 3 provides a summary of the NHS Website / Care Opinion postings received in Q4.

9. Complaints

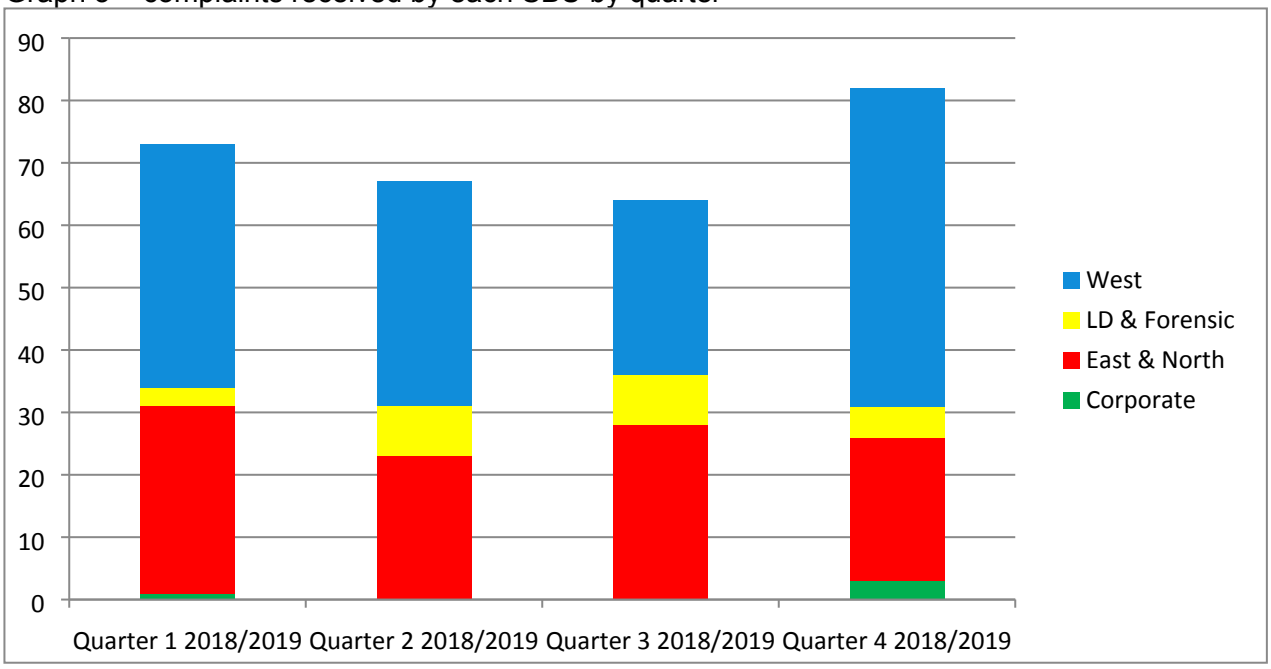
9.1 Table 4: number of complaints received for a four-quarter period, with percentage acknowledgment and response times

9.2 There was a 28% increase in the number of complaints received compared to Q3, with a decrease in the number of complaints first responded to within 25 working days.

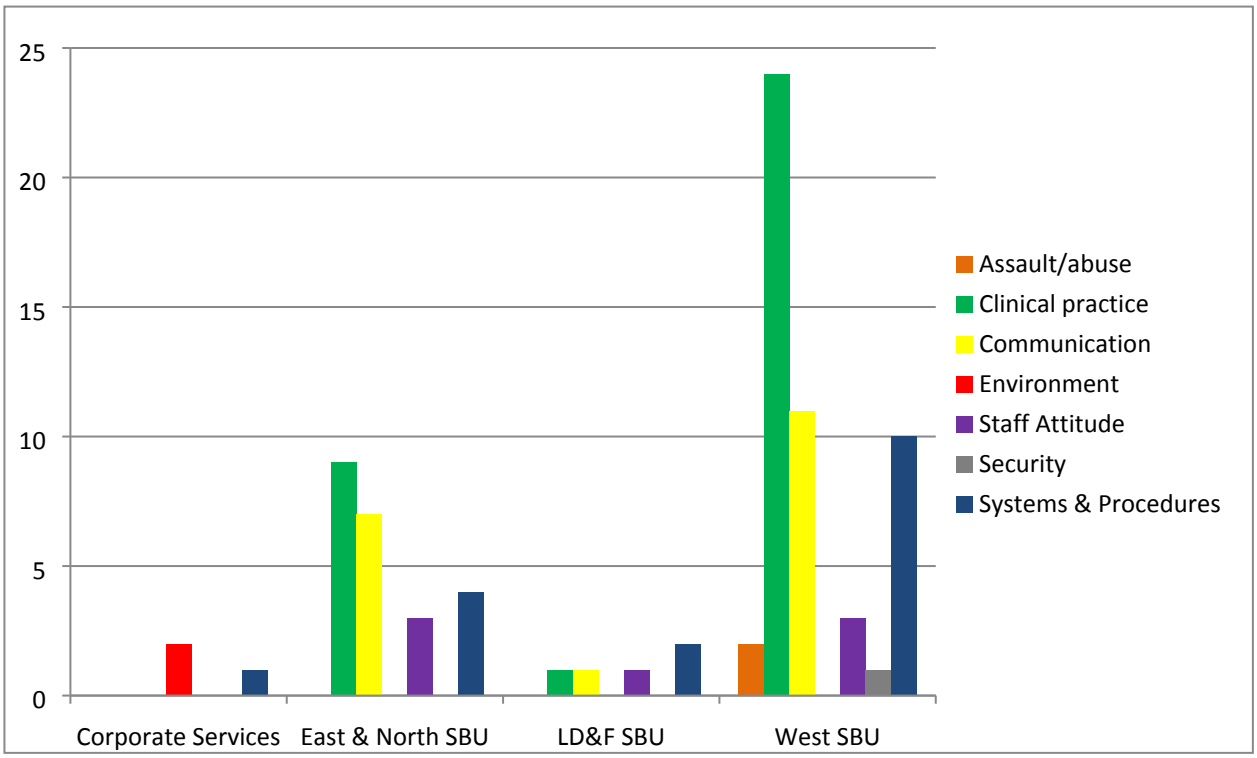
	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Total 2018/19
Complaints received	56	72	67	64	**82**	**285**
% of complaints acknowledged within 3 working days	93%	99%	97%	98%	**96%**	**98%**
% of complaints with a first response within 25 working days (90% target)	86%	72%	75%	86%	**76%**	**77%**

9.3 Graph 3: provides shows the number of complaints received by each SBU by quarter

Graph 3 – complaints received by each SBU by quarter



9.4 Graph 4: Q4 complaints by primary subject and SBU



9.5 All complaints received are immediately shared with the clinical team so appropriate actions are taken. This includes contacting the complainant to understand the issues and try and rectify them as soon as possible. Where there are system issues relating to an appointment these are dealt with and, where ever possible, appointments are made and support offered by the clinicians.

9.6 The Trust offers meetings with service users to manage their concerns raised, this approach works well, as service users can explain in depth their concerns and staff have the opportunity to discuss options and resolution.

9.7 The increased number of complaints relates to the West SBU, in particular Adult Community Services and inpatients. A deep dive into these complaints to understand any themes will be reported on in Quarter 1 of 2019/20.

9.8 Table 5: Analysis of complaints by SBU

SBU	Observations
East & North	• 23 complaints (an18% decrease in complaints compared to Q3 when there were 28 complaints) • 39% (9) of complaints relate to CAMHS • 30% (7) of complaints related to adult community mental health services (86% for East & South East and 14% North) • 30% (7) of complaints were about older peoples services (86% inpatient services) Three of these complaints were about The Stewarts which has now closed. One complaint is the subject of a Serious Incident Review – see Appendix 4. • 87% of complaints were first responded to within 25 working days. • 39% of the complaints were about clinical practice, 30% about poor communication; 17% about systems and procedures and 13% about staff attitude.

SBU	Observations
West	• 51 complaints which is an 82% increase in complaints compared to Q3 (28 complaints) • 59% of complaints related to Adult Community Mental Health Services (59% for South West and 41% for North West Community services). • 35% of complaints related to acute patient services, 11 about inpatient services and 7 about crisis services. • There was 1 complaint each for PATH, Wellbeing Services and the Community Eating Disorders Service • Of the 11 complaints about inpatient units 4 were about Swift, 1 about Robin, and 1 about Albany Lodge. 3 complaints were about Oak unit. • 69% of complaints were first responded to within 25 working days • 47% of complaints were about clinical practice, 22% about poor communication and 20% about systems and procedures.
LD & F	• 5 complaints - 3 about Essex IAPT services, 1 about forensic inpatient services (Warren Court), and 1 about Bed Management and Placement Service compared to 8 complaints the previous quarter. • 3 complaints relate to West Essex IAPT services • 100% of complaints were first responded to within 25 working days • For 2019/20 Essex IAPT and Learning Disabilities will be reported separately as Essex and IAPT Strategic Business Unit
Corporate	• There were 3 complaints about Corporate Services • 2 complaints about catering (one for Robin ward and one for Wren ward at Kingfisher Court) • 1 complaint about a suspected breach of confidentiality (not upheld) • 100% of complaints were responded to within 25 Working days.
General observations	• 49% of complaints were upheld or partly upheld (with 34% not yet responded to) • Primary subject of the majority of complaints: 41% clinical practice; 22% communication and 21% systems and procedures.

9.8 Ombudsmen requests

i. 1 file was requested by the Parliamentary and Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO) or the Ombudsmen's Joint Working Team (JWT).

ii. During Q3 PHSO returned 2 decisions – in each case the PHSO decided not to investigate the complaint and there was no further action for the Trust.

Service	Background to complaint and Ombudsman's response
Adult Community Mental Health Services C3008	A service user complained about their diagnosis and treatment. The complaint was partly upheld due to delays in ensuring concerns were passed to the complaints team. Additional psychological support was offered with senior psychologist. First received in Feb 2017 and final response July 2017. Service user remained unhappy and approached the PHSO in November 2018, The PHSO decided not to investigate as the complaint was deemed to be out of time. No further action for the Trust.
Adult Community Mental Health Services C3266	A service user complained about the Flexible Assertive Community Treatment team entering his home; being coerced into taking medication against his wishes and their detention. The complaint was not upheld as the service user was demonstrably unwell at the time.

	After reviewing the Trust records the PHSO decided not to investigate this complaint as they were satisfied that the investigation and response were appropriate. There was no further action for the Trust.

10. Continuous Improvement

10.1 When reviewing FFT, HYS, Compliments, Complaints and PALS the following development can be identified as being needed by service areas to promote continuous improvements for service users and carers.

10.2 Table 7 Improvements required

Service	Improvements needed/needing to be maintained in next quarter
Adult Community Mental Health Services	• Increase in HYS responses for north locality teams. • Amount of feedback from carers, parent, friends and family. • Communication between reception and clinicians. • Increased awareness and use of ipad by staff to encourage feedback
Inpatient services	• A copy of the minutes from mutual help meetings must be sent to the service experience team for recording.
SPA	• Increase in feedback required.
CATT	• Timeliness of appointments – communicaton with service users.
CAMHS Inpatient	• Young people need to be encouraged to give feedback.
Older peoples' services	• Action posters need to be completed for every team.
Learning Disability Services	• Increase in feedback required
Inpatient services	• Ensuring the quality of meals in of an appropriate standard and service users' individual needs are met.

11. Performance summary and conclusion

- 1,546 pieces of feedback were received in Q4, a 2% increase compared to Q3.
- Our Friends and Family Test score remains unchanged and in the upper range for comparative trusts at 88%.
- There was a 28% increase in complaints, a 14% increase in PALS contacts and a 19% increase in compliments being forwarded by the services for recording.
- The PALS & Complaints team continues to encourage investigators to communicate effectively with complainants during the investigation to ensure all issues are identified and addressed and to improve the quality of the response. Teams are asked to manage immediate actions to ensure the service user receives the best outcome in a timely manner.
- The PALS & Complaints team contribute a module to the new Management Fundamentals programme being run by the Trust for aspiring and new managers.
- Figures for the Essex & IAPT Strategic Business Unit will be reported separately from Q1 2019/20.

Appendix 1 - Quantities of feedback

	Q4 2017-18	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	
Service User Feedback Surveys completed	1424	1594	1312	1124	1142	↑
Carer Feedback Surveys completed	350	345	328	391	404	↑
Compliments	389	442	376	342	408	↑
Complaints	56	72	67	64	82	↑
PALS contacts	228	240	212	196	224	↑

Appendix 2 – Board Stories Outcomes

Date	Story	Outcomes/Issues
7-2-19	Older Peoples' Services Colne House	• Some of the paperwork (CBT) felt like it was "for dummies". • Vital for support workers to know their clients "don't talk about irrelevant things, things I'm not interested in".
14-2-19	CAMHS Eating Disorder Service	• Board agreed that waiting times are not good enough and they would work hard to ensure adequate levels of treatment are available at the right time. • Can feel like entry is based on weight rather than wait which can lead to the ED progressing. • Trail blazer project in schools was discussed.
7-3-19	Parent carer of son receiving LD Community services.	• Medication – not understanding why a particular med was prescribed, felt was more about controlling behaviour than what was best for her son. • Training for the care provider through PPT has been a very welcome service. • Should the Carer Council include more carers of people with LD, or should there be an alternative council? • Agreement to look at introducing a welcome pack for LD services – to include more information for carers including practical help.

Appendix 3 Summary of comments made through NHS website / Care Opinion

Service Area	Summary of comments made through NHS Choices / Care Opinion
Unknown service	Negative Comments: Difficulty in contacting services during working hours, too many poorly trained staff visiting instead of Psychiatrists. Flawed working system for service users, lack of support in crisis.
Unknown service	Negative comments: Problems accessing a service, unprofessional and uncaring, no compassion displayed at all.
Adult Community Services	Negative Comments: Long wait for initial appointment, calls not returned, letters not answered, receptionist was rude and disrespectful.
Mental Health Helpline	Staff patronising and lacking compassion.
Essex IAPT	Negative comments: Phone calls not answered, offered computer based Cognitive Behavioural Therapy when aware the service user did not like using their computer.
Essex IAPT	Negative comments: Poor service provided to a friend in distress. Long wait for own treatment, lack of flexibility around appointments. Appointment delayed then location changed. Room was unwelcoming. Worker was a trainee and lacked the necessary experience to help the service user.
Essex IAPT	Positive comments: Service user suffered from Agoraphobia and social anxiety. They found they were first helped over the phone then through home visits. “all I can say was that I couldn't of asked for anything more as my therapist was always available and gave me the information and help I needed to help me with my condition would definitely recommend to anyone who was in the same situation as me.”
Essex IAPT	Positive comments: Following self-referral for a combination of symptoms including anxiety and depression, the service user felt safe and listened to, their problems were acknowledged and respected. The therapist was flexible with times and locations of appointments and signposted them to helpful resources. They felt they could trust their therapist and personalised the therapy. “I believe that this is an essential service and that it is free to everyone is absolutely amazing. Thank you so much.”
Essex IAPT	Positive comments: The service carried out a home assessment, the therapist was kind, knowledgeable and managed to put the service user at ease. The therapist allocated to carry out CBT was kind, gentle and soon gained the trust of the service user. “Our therapist has managed to get my child’s life back and given them the tools to manage situations in the future. I have the utmost respect and admiration for the Healthy Minds team and to be honest I'm not sure where we would be without them.”

Appendix 4

Moderate* graded complaints - there were no high graded complaints during the quarter

Table 10: Summary of Moderate* Risk complaints for Q4 2018/19

Service	Description	Outcome
Moderate		
C3474 Older people's inpatients	A service user complained about discharge meeting transferring his care to CATT.	**Under investigation** Meeting during Q1 2019-20. May be re-graded when investigation is completed .
C3494 Older people's inpatients	The family of a service user complained about the care their mother received from Seward Lodge and Lister A&E, leading to her suffering a stroke.	**Subject to Serious Incident investigation after consideration by the moderate harm panel.**
C3522 Acute inpatients	A service user's daughter complained that her mother was pushed while on the ward resulting in being taken to Watford General Hospital with a broken hip.	**Subject to Serious Incident investigation**
C3534 Crisis services	A service user complained about their discharge meeting transferring his care to CATT.	**Under investigation** Meeting during Q1 2019-20. May be re-graded when investigation is completed .

*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.

Mary Stephenson
Complaints and Service Experience Manager

May 2019

Hertfordshire Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	6 June 2019	**Agenda Item:** 14
Subject:	Report from Finance & Investment Committee – 21 May 2019	**For Publication: Yes**
Author:	Keith Loveman Executive Director - Finance	**Approved by:**
Presented by:	Simon Barter, NED Chair - FIC	Keith Loveman Executive Director - Finance

Purpose of the report:

This paper provides a summary report of the items discussed at the Finance & Investment Committee meeting on 21 May 2019.

Action required:

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

Summary and recommendations to the Board:

The Agenda for the 21 May Finance & Investment Committee was structured under three areas of focus and the meeting covered:

- Deep Dive – Managing Operational Performance Pressures – Key Workstreams

Strategic

- Business Development
  - (a) New Care Models
  - (b) Commercial Development Activity Other
- Strategic Investment Programme
  - Bed provision E&N Herts – draft programme
- 2019/20 Capital Plan & Progress Report
- STP Estates Strategy

Operational 2019/20

- Performance Report – Period to end April 2019
- Financial Summary – Period to end April 2019
- Delivering Value Programme

2018/19 Closure

- 2018/19 Final Accounts
- 2018/19 Capital Expenditure Summary

- FIC Business Programme 2019

The performance report was moved to the start of the meeting to better inform the deep dive.

Performance Report – Period to end April 2019

The Director of Innovation and Transformation presented the performance report for April. Overall there were ongoing high levels of referrals into SPA representing increasing demand across March and April. The focus is very much on looking at new ways of working to address demand issues and teams were starting to utilise the CQI approach which had already seen some impact and improvement in EMDASS access times through making small changes to the service model. Positive improvements are also being seen for areas where SPIKE enables real-time reporting e.g. accommodation status.

FIC discussed a number of areas in detail and noted that it remained important to look at inter related factors and not individual metrics and the role of CQI in supporting this approach.

Deep Dive – STP Planning
The Director of Service Delivery & Service User Experience delivered a presentation covering the key performance pressures associated with access and waiting time for referral to assessment and the work being undertaken to address these. Whilst this focussed on adult community, CAMH community and EMDASS access separately, the analysis set out common themes associated with:

- use of data
- forward planning
- variation across localities
- ability to flex systems
- continuity of clinical leadership

The Committee discussed the current detail and issues for each area and the approach being taken supported by CQI methodology to deliver services differently. It was noted that whilst we are performing below target against 28 day access measures, we continue to benchmark strongly against national metrics. The Committee reinforced the need to focus on what the position for our service users is and the experience we would wish to deliver.

The Committee were advised on the key workstreams, progress and timelines for recovery of the position, but noted that full achievement of targets would need external partners to also work closely with the Trust on system wide solutions. FIC raise a number of questions and discussed the position and approach in significant detail and asked for the issue to remain one of focus in terms of performance reporting with a further detailed update in six months to evaluate progress.

Business Development

a) **New Models of Care**
FIC received an update on the development of New Care Models (NCM) at regional and sub-regional level. Through the collaborative approach the direction of travel has been agreed in principle with a more detailed MoU being developed. The Director of Strategy & Integration set out the three phases of work and the need to seek approval to continue at each stage. There is a significant amount of work to be undertaken to understand any associated risks but until more detailed financial and activity data is available the necessary due diligence cannot be sufficiently progressed.

FIC discussed at length the importance of governance and appropriate time to discuss fully the developing but complex arrangements for improved integrated working and noted that reinstating the 'Strategy Group' would be important to inform the Board's decisions.

b) **New Commercial Development Activity**
FIC received an update on other commercial activity taking place with particular areas for attention that will need to come back to the Committee for approval as appropriate:
- Community Adult MH Transformation, where expressions of interest for collaborative pilots had been requested by NHSE and following this the Trust had been asked to develop a full bid by 20 June (c.£4-5m). Discussions were progressing with CPFT.
- Community Forensic services which will form part of the NCM collaborative work

Strategic Investment Programme
FIC considered the report from the Director of Finance in relation to progressing significant elements of the forward investment programme. It was noted that the Digital Strategy and Estates Strategy were well developed and would come to the Committee for review. However, due to changes in contract arrangements in west Herts it was recognised that the integrated approach with HCT would need to be reviewed in terms of the approach to estates delivery.

- **Bed Re-provision E&N Herts**

FIC had previously received an update confirming the strategy for reprovision of adult acute beds for

East and North Hertfordshire and had approved a budget of £150k to support the initial work in developing plans. The Director of Finance set out for the Committee the work that had commenced and the process and timeline for development of each stage of the business case. The Committee also discussed the approvals process and considered the role of NHSI and potentially DH, given the significance of the potential investment. Overall the provisional timeline was ambitious indicating completion by June 2023 and the Committee noted the key risks that had been identified to date as the site for any provision, any necessary planning permission and any changes to the financial regime for Foundation Trusts. FIC noted that the intention is to develop the draft SOC for review at the July meeting.

2019/20 Capital Plan
The Director of Finance reported that there were no significant changes to the capital programme for the year since the previous meeting. However, the Committee discussed the recognised shortage in availability of capital to the NHS more generally and the request that all organisations review plans to see if any non-essential work could be delayed. FIC supported the view that the plan agreed by the Board in April was robust and that all elements were essential for quality and safety and that no downward revision of planned expenditure was appropriate. The Committee also approved the proposal to add the additional £1.8m PSF received as a 'bonus' to the capital plan for future expenditure.

FIC reviewed the plan and asked that further consideration be given to the potential for a fuller refurbishment of Forest House and that it be also considered within any potential options for bed reprovision.

The Director of Finance reported progress against the plan and the Committee discussed in particular the use of additional space at The Colonnades.

STP Estates Strategy
FIC received the STP Estates Strategy and the Director of Finance talked to the key elements. Much of the current strategy focusses on the need for significant reprovision at Watford General and PAH, but also that success of STP sustainability plans will require activity shift from acute sites and that the Trust will need to play a full part in supporting this direction of travel. Diane Brent provides the estates expertise into the STP group and ensures that the requirements of MH/LD are properly recognised and an integrated approach taken forward. The Committee also heard that potentially the capital regime for FTs may change and that the STP may become the only route to access capital funding beyond internally generated resources in the future.

Financial Summary – Period to end April 2019
The Deputy Director of Finance updated the Committee on the current financial position and the key highlights and risks. FIC noted that the April financial position was on plan but that overall the position remains one of caution. In particular:

- There is significant pressure on beds and placements which is temporarily offset by positive pay variances
- The Delivering Value (CRES) programme has not yet fully identified required savings for the year
- Whilst CQUIN is a lower % for 2019/20, the schemes for delivery are significantly stretching

The Committee discussed the bed pressures at length, how this reflected the picture seen nationally and the work to manage these and maintain safety for service users. The Deputy Director of Finance also described the weekly tracker of key cost drivers and that this had brought the necessary focus to the key aspects of overspend with timely dialogue and actions being taken.

FIC has previously reviewed the work around placements in significant detail and requested that this now come back for a progress update and to understand more fully the longer term social care savings requirements and plans to address this.

Delivering Value Programme

The Deputy Director of Finance set out the key elements of the work programme for 2019/20 against the target savings requirement of £6.5m. It was recognised that this is a significant stretch in any one year and given the level of savings delivered over a number of years. Progress had not been to the extent required; but it was recognised that the focus required for the CQC inspection had impacted this. A nine point approach picking out areas of best practice nationally has been adopted within a comprehensive framework and this is helping managers to think about specific workstreams rather than the total requirement which can feel daunting. The Committee again reflected that the CQI approach is very important in supporting staff to think differently.

Progress will continue to be reported to FIC as routine.

2018/19 Final Accounts
FIC received a presentation setting out the position in terms of the final accounts for 2018/19. The financial position was heavily supported in Q1 which has enabled the Trust to sustain improvement from Q2 onwards. FIC noted the significant achievement across key financial targets including:

- Control total met
- Agency expenditure cap undershot
- Delivering Value Programme (formerly CRES) exceeded expectations.

However, it was noted that the CQUIN target was not fully met.

The financial audit had been very positive and FIC were advised by the Deputy Director of Finance that a clean opinion was expected with no material issues arising. This was a significant achievement and alongside the 'outstanding' rating from CQC this proved that high quality services and a positive financial performance can be delivered together.

The Committee reflected that this was a tremendous achievement given the pressure on services and thanked Paul Ronald and the finance team for their hard work.

Capital Expenditure Final Report 2018/19
The Director of Finance summarised the capital expenditure for the year and noted that whilst this had been lower than in previous year, there were some key elements delivered which would provide a significant positive impact for services moving forwards. The areas highlighted were:

- Forest House Place of Safety
- IM&T investment (equipment for staff and SPIKE II)
- Fire Safety work
- Environment improvements associated with PLACE

It was noted that the CQC had been impressed with the responsiveness of the Estates & Facilities service.

FIC Business Programme 2019
The FIC Business programme was reviewed and forward items agreed.

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

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

Summary of Implications for:

1 Finance
2 IT
3 Staffing
4 NHS Constitution
5 Carbon Footprint
6 Legal

Hertfordshire

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

Hertfordshire Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	6th June 2019	**Agenda Item: 15**
Subject:	Financial Summary for April 2019	**For Publication:** No
Author:	Sam Garrett, Head of Financial Planning & Reporting	**Approved by:** Paul Ronald, Deputy Director of Finance
Presented by:	Paul Ronald, Deputy Director of Finance	

Purpose of the report:

To inform the Committee 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 Committee:

For the month of April 2019 the reported position was a surplus of £105k, ahead of the Control Total of £102k surplus by £3k. All figures are reported before any income from the Provider Sustainability Fund (PSF), which is expected to be £94k for the month and £1887k for the full year, reflecting the achievement of the Control Total. The NHSI Use of Resources (UOR) Rating reports as an overall 1.

UOR	1	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000	Full Year Plan £000	Trend
Overall Surplus (Deficit)		102	105	102	105	0	⟷
Pay Overall		13,931	13,460	13,931	13,460	163,133	⟷
Agency		483	459	483	459	5,800	⟷
Secondary Commissioning		2,652	2,737	2,652	2,737	31,528	⟷

This position whilst favourable is driven in part by vacancies for service expansion in month, which has offset the increase spend on external beds in the month.

Key figures for the month are summarised below:

1. Total Pay is reported below Plan for the month. This reflects overall the level of vacancies, both existing uncovered vacancies, and those for new service developments. Substantive pay is below Plan and Bank is above Plan. Agency at £459k is below the Trust Plan of £483k per month (£5.8m per year) by £24k

and represents just 3.4% of the overall pay spend the lowest level for several years and well within the NHSI Ceiling.

2. Secondary commissioning is reported at £2.7m in the month above Plan by £85k, despite the Plan having increased in the New Year. Most areas were broadly similar to month 12 with both Social Care and Main Health Placements having reduced by £49k and £27k respectively, and Acute and PICU having increased by £44k due to additional beds at Cygnet Hospital. CAMHS did increase but was in line with February, March having been much lower due to a prior month adjustment.
3. Income is reported as worse than Plan by £286k however this is largely (£223k) due to deferred income which although planned has not been released into the position as the matching pay expenditure has yet to be incurred. £63k is due to block contracts mainly £19k for reduced activity on NHSE and £50k for Herts CQUIN which is projecting as 70% currently against a budgeted 90%.
4. Overhead costs are reported as £175k above Plan comprising a number of smaller variances with the largest being Site Costs at £81k, a number of New Year invoices particularly utilities are higher than plan and are being reviewed with the Estates Team. Project costs across a number of categories within Overheads total £138k for the month relating in the main to improvement of environments.

Although this is overall a positive position and the Control Total has been achieved, the following risks should be noted going into the new financial year:

a) Pay cost underspend will significantly reduce as new services are recruited to of which part will be matched by income. This could also increase agency costs if recruitment proves problematic.
b) Secondary commissioning continues to overspend and although some planned reductions have been successful (notably CAMHs) others have been less so. Main Health Placements has reduced, but New Sovereign House has been delayed so it is likely numbers will remain static for now.
c) There is a shortfall on the Delivering value Program currently estimated at circa £2m for the full year.

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

Effective use of resources, in particular the organisation's continuing financial requirements.

Summary of Implications for:

Finance – achievement of the 2018/19 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 2019/20

1.1 The Control Total for last year was met with a strong turnaround in financial performance in the second half of the year. Whilst this provides a good entry position into the new year we see that 19/20 will be a very challenging year in particular due to ;

1.1.1 We continue to see a growth in referral numbers whilst operating with a fixed revenue budget.

1.1.2 the pressures around pay costs with the second year of the new agenda for change Pay scales;

1.1.3 The level of non-pay inflation in areas such as third part bed provision and within estate costs.

1.1.4 There have been a number of structural changes to the NHS financial systems which have been focussed on reducing the large acute sector deficits.

1.2 The Plan is summarised in Fig. 1a below:

Fig. 1a Plan	2017/18 Plan	2017/18 Actual	2018/19 Plan	2019/20 Plan
Income	221.7	225.6	229.8	252.0
Pay	147.8	147.1	149.8	163.4
Other Direct Costs	28.2	32.2	33.9	43.7
Overheads	35.6	34.8	36.7	35.4
EBITDA	**10.1**	**11.5**	**9.4**	**9.5**
EBITDA Margin	4.60%	5.10%	4.10%	4.46%
Financing	9.3	8.1	9.0	9.5
Surplus	**0.8**	**3.4**	**0.4**	**0**

* This is before any amounts due under the Provider Sustainability Fund

2. Summary and Risk Rating

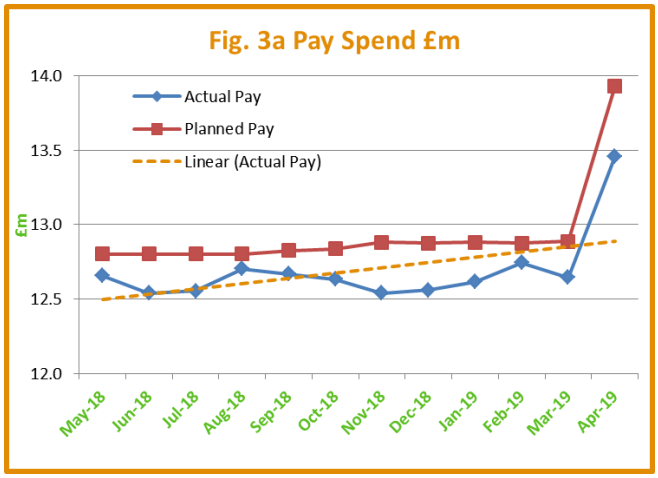
2.1 The Trust's Use of Resources (UOR) Framework rating for the month is a 1. The Trust surplus position is slightly ahead of Plan and agency spend continues to be under the NHSI Ceiling. The detailed calculation of the UOR is shown in the appendices, with the main in month movements highlighted in Fig. 2a below:

Metric	Rating	Reported Rating	Commentary
Capital Servicing Capacity	1.9	1	Rating of 1 expected until month 6 when the term loan repayment is made resulting in a rating of 2
Liquidity	1.1	1	Strong cash position of £56m supporting liquidity metric.
I&E Margin	2.4	2	Surplus for month 1 slightly ahead of plan but not enough for a rating of 1
I&E Variance	1.9	1	Surplus for month 1 slightly ahead of plan
Agency Spend	1.8	1	Agency spend well under agency cap
UOR Overall		1	

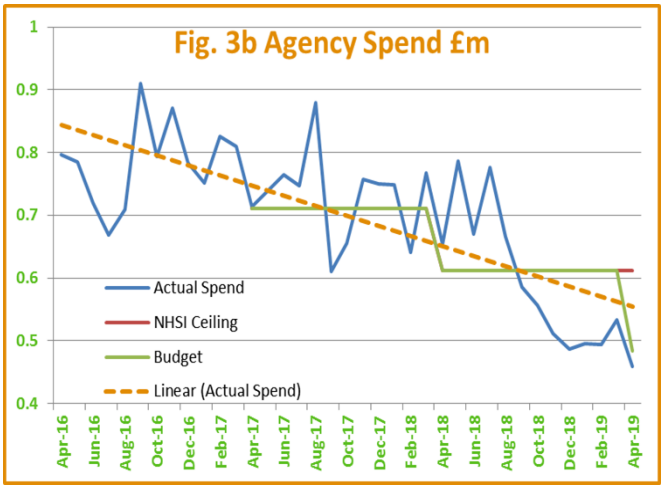
Green = 1, Yellow = 2, Amber = 3, Red = 4

2.2 For the month of April the reported position was a surplus of £102k, ahead of the Control Total of £102k surplus by £3k. All figures are reported before any income from the Provider Sustainability Fund (PSF, expected £94k for the month).

3. *Trading Position*



3.1 Pay costs totalled £13.5m for the month as shown for a rolling 12 month period in Fig. 3a. There was a significant increase in April in part due to main uplift to the Agenda for Change pay award, and also due to a one-off non-consolidated payment of 1.1% made only to staff at the top of their band, which equated to £421k in April. Substantive pay spend was 86% of the total pay for the year and Bank pay was 10%.



3.2 Agency spend was £459k for the month against the internal Trust Plan of £483k per month (£5.8m per year), 3.5% of the overall pay spend, and a small increase on previous months. This also achieves the NHSI Ceiling which remains at £7.3m for the year. Fig. 3b shows a linear reduction (dotted orange line) over the last several years, from average £785k / month 16/17, to average £601k / month 18/19, and below £500k for month 1 19/20.

3.3 Each SBU has agreed to a set control total based on last year's spend and has been tasked with drawing up detailed trajectories to deliver against this commitment, which will support the Trust's Delivering Value programme. Success will be dependent upon continued focus on recruitment and retention of key staff, particularly in inpatient, CAMHs Medical, and Care Co-ordinators within Adult Community and CAMHs teams. The use of Safecare and more efficient use of Health Roster need to be embedded further in respect of inpatient agency use.

3.4 Year to date performance is illustrated in Fig. 3c below:

Fig. 3c Performance against Trust Ceiling by SBU	Actual Full Year 2018/19	Full Year Trust ceiling	Year to Date Trust ceiling	Year to Date Actual Spend (as at Month 1)	Year to Date Variance (+adv./-fav)
	£000	£000	£000	£000	£000
E&N SBU	3,146	2,837	236	229	-7
LD&F SBU	551	424	35	27	-9
Essex & IAPT SBU	272	213	18	6	-11
West SBU	2,520	2,100	221	180	-41
Support Services	746	227	19	16	-2
Capital & YE accounting	-346			-0	-0
Total	**6,889**	**5,801**	**529**	**459**	**-70**

Performance against NHSI Ceiling	Actual Full Year 2018/19	Full Year NHSI ceiling	Year to Date Trust ceiling	Year to Date Actual Spend (as at Month 530.14778)	Year to Date Variance (+adv./-fav)
Trust total	6,889	7,327	611	459	-151

3.5 Secondary Commissioning reports at £2.7m, above Plan by £85k for the month, after the release of £100k non-recurring support in respect of beds at Cygnet Hospital, as planned. Most areas were broadly similar to month 12, with both Social Care and Main Health Placements reducing (by £49k and £27k respectively) though some of this relates to there being one fewer day in the month.

3.6 This remains therefore an area of significant focus going forward, highlighted in several places in the weekly Financial Health Check circulated to the Executive and other key staff. Actions in place include:

3.6.1 Regular review of External Acute and PICU placements and of observation levels. Significant work being undertaken to review internal inpatient beds to release capacity back to those currently placed externally. Operational, placement, and finance staff to meet in the next few weeks to look at next steps.

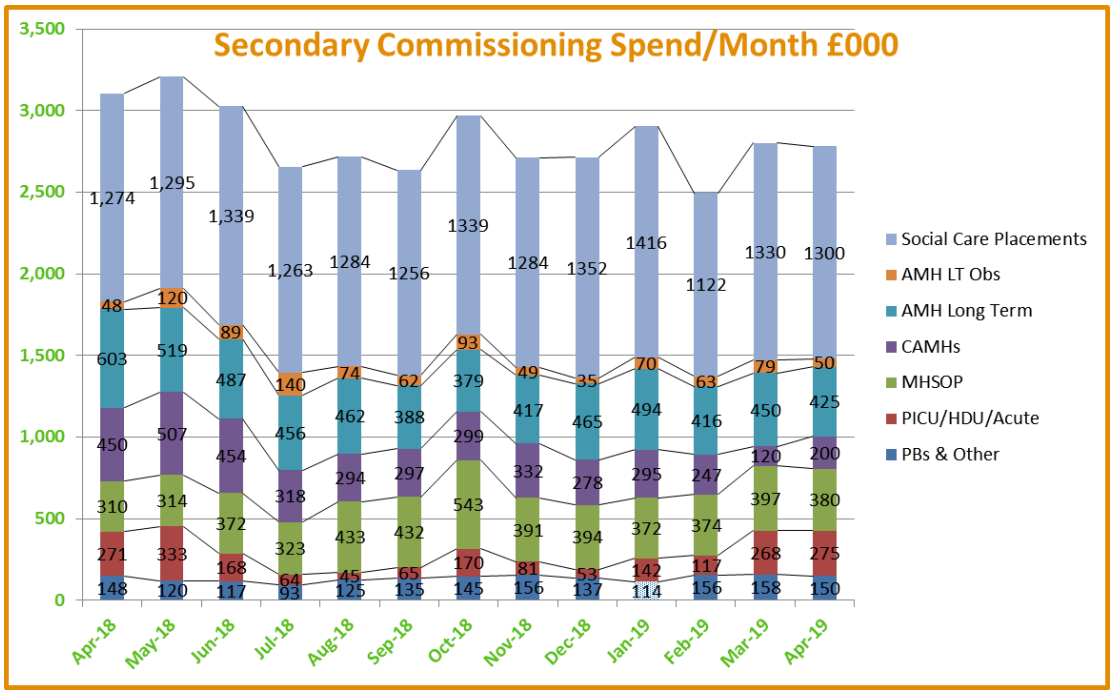
3.6.2 Social care transformation project to address social care spend on both placements and personal budgets in the medium to long term.

3.6.3 Some further reductions expected on Health Placements as the result of New Sovereign House opening but this has been delayed from May to September due to legal issues.

3.6.4 Discharge to Assess Pilot starting in May funded directly by commissioners, which should relieve pressure to place in Social Care Placements direct from acute beds.

3.6.5 The final person with a Korsakoffs diagnosis needing transfer to Hertfordshire County Council for social care has moved week ending 17th May at a cost saving to the Trust.

Fig. 3e below shows the position by type:



3.7 Overhead costs are reported as £175k above Plan comprising a number of small variances including Travel, with the largest being Site Costs at £81k, a number of New Year invoices particularly Utilities are higher than had been anticipated. These are being queries with authorisers. Project costs across a number of categories within Overheads total £138k for the month relating in the main to improving environments and services across the Trust.

4. *Risks and Mitigating Actions*

4.1 The full Statement of Comprehensive Income (SOCI) is set out in the appendices, giving the detailed position and comparison to Plan for the full year. Whilst this sets out a positive picture overall, it should be noted that there are risks which may not be immediately evident:

4.1.1 The pay cost underspend will significantly reduce as new services are recruited to, and this could also increase agency costs if recruitment proves problematic. Key areas also remain difficult to recruit particularly CAMHs and Medical.

4.1.2 Secondary commissioning continues to overspend and although some planned reductions have been successful (notably CAMHs) others have been less so. The delay in New Sovereign House opening due to legal issues has an adverse impact on Main Health Placements which are likely to remain static for now.

4.1.3 CQUIN particularly for Hertfordshire is an emerging risk, currently projected as 64% against 18/19 achievement of c. 80% and budgeted at 90%.

5. Income and Major Contracts

5.1 Total income planned for the year is £252.0m, before PSF, including £235.9m from Main Commissioners, of which £182.5m is in respect of Hertfordshire. For April there was an adverse variance of £63k on Block Income and of £223k on Other Income, the latter due in the main to planned deferred income not yet being released to cover services that have yet to start.

5.2 CQUIN income is included in the position at 100% for all contracts except Hertfordshire. NHS England is projected at 96% so it is expected this difference can be made up; Quarter 4 2018/19 has just been agreed at 100%. For the other non-Hertfordshire contracts 100% seems realistic at this time.

5.3 For Hertfordshire, the current projection is included at 70%, a difference of c. £40k, with plans being put in place to address this.

5.4 NHS England income for Specialist Services has been reducing and there is an adverse variance of £19k in respect of activity for month 1.

6. Delivering Value

6.1 The current estimate of the Delivering Value Programme requirement for 2019/20 is c. £6.5m.

6.2 A list of developed schemes plans in progress, and opportunities for efficiency has been drawn up which identifies potential savings totalling between £3.1 and £5.1m. A separate paper will be reported to the Finance and Investment Committee.

7.

Fig. 6a Indicative programme value range RAG rated	Worst case £000s	Best case £000s	Average £000s
Green	510	510	510
Green/ Amber	1,356	1,375	1,364
Amber	1,047	2,396	1,722
Red	226	854	540
Programme value range RAG rated total	**3,139**	**5,132**	**4,136**

8. Statement of Financial Position, Cash Flow and Treasury Management

8.1 The full Statement of Financial Position is set out in the appendices.

8.2 Receivables increased by £3.0m in the month, predominately related to accrued income to be raised in Month 2. Payables and Accruals increased by £1.5m in the month.

8.3 The Statement of Cash Flows is set out in the appendices and shows that cash balances have decreased by £1.6m in the month. The main movements in month are:

8.3.1 Cash outflow from operating activities £1.4m

8.3.2 Cash outflow from investing activities £200k

9. Forecast for Full Year

8.1 It is too early to provide an updated assessment on the likely full year position and updates will be provided from June onwards. At this point the key risks are; the additional cost on external beds, areas of non-pay inflation and the shortfall on this year's Delivering Value program

Hertfordshire Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	Trust Board	**Agenda Item:** 16
Subject:	Trust Risk Register May 2019	**For Publication:** Yes/No
Author:	Nick Egginton, Compliance and Risk Manager	**Approved by:** Dr Jane Padmore, Director of Quality and Safety (Chief Nurse)
Presented by:	Dr Jane Padmore, Director of Quality and Safety (Chief Nurse)	

Purpose of the report:

Approve: To formally agree the report and its recommendations and updates in relation to the current Trust Risk Register (TRR)

Action required:

The Trust Board is asked to review the Trust Risk Register

- Approve the recommended changes

Summary and recommendations:

This report gives an update on the Trust's Risk Register. It recommends changes to grading, consideration of new risks and sets out the updates in relation to the mitigations.
There are currently 11 risks on the Trust Risk Register.
IGC have increased 1 risk score

- Data Protection: Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident (Risk 920)

IGC have downgraded 1 risk:

- Quality and Safety: The Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff (Risk 978)

The following risks are being formulated and will be considered for the Trust risk register

- Impact of the failure of HCT to retain Adult Community Services in Herts Valley
- Capacity, Demand and Access

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/AuditIGC 22.05.2019

Trust Risk Register May 2019

1. Introduction / Background

1.1. The purpose of this report is to present the Trust Risk Register (TRR) to the Trust Board for discussion. Consideration should be given to the proposed changes and mitigations that have been put in place.

1.2. The TRR identifies the high level risks facing the organisation and summarises the mitigating actions being taken to control and minimise them. There are 11 risks currently on the Trust Risk Register.

1.3. The updates to individual risks are summarised and then the TRR is set out in full with details of the controls, the early indicators and comments on the current position as well as the initial and current scores.

1.4. Each Director has reviewed the risks that they are Senior Responsible Officer for. In addition the Executive Team met to peer review the TRR as a whole, along with the scoring.

2. Risks to be considered for escalation to the Trust Risk Register

2.1 The following risks have been identified and are being formulated. They will be considered for the Trust risk register.

2.2 **Impact of the failure of HCT to retain Adult Community Services in Herts Valley**

Central London Community Health (CLCH) has been awarded the contract for Adult Community Services with the incumbent provider Hertfordshire Community Trust (HCT) failing to retain the contract. The contractual arrangements will commence with the new provider on the 1st October 2019; the initial impact will be half year in 2019/2010 and full year thereafter. The Trust has a number of shared services with HCT, including HBLICT, Interserve and Estates which will be impacted.

2.3 **Capacity, Demand and Access**

The Trust risk register includes risks for CAMHS and Adult Community services and within theses the ability of service users to access these services. The Exec are considering whether a more specific risk around access, capacity and demand across the Trust is required to specifically outline the risk and the mitigating actions in place.

Overall, there was a slight uplift in access performance as measured by the Key Performance Indicators (KPI's) met. Q4 KPI metrics suggest that the quarter was the 4th highest performing quarter of the last 16 quarters (4 years) however, this positive news is balanced against deepening performance dips in Q4 for important access metrics for the Child and Adolescent Mental Health Services (CAMHS), Early Memory Diagnosis And Support Service (EMDASS), and Adult Community Services, where we underperformed against our KPIs:

- The adult community 28 day wait was at 84.78% for Q4, a decrease of 2.46% on the Q3 figure of 87.24% and 155 people short of the 98% target. The target has now been amended as part of the Hertfordshire contract renewal and will be 95% from April 2019, with the expectation of progressive improvement towards this over 18/19 and achievement by March 2020.
- CAMHS Performance decreased significantly in Q4 to 34.07% - a drop of 46.4% from the Q3 figure. As part of the Herts contract renewal, pressure on the system has been acknowledged and whilst the target remains at 95% there is commitment that continued

- progression toward the sustainable access of CAMH services within HPFT Tier 3 will require a system wide approach to redesigning the CAMHS pathway. CAMHS CQI has been initiated to review and re-configure the assessment process to balance HPFT demand and capacity ahead of system-wide review to strengthen Step 2 services.
- EMDASS diagnosis within 12 weeks fell slightly to 49.15% in Q4 from the Q3 level of 50.55% against a target is 80 %. The service is taking a Continuous Quality Improvement approach to performance and there is now evidence that the backlog is starting to reduce as a greater number of appointments are offered. Weekly hotspot reports are being sent to commissioners to update on progress. Contractually there is an expectation that the 80% target will be met by Q3 19/20.

3. Risk downgraded from Trust Risk Register

3.1 There is 1 risk which has been downgraded by IGC.

3.2 **Quality and Safety: The Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff (Risk 978)**

This risk was formulated based on a number of concerns brought together which could impact the Trusts ability to deliver consistent and safe care across its services. A number of these concerns have been mitigated against:

- Weekly ligature assessment and annual audit programme is in place. The ligature policy has been updated and these weekly assessments are being rolled out to community services. They are now consistently being used in services.
- We have implemented a number of actions and strengthened the oversight regarding the use of restrictive interventions – including seclusion, to focus on using the least restrictive practice in our service areas. Moving forwards these will be incorporated in to our co-produced MOSS 2gether strategy, which we are currently being consulted on.
- Seclusion & Safe Space Programme. Current facilities have been identified as requiring upgrade and improvement to support least restrictive operational practice and with a vision of “best in Class” high quality environments for service users. Significant work has been completed to work up designs with staff and service users and further work is now required to progress both planning and permissions FIC agreed an initial budget of £200K to support this work, requiring an update at each stage of the process.
- Discovery is now in place recording supervision numbers. The next stage is to utilise Discovery to record the content of supervision to support the quality of supervision and to be able to report compliance percentages centrally. However, supervision compliance and monitoring was identified as a ‘must do’ action for Older People Inpatient Services under effectiveness, rather than Safety.

A safety risk register sits below the Trust risk register and it was agreed that individual risks that remain in relation to safety are detailed and monitored through this register and is reported through the safety committee to QRMC and included in the quarterly integrated safety report.

4. Risk scores to be considered for increasing

4.1 There is 1 risk which has increased in its risk score.

4.2 **Data Protection: Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident (Risk 920)**

- YTD 2018/19 the Trust has received 481 reports of possible data incidents via Datix. 15 incidents had been reported to the Information Commissioners Office (ICO) since 1st April

2018, 11 were returned with no action required. The outstanding four incidents are awaiting a decision by the commissioner.

- There has been a recent incident identified via internal audit whereby some HR staff had super-user access to ESR when they should not have done. Initial review is that they had been granted access for a specific project and it should have been closed down, but was not. Under the data protection act the Trust is obliged to keep personal data secure including that of its staff, this case unlikely to be reportable to the ICO unless records were accessed inappropriately, however it will need to be investigated internally.

The following actions have already been taken:

- The revoking of access to ESR for the L & D members of staff
- A review of ESR processes to access and revoke (forms in place for completion by line managers) forms have been completed for staff who have access in the last 12 months.
- An email has been sent out to Heads of service to let them of the process required to be followed in order to access ESR and to revoke access
- A review of all staff who have access to ESR the first of these reviews took place on 29 April 2019 via an email sent to all line managers whose staff have access to ESR requesting them to review this access and to let us know if it still required.
- A review of national ESR guidance to ensure that we are working to national ESR systems and levels of access.

In light of the reporting threshold to the ICO changing and the increased consequence of reporting more data breaches to the ICO this risk has increased in consequence to Major (4).

5. Risk score to be considered for decreasing

5.1 There are no risk scores being considered for decreasing

6. Risk Updates

6.1 **Workforce: The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff (Risk 215)**

- April 2019 vacancy rate is 12.68%
- In Q4 there was a net gain of 17 staff with 140 new starters and 123 leavers.
- The Time to Hire (T2H) was 45.1 days in March, down 4.3 days from February (Target 35 days)
- Focused recruitment campaigns are currently being planned for PATH and CAMHS, this includes using targeted social media adverts as well as strategically placed train adverts to generate interest from passive candidates and local qualified nurses commuting in to London. Similar campaigns will also take place in other hot spot areas, with a meeting scheduled to plan a campaign for Norfolk
- Recruitment initiatives - Attraction plan is being developed and the marketing of Recruitment Open Days together with times, dates and venues is being reviewed.
- Further risks have been highlighted for the psychiatry workforce and these will be added to the register.

6.2 **Workforce: The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services (Risk 657)**

- Turnover is higher than target, with 42% of our leavers going with less than 2 years' service and 10% with less than 6 months.
- April turnover rate is 15.38

- A welcome pack is being designed for new joiners, this will bring together information about the Trust, employee benefits and signpost them to range of resources they access as a staff member. It will also include a welcome letter from the Chief Executive. This is important part of improving the overall on boarding experience of new hires.
- A more streamlined approach to ICT procurement and network access is being developed. In the interim all the forms have been brought together and are being sent to managers at the point when a start date has been agreed and are being asked to complete these forms in advance of the starting date to enable us to provide IT equipment on their first day. An audit is taking place to assess whether this has had the intended impact.
- Career clinics launched in February, to date 10 Career conversations have taken place with 11 more that are booked to take place. A career conversations toolkit has also been produced to share with staff. Based on analysis, the majority of the bookings have been made by non-registered staff.
- The Buddy Scheme was rolled out trust wide in Q4, A buddy pack has been produced with guidance on the process as well as a buddy card which is issued to new starters and includes details of their buddy.
- 100 day conversations - The process has been refreshed and a toolkit has been produced to support managers through the process.
- Notice periods were extended for new staff as of 1st Jan to ease pressure on services when staff leave / need to recruit.
- Retire and Return policy to be re-launched with guidance

Recruitment and Retention initiatives and changes to process are tracked via a project process within Workforce and OD. All these activities are monitored on a weekly basis to ensure progress and that progress is tracked in line with the Trust transformation programme paperwork.

6.3 **Brexit: The Trust may experience continuity and/or cost of supply issues for critical goods/services. (Risk 1000)**

- The Government has now agreed with the EU a further extension of the Article 50 period to 31 October 2019.
- NHS England have stood down the requirement for daily situation reporting.
- However until a deal is agreed and ratified, there is a possibility of a no deal exit at the end of the extension period on 31 October.
- The Trust continues to monitor the situation and is ready to stand up plans as and when required. NHS England will continue to keep NHS Trusts updated as the process unfolds.

6.4 **Finance: The Trust may not have sufficient resources to ensure long term financial sustainability (Risk 1001)**

- Hertfordshire - A five year contract with an option to extend for a further two years has been signed. Included in the contract are agreements in relation to access target thresholds for CAMHS and Adult services. Additionally, funding meets the Mental Health Investment Standard and allows us to meet the commitments made within the Five Year Forward View for Mental Health.
- NHS England Specialist Commissioning- A twelve month contract has been signed.
- Essex Learning Disability Services - This contract was only recently agreed (November 2018) with the Essex Commissioners.

6.5 **Finance: The Trust is unable to ensure short term financial performance in the current year (Risk 116)**

- For the financial year to 31st March 2019 the reported position is a surplus of £392k, ahead of the Control Total of £360k surplus by £32k.

- The Trust met its control total for 18.19 albeit the position in Q1 was supported by the use of provisions.
- 2019/20 Control Total from NHSI, target is to break even.
- Although this is overall a positive position and the Control Total has been achieved, the following risks should be noted going into the new financial year:
  a) This successful position for 2018/19 was achieved only with non-recurring releases of £1.4m during Quarter 1.
  b) Although secondary commissioning costs decreased in some areas during 2018/19 (notably CAMHs T4 NCM, PICU and Main Health Placements), other areas didn't (Social Care Placements, Personal Budgets). Additionally, there has recently been significant additional pressure from both PICU and External Acute Placements.
  c) Whilst the above shows a strong performance with a good exit point into 2019/20, the new year will be challenging. The Delivering Value Plan for 2019/20 is £6.5m which is a stretching target and includes a further reduction in agency costs.
  d) Pay costs increase significantly again from 1st April 2019, and whilst this is broadly funded, there are incremental pressures from pay points being merged that indicate a greater level of risk.
- Schemes for 2019/20 are currently being developed. The current estimate of the Delivering Value Programme requirement for 2019/20 is c. £6.5m.

6.6 **<u>Changing External Landscape:</u> The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from HPFT (Risk 749)**

- HPFT has renewed & secured all its contracts; with a 5 year contract in place for Hertfordshire and a 7 year contract for LD services in Essex.
- The Mental Health Investment standard has been met across the STP
- Income for 19/20 has been secured with both Herts CCGs meeting the Investment standard and providing demography funding.
- STP design brief has been developed, and includes consideration of the future provision and form of mental health and learning disabilities; HPFT active in those discussions and development. A specialist MH being considered in additional to the 'geographical' ICA model.
- Board strategy workshop took place in April; second planned for June/July.

6.7 **<u>CAMHS:</u> Failure to provide an efficient and effective CAMHS service which impacts on the clinical care provided to young people (Risk 617)**

- CAMHS current 28 day access performance is approx. 40%
- Weekend clinics are being provided to reduce backlog in East quadrant. All job-plans are being reviewed to ensure capacity is maximised. CQI methodology to be used to review model of assessment and treatment and to establish capacity and ways to increase and reduce variation. All teams have a duty worker in place.
- Tier 4 –No admissions to acute CAMHS have taken place during Q4 and the numbers in out of area specialist beds have remained within business case levels. The DBT team had been recruited to with plans to start to take on a caseload during May 2019
- FHAU Staffing- Staffing review completed by the Head of Nursing is now ready for further review by the Exec. Significant progress has been made across CAMHS in terms of recruitment with the East quadrant and CCAT remaining as hotspots. Agency expenditure has reduced across the community teams.

Actions being taken:

- Ongoing recruitment to vacant posts and search for temporary cover
- Full leadership establishment across the quadrants and senior support in place for new quadrant managers.

- Agreement with recognised National provider to provide assessment service to reduce ADHD waiting list.
- CAMHS Director Steering group established – (providers and commissioners) to oversee review of CAMHS model with a view to reviewing demand and capacity across system and redesign of CAMHs model with a focus on early intervention.
- Recruitment to Consultant posts remains challenging. Additional staff grade posts established to support medical structure

6.8 **S136: Unlawful detention of service users under S136 breaches beyond 24hrs (Risk 882)**

Following the implementation of the police and crime act, despite having been running in shadow form for the 6 months prior, the Hertfordshire Constabulary have increased the number of individuals that have been placed on a section 136 without recourse to the street triage team and that significantly the numbers of individuals heavily intoxicated have led to delays on our ability to carry out legally compliant MHAs. The compound impact of this is that the overall demand for 136 assessments has increased and that the specific challenges arising from the detention period changing to a routine 24 hour period have increased. This has in a number of cases resulted in delays in the ability to locate a bed within the 24 hour period and that the application for an extension is not clinically indicated.

Between 1st January and December 31st 2018, there were 86 detentions which exceeded 24 hours, of these only 22 were extended with valid reasons; the predominant reason for unlawfully detaining patients beyond 24 hours was due to the lack of available admission beds, 34%, (lack of beds is not a legitimate reason for extending a S136 detention).

An audit was undertaken, covering the period October to December 2019 and the findings were presented at the S136 Interagency meeting on 19th March 2019. This audit showed that 8% (19 out of 231) of S136 exceeded the 24 hours (3% drop on the previous audit Jul – Sep). Out of the 19 cases exceeding 24 hours 8 of these could have had extensions and 7 forms were received. This shows that the actions being taken are having a positive impact.

The MHLD are working with the S136 Modern Matron to support implementation of actions required in order for compliance with the MHA; this has included developing a Care Document to ensure accurate reporting on PARIS and ongoing monitoring by the MHLD through robust auditing of all S136 detentions.

Scenario based training sessions have been held with all staff involved in S136 detentions. The Trust's Information and Management Team have been asked to develop a report on Spike 2, to enable relevant information for S136 detentions to be retrieved quickly for audit purposes

6.9 **Adult Community: Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites (Risk 773)**

There was an increase in overall demand for adult services especially over the summer of 2018. We applied NHSI demand and capacity tools to manage the increase in demand. We continue to use this model and are working with our GP's on few projects, which have been submitted in previous evidence (Example: Primary care mental health pilot is in the process of being rolled out and this will ultimately have an impact on the demand to Initial Assessment teams as well as reduce DNA and improve the ability to dedicate resource to treatment teams in secondary care).

In addition we have assigned a staff member to concentrate solely on the review of people waiting Initial Assessment - to triage for risk, review needs with the aim of managing their wait and the risks effectively. We have also been running a Saturday clinic for some time in Watford

which offers 4-8 slots per week depending on staff availability. Only service users whose risk profile can be managed in an out of hours clinic are seen at this time.

We are aware of our hotspot areas and are working to address these, placing the demand on community services on the risk register. We have mitigation in place to ensure we are monitoring individuals who are waiting for particular treatment, interventions or packages of care and a number of individuals have been awaiting 100+ days. There are specific circumstances for each of these individuals that have contributed to these delays and we work with them to ensure that they receive the correct packages of care either through HPFT or partnering agencies. Some of these individual have had prolonged waiting periods as result of their cancellations or DNA's of their appointments. We are working with them to resolve this as soon as possible.

Innovative Primary Care Mental Health Pilot projects have been running in three areas of Hertfordshire and have had evaluations supporting their continuation and extension. The pilots are in Stevenage, Hertford and Watford. In Hertford and Watford a mental health practitioner has been embedded in a number of practices to triage referrals to secondary care and signpost as appropriate, provide advice to primary care workers regarding care or passing the referral on to secondary care.

There has been a reduction in the number of initial assessments required by the CMHTs as a result. GPs and service users have provided very positive feedback. Service design principles have been agreed to support the extension of the pilot engaging local systems in developing the service. The pilot service is being extended across further localities county-wide. In Stevenage, an alternative model has been piloted which has provided a drop in clinic for GPs to refer to. This has resulted in a significant reduction in demand going into the CMHT but also positive feedback from both service users and GPs particularly in terms of responsiveness. This model is being reviewed to see how it could be replicated elsewhere.

6.10 **Cyber Security: Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability (Risk 747)**

HBL ICT March 2019 Service Statement presented at the IM&T/IG committee stated that there were no cyber security incidents during March 2019. Assessment for Cyber Essentials has been completed and we are now working with the Partner organisations to develop a plan for accreditation.

7 Conclusion

7.1 This report has detailed the suggested changes to the Trust Risk Register to be considered by the Trust Board. It has detailed the actions that have been taken and the mitigations put in place to manage the risks that have been identified.

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

	Opened	ID	Risk Title	Rating (initial) LxC	Rating (current) LxC	Rating (Target) LxC	Risk to Strategic Objective (Good to Great 5 year Strategy)	Executive Lead
1	02.02.19	749	**External landscape:** The changing external landscape and wider system pressures and agenda leads to a shift of influence and resources away from mental health and learning disability services provided by HPFT	20	15 (3x5)	10	Mental health and learning disability will be given the same emphasis as physical health in local care planning and delivery	Karen Taylor
2	16.10.14	215	**Workforce:** The Trust is unable to recruit sufficient staff to be able to deliver safe services due to national shortages of key staff	15	15 (5x3)	6	We will be seen as an employer of choice where people grow, thrive and succeed	Mariejke Maciejewski
3	30.06.16	657	**Workforce:** The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services	15	15 (5x3)	6	Our staff will report feeling engaged and motivated, and recommend the Trust as a place to work	Mariejke Maciejewski
4	16.10.18	1001	**Finance:** The Trust may not have sufficient resources to ensure long term financial sustainability	12	12 (3x4)	8	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
5	16.10.18	1000	**Brexit:** Implications for the Trust of different scenarios arising from Brexit	12	12 (3x4)	4	Staff will report that they are able to deliver safe and effective services	Keith Loveman
6	21.04.16	617	**Quality and safety:** Failure to provide an efficient and effective CAMHS service which impacts on the clinical care provided to young people.	16	12 (3x4)	6	Staff will report that they are able to deliver safe and effective services	Sandra Brookes
7	27.12.17	882	**Quality and safety:** Unlawful detention of service users under S136 breaches beyond 24hrs	12	12 (4x3)	6	Staff will report that they are able to deliver safe and effective services	Sandra Brookes
8	29.03.17	773	**Quality and safety:** Failure to respond effectively to increasing demand in Adult Community resulting in a risk to safety, quality and effectiveness	12	12 (4x3)	6	Staff will report that they are able to deliver safe and effective services	Sandra Brookes
9	01.03.18	920	**Information Management and Technology:** Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident	9	12 (3x4)	6	We will constantly learn, innovate and improve for the benefit of those we serve, including making the very best use of technology and information	Ronke Akerele
10	05.10.09	116	**Finance:** The Trust is unable to ensure short term financial performance in current financial year	16	8 (2x4)	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
11	30.01.17	747	**Information Management and Technology** : Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability	12	8 (2x4)	6	We will constantly learn, innovate and improve for the benefit of those we serve, including making the very best use of technology and information	Ronke Akerele

Appendix 2 Trust Risk Register Matrix

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Trust Risk Register
May 2019

To be reviewed by:

Integrated Governance Committee:
22.05.2019

Audit Committee: tbc

Trust Board: tbc

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	Title	Description	Rating (initial)	Controls in place	Rating (current)	Rating (Target)	Early warning indicators	Current Position	Executive Lead	Review date	Next review date
749	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	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 STP Work streams including Mental Health which HPFT chairs	15	10	De-emphasis within commissioning intentions Parity of esteem agenda not honoured within contract negotiations or lack of commitment. Lack of discussion about Mental Health & LD priorities across STP and in Local Delivery Boards No demography increase and / or usual commitments aren't delivered by CCG's.	Mental Health Five Year Forward View and the recent 10 year plan announcements continue to provide the national focus and emphasis on Mental Health and Learning Disability. HPFT has renewed & secured all its contracts; with a 5 year contract in place for Hertfordshire and a 7 year contract for LD services in Essex. The Mental Health Investment standard has been met across the STP Income for 19/20 has been secured with both herts CCGs meeting the Investment standard and providing demography funding. STP design brief has been developed, and includes consideration of the future provision and form of mental health and learning disabilities; HPFT active in those discussions and development. A specialist	Karen Taylor (Director of Strategy & Integration)	09/05/2019	09/08/2019

		• Increased sharing of risks and financial pressures across the system resulting in shifting of resources away from mental health and learning disability services						MH being considered in additional to the 'geographical' ICA model. 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. Discussions underway to explore a regional collaborative model to support the development of New Care Models across the East of England . Board strategy workshop took place in April; second planned for June/July.			

215	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 monitors recruitment and retention activities and KPI's.	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	April 2019 vacancy rate is 12.68%. In Q4 there was a net gain of 17 staff with 140 new starters and 123 leavers. The Time to Hire (T2H) was 45.1 days in March, down 4.3 days from February. Focused recruitment campaigns are currently being planned for PATH and CAMHS, this includes using targeted social media adverts as well as strategically placed train adverts to generate interest from passive candidates and local qualified nurses commuting in to London. Similar campaigns will also take place in other hot spot areas, with a meeting scheduled to plan a campaign for Norfolk. Recruitment initiatives - Attraction plan is being developed and the marketing of Recruitment Open Days together with times, dates and venues is being reviewed. Recruitment hotspots include the following:	Mariejke Maciejewski Interim Director of Workforce and OD	03/05/2019	02/08/2019

								• Band 5 and band 6 nurses • NW & SW CATT • CAMHS – all professions • Junior doctors • Norfolk • AHPs The Recruitment and Retention Group continues to meet on a monthly basis. Each SBU has developed a local recruitment and retention plan for their areas which has been reviewed and updated. Implementation of a new careers website has commenced. The plan is that the careers site should attract candidates to HPFT but will also assist current staff with career pathways and progression. Focusing on 'on boarding' staff on their first day and / or from the time that they are recruited that we continue to keep the recruited member of staff engaged with regular contacts and a welcome to HPFT pack including IT equipment required for their role when they commence in post.			

657	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	Turnover is higher than target, with 42% of our leavers going with less than 2 years' service and 10% with less than 6 months. April turnover rate is 15.38 A welcome pack is being designed for new joiners, this will bring together information about the Trust, employee benefits and signpost them to range of resources they access as a staff member. It will also include a welcome letter from the Chief Executive. This is important part of improving the overall on boarding experience of new hires. A more streamlined approach to ICT procurement and network access is being developed. In the interim all the forms have been brought together and are being sent to managers at the point when a start date has been agreed and are being asked to complete these forms in advance of the starting date to enable us to provide IT equipment on their first day. An audit	Mariejke Maciejewski Interim Director of Workforce and OD	03/05/2019	02/08/2019

								is taking place to assess whether this has had the intended impact. Career clinics launched in February, to date 10 Career conversations have taken place with 11 more that are booked to take place. A career conversations toolkit has also been produced to share with staff. based on analysis, the majority of the bookings have been made by non-registered staff. The Buddy Scheme was rolled out trust wide in Q4, A buddy pack has been produced with guidance on the process as well as a buddy card which is issued to new starters and includes details of their buddy. 100 day conversations - The process has been refreshed and a toolkit has been produced to support managers through the process. Notice periods were extended for new staff as of 1st Jan to ease pressure on services when staff leave / need to recruit.			

								Retire and Return policy to be re-launched with guidance			

1001	The Trust may not have sufficient resources to ensure long term financial sustainability	Failure to maintain long term financial sustainability 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 long term financial performance is not sustainable 3) Significant unidentified QIPP requirements across the STP, this could lead to an increase in the risk score if these QIPP	12	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 2018/19 Contract variations in place for health and social care contracts. Relationship management with commissioners Primary Care Mental Health pilots around demand management to	12	8	Agreed income tariff uplifts Negotiations with commissioners 3 year CRES proposals	Hertfordshire - A five year contract with an option to extend for a further two years has been signed. Included in the contract are agreements in relation to access target thresholds for CAMHS and Adult services. Additionally, funding meets the Mental Health Investment Standard and allows us to meet the commitments made within the Five Year Forward View for Mental Health. NHS England Specialist Commissioning- A twelve month contract has been signed. Essex Learning Disability Services - This contract was only recently agreed (November 2018) with the Essex Commissioners. 5 year Department of Health funding agreement Developing Long Term Financial Model - 0-3 years detailed - 4-5 years headlines - 6-10 years to be confirmed Fits in with STP medium term financial strategy	Keith Loveman (Director of Finance)	14/05/2019	14/08/2019

		requirements materialise in the future		mitigate risk, better signposting will hopefully reduce Initial Assessment demand.							

1000	The Trust may experience continuity and/or cost of supply issues for critical goods/services.	There are risk implications for the trust of different scenarios arising from Brexit, particularly a 'no deal' scenario. The Trust is unable to maintain sufficient quantity and volume of key supplies and/or the unit price may rise: - Medications - Equipment - Staff	12	EU staff contacted and supported. Department of Health and Social Care (DHSC) guidance on contingency plans Self Assessment for NHS Trusts to use to identify contracts that may be impacted by EU exit Identification of Contracts at risk to be completed by 30.11.18 Summarise highly impacted contracts and mitigating activities by 30.11.2018 Board level lead identified - DoF DHSC EU Exit Operational Readiness Guidance framework for	12	4	Increase difficulty or delay in sourcing sufficient quantities of medication or equipment. Increased staff turnover of EU registered staff Increase in unit price	All affected EU employees (c.230 staff) contacted and supported in completing appropriate documentation. DHSC has written to trusts and suppliers setting out requirements for contingency in the event of a disrupted supply to the NHS arising as a consequence of Brexit arrangements. DHSC has been working closely with Cabinet Office to implement a cross-Government approach to identifying contracts that may be impacted by potential changes to trading relations with the EU, and developing mitigating actions to help ensure that there are suitable arrangements in place at the point of exit. DHSC has developed a self-assessment methodology for NHS Trusts to use to identify contracts that may be impacted by EU exit. The Trust has undertaken this analysis and no significant contract issues have been identified. Ongoing assessment of	Keith Loveman (Director of Finance)	14/05/2019	14/08/2019

				assessment of risks completed January 2019 Business continuity and incident management plans tested				risks associated with EU Exit in line with DHSC 'Action card for providers'. Testing existing business continuity and incident management plans against EU Exit scenarios. The Pharmacy Department has a developed process for sourcing alternative suppliers or substitute medications. Over the last 18 months drug supplies have been volatile and the pharmacy has in place guidance on substitute prescriptions for all key medicines Progressing implementation of new pharmacy software to identify fraudulent medication Developing plans for additional pharmacy resource to carry out the above measures. The Government has now agreed with the EU a further extension of the Article 50 period to 31 October 2019. NHS England have stood down the requirement for daily situation reporting. However until a deal is			

								agreed and ratified, there is a possibility of a no deal exit at the end of the extension period on 31 October. The Trust continues to monitor the situation and is ready to stand up plans as and when required. NHS England will continue to keep NHS Trusts updated as the process unfolds.			

617	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	All acute admissions to go into FHAU Weekly performance reports and weekly management review HR Dashboards / HPFT Workforce Information Report Summary Service Improvement plan Deep Dive Review 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 Speaking Up Concerns	CAMHS Access Total referral volumes into SPA increased from 652 in September 2018 to 931 in January 2019 and of these the referrals passed on to HPFT services increased from 142 in September 2018 to 446 in January 2019. CAMHS current 28 day access performance is approx. 40%. Weekend clinics are being provided to reduce backlog in East quadrant. All job-plans are being reviewed to ensure capacity is maximised. CQI methodology to be used to review model of assessment and treatment and to establish capacity and ways to increase and reduce variation. All teams have a duty worker in place. This is demonstrably the consequence of a host of system issues, compounded with local capacity within individual teams. The demand for CAMHS at SPA is >30% on last year and HCT are reporting 300 referrals per month when they are able to meet approx. 100. Capacity in the county	Sandra Brookes (Director Of Service Delivery and Service User Experience)	13/05/2019	13/08/2019

								council's services have been significantly reduced, this has resulted in considerable waiting times of 6+ months for step 2 support and counselling services. As a consequence of this we have seen an increase in referrers to SPA due to young people unable to be seen in other services deteriorating, we have also seen a significant increase in crisis presentations via our A&E and our C-CATT services as families take their children their as due to escalating needs. The combination of all these factors mean that despite CAMHS offering their greatest number of assessment slots in a month of 163 during January and C-CATT seeing 109 referrals, the teams have not been able to balance demand with capacity. Actions being taken • On-going recruitment to vacant posts and search for temporary cover • Full leadership establishment across the quadrants and senior support in place for new			

								quadrant managers. • Agreement with recognised National provider to provide assessment service to reduce ADHD waiting list. • CAMHS Director Steering group established – (providers and commissioners) to over see review of CAMHS model with a view to reviewing demand and capacity across system and redesign of CAMHs model with a focus on early intervention. • Recruitment to Consultant posts remains challenging. Additional staff grade posts established to support medical structure • CCM posts and modern matron are recruited to. Forest House team leader has been recruited to which strengthens inpatient leadership. Finance Tier 4 –No admissions to acute CAMHS have taken place during Q4 and the numbers in out of area specialist beds have remained within business case levels. The DBT team had been recruited to with plans to start to take on a			

								caseload during May 2019. FHAU Staffing Staffing review completed by the Head of Nursing is now ready for further review by the Exec. Significant progress has been made across CAMHS in terms of recruitment with the East quadrant and CCAT remaining as hotspots. Agency expenditure has reduced across the community teams.			

882	Unlawful detention of service users under S136 breaches beyond 24hrs.	From 11th December 2017, changes to Section 136 of the Mental Health Act came into force as a result of the Police and Crime Act. These changes have an impact on the Trust's responsibility to make available a qualified clinician for the Police to consult with prior to using Section 136, and for Section 136 detentions to last no longer than 24 hours (unless there are circumstances that warrant an extension of up to 12 hours). Extensions are not granted for either incomplete assessment due to clinician availability or	12	- Availability of Street Triage 9am - 4am 7 days a week, in order for Police to consult regarding anyone over 16. Crisis Assessment and Treatment Team available 4am - 9am. - Forest House Adolescent Unit to provide a clinician for consultation with Police regarding use of Section 136 at all times for anyone under 16. - Dedicated Section 136 team to monitor progress against 24 hour timeframe and co-ordinate assessing clinicians; Section 136 team to monitor and note where an extension to the detention can be authorised	12	6	- Lack of Street Triage involvement in Police decision to detain - Use of Section 136 by Police to manage risk as a result of intoxication, rather than use of public order offence or return to home - Lack of availability of AMHP's out of hours to undertake assessment - Numbers of people discharged from Section 136 with no evidence of mental disorder or no further action required either continues at current rate or increases - Lack of availability of S136 suites and Police waiting due to inability to move patients through	In order to manage the risks related to failure to implement the updated Section 136 Policy, the Trust has ensured a 24 hour, 7 day a week coverage of clinicians for Police to consult with prior to detention via Street Triage and Community Assessment and Treatment Teams. An updated Interagency Section 136 Police has been finalised and agreed between all parties. There is an established governance process for monitoring the use of Section 136 and informal networks in place for management of issues between parties. There have been a number of occasions since the start of 2018 when an extension to the detention could have been requested, but this has not been implemented. A team leader post for section 136 suite has been implemented and recruited to, training and support from the MH Legislation Office has been delivered, with closer monitoring, requests for	Sandra Brookes (Director Of Service Delivery and Service User Experience)	13/05/2019	13/08/2019

		for lack of bed availability should an inpatient admission be required. In order to meet these timescales and manage the requirements of the changes, the Trust has to provide 24 hour clinical coverage for the Police; to ensure that the demand for Section 136 does not increase dramatically by monitoring inappropriate or unwarranted use of S136 in cases of intoxication only or presence of no mental disorder; to ensure availability of relevant professionals (AMHP, Section 12 approved		- Between 9 - 5, Monday to Friday, AMHP Service prioritise Section 136 assessments in order to meet timescales - Presence of CATT staff in Kingfisher Court overnight, increasing availability for assessment - Interagency meetings and governance arrangements in place to monitor implementation of the Police and Crime Act changes to Section 136, reporting to Hertfordshire's Crisis Care Concordat Group				extensions are being made, and monitored via datix. There continue to be incidents of the following: - Occasions where the Police have not consulted with Street Triage, or approved alternative, before detaining an individual. - Underutilisation of alternatives such as Nightlight or home visits from CATT for people in crisis - Increase in number of individuals who have been dearrested and bought in to S136 on the advice of the Forensic Medical Examiner or G4 nurse (custody nurse) who have no evidence of mental ill health - Occasions where there has been no availability of an AMHP out of hours to see an individual within 3 hours (as per local interagency policy) - Young people being brought into s136 suite by police where their family feel unable to manage their presentation of challenging behaviour, and social services are unable to identify a placement			

		Doctor and Crisis Assessment and Treatment Team where admission indicated) in order to assess and recommend individuals. Since implementation of the legislation, there has been an increase in incidents of illegal detentions. Analysis of these incidents has identified the following themes as factors driving this increase: - Delays due to AMHP availability out of hours - The individual being too intoxicated to assess - Complex social issues such as						These are being monitored on a case by case basis, managed and resolved between Senior Managers within the Trust and partner organisations, and inform the agenda of interagency discussions seeking to resolve the challenges at a strategic level.			

		homelessness or vulnerability, or waiting for transfer back to home area for treatment. A particularly challenge has been the presentation of children and adolescents, who are unable to return to their home Of these, only intoxication is an accepted reason for extension of the 24 hour deadline.									

773	Failure to respond effectively to demand in Adult Community impacting safety, quality & effectiveness - all sites	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. Service users pending care co-ordination allocation remains a significant risk	12	Review of staff skill mix across quadrants and introduction of new roles Primary care projects commencing to look at work before IA referral made. 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	Vacancy Levels Agency spend Increase in incident reporting Number of cases pending allocation Number of initial assessments Turnover of staff Increase in Complaints Performance against targets deteriorating Staff feedback/raising of concerns Increased length of time to be allocated a care coordinator Increase in the total amount of cases pending allocation or as a % of overall	Primary mental health care pilots underway in three locations (Stevenage & Watford and Hertford), this is now being rolled out across all quadrants. Agreed as part of the Did Not Attend Standard Operating Procedure, plan to improve triaging in SPA agreed with commissioners. SPA will no longer pass referrals through to adult community teams for initial appointments if the Trust has not been able to make contact the service user in SPA. This will take effect from 5th Nov. It should have a significant impact on IA slots and wider capacity. Caseload Reviews – all quadrants Identification of cases that are ready for stepdown / discharge. Regular tracking of these cases to ensure plans are being actioned. 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	Sandra Brookes (Director Of Service Delivery and Service User Experience)	13/05/2019	13/08/2019

							community team caseloads	that individuals have no access to support from HPFT community services. Work has recently taken place within PARIS to further define the Awaiting Allocation lists within teams to support an individualised approach to those waiting for specific professional input such as psychiatry, care co-ordination and Psychology etc Further Mitigation includes; use of duty system at times of increased or changing needs, joint working across teams to provide support i.e. Wellbeing & Psychology, increased interface where step up or down is a particular issue i.e. CATT to community, ongoing team and individual case load reviews to improve flow and group sessions offer whilst waiting. Some teams are using a mini team model to support individuals requiring care coordination. This is a mini team of 3 people who will work with an individual,			

								this provides a broader group of people who will work collaboratively rather than one single identified Care Coordinator. This potentially will allow for a larger caseload across the mini team.			

920	Failure to maintain compliance with Data Protection legislation leading to serious or catastrophic data breach/incident	Failure to maintain compliance with data protection legislation creates a risk of a data incident occuring which leads to serious or catastrophic impact on data subjects (Staff or Service users). Should the Trust then fail to comply with an enforcement notice from the Information Commissioner, it would be at risk of a fine of up to €20million. Financial compensation could also be sought by affected data subjects. This would result in a serious impact on Trust finances and reputation. There is a	9	The Trust has an open and timely culture of reporting incidents that occur, which facilitates early intervention and management of incidents. This supports reporting to the relevant authorities (NHSD and ICO) within the statutory 72 hour timescale. In addition, the Trust has undertaken data flow mapping across the organisation, and maintains a detailed information asset register, with identified Information Asset Owners. A Data Protection Impact Assessment process is in place, which promotes visibility of new projects, and	12	6	Increase in serious data incidents reports. Increased complaints to the Information Commissioner leading to enforcement action, including audits or financial penalties. Reduction in staff compliance with mandatory training. Projects or initiatives going live without data protection or governance oversight. Failure to maintain Information Asset Register, Data flow mapping or Care record quality audit. Reduction in compliance with Data Subject	YTD 2018/19 the Trust has received 481 reports of possible data incidents via Datix. 15 incidents had been reported to the ICO since 1st April 2018, 11 were returned with no action required. The outstanding four incidents are awaiting a decision by the commissioner. The Trust is actively engaging with suppliers to establish their ongoing data protection position. DPIAs are being completed by new projects, and reviewed by the DPO. The Trust has an over-arching Privacy Notice, and services are implementing 'point of care' specific information for service users as appropriate. In 2017-18, the Trust received 350 reports of possible data incidents via Datix. Five were found to be sufficiently serious to escalate to the Information Commissioner. The increase in reporting from 17-18 to 18-19 is seen as a positive trend,	Ronke Akerele (Director Innovation and Transformati on)	13/05/2019	13/08/2019

		potential loss of trust in clinical and therapeutic relationships, leading to reduced quality of care and outcomes.		facilitates early input by the Data Protection Officer. This contributes to meeting the statutory requirements of Article 35 of GDPR (2016). All staff are made aware of their statutory and professional responsibilities to safeguard and manage data appropriately. The quality of care record management at ward level is audited on a 24 month cycle.			Rights requests (including Subject Access).	which reflects the increased awareness of data incidents within the Trust, and staff confidence in reporting issues in a timely manner when they are discovered. In addition, the change in legislation lowered the threshold for reporting to the Information Commissioner. Previously, classification hinged on number of data subject affected, and the actual harm caused by the breach. Under GDPR, classification is determined by the reported impact on the data subject; this does not need to be a quantifiable impact (i.e. actual financial loss). Given these factors, it is reasonable to assume that the Trust will see a 'spike' in reports, which will gradually reduce as the Trust addresses systemic causes of breaches (processes/practices which are unsafe). It is not possible, or desirable, to seek nil reporting. The Trust has seen 5 reports of handover sheets found outside of the clinical environment, both			

								by staff and the public. The Information Rights and Compliance team is working with affected areas to review the management of handover sheets to prevent the likelihood of future losses. This includes printing sheets on coloured paper, and possible digital solutions ("e-handover sheets"). The Information Rights and Compliance team is currently undertaking a series of clinical record audits, which will be used to target future work with high risk areas. The Trust has a well-established Data Protection Impact Assessment process, and the majority of projects seek input from the Data Protection Officer at an early stage. The Information Rights and Compliance Team offers support and advice to staff on data protection by design and default. The Trust has also appointed a Data Protection Officer, and therefore complies with			

								Article 37 GDPR.			

116	The Trust is unable to ensure short term financial performance in current financial year	Failure to maintain recurrent and sustainable financial performance, specifically: Failure to address immediate demand and / or cost pressures and / or to deliver required efficiency savings. Failure to achieve control total in 2018.2019 Key Issues 2018/19: Cost Pressures: - Agency expenditure and NHSI cap Demand Pressures: - Social Care Placements - External PICU Placements - Increasing referrals to	16	Revisited and Strengthened CRES Programme Assurance Board, monthly monitoring Dedicated finance resource: Head of Finance – Efficiencies Programme Weekly monitoring of key financial indicators associated with areas of volatile spend eg placements Raised authorisation levels for agency expenditure Vacancy Review process Implemented in-year recovery plan	8	6	Day One 'flash forecasts' for monthly outturn Weekly monitoring of key indicators - agency - placements - movement forecast Quarterly Review / Horizon Scanning Increased agency spend Increased number of placements outside HPFT CRES programme RAG rating	The Trust's overall NHS Improvement Use of Resources Risk Rating remains a 1. The Trust continues to have a strong relationship with NHSI. For the financial year to 31st March 2019 the reported position is a surplus of £392k, ahead of the Control Total of £360k surplus by £32k. The Trust met its control total for 18.19 albeit the position in Q1 was supported by the use of provisions. 2019/20 Control Total from NHSI, target is to break even. Although this is overall a positive position and the Control Total has been achieved, the following risks should be noted going into the new financial year: a)This successful position for 2018/19 was achieved only with non-recurring releases of £1.4m during Quarter 1. b)Although secondary commissioning costs	Keith Loveman (Director of Finance)	14/05/2019	14/08/2019

		community services - CAMHS Tier 4 placements						decreased in some areas during 2018/19 (notably CAMHs T4 NCM, PICU and Main Health Placements), other areas didn't (Social Care Placements, Personal Budgets). Additionally, there has recently been significant additional pressure from both PICU and External Acute Placements. c)Whilst the above shows a strong performance with a good exit point into 2019/20, the new year will be challenging. The Delivering Value Plan for 2019/20 is £6.5m which is a stretching target and includes a further reduction in agency costs. d)Pay costs increase significantly again from 1st April 2019, and whilst this is broadly funded, there are incremental pressures from pay points being merged that indicate a greater level of risk.			

747	Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability	Failure to manage cyber risks effectively could lead to the loss of systems, confidentiality and availability, together with a negative impact on organisational reputation and potential financial legislative penalties. Our IT infrastructure contains some vulnerability and there are some insecure working practices which are contributing to our exposure to Cyber risk.	12	Series of audits being undertaken within HBL ICT IT Security Policy in place Email and Internet Policy in place Mobile Device Policy in place Network management through Solarwinds Action in response to threats identified by HSCIC Audits findings Intrusion Prevention Sensors on all 'internet' connections Regular/periodic messaging to staff regarding potential issues, vigilance, expected behaviours and appropriate	8	6	Increase in cyber security related or suspected related issues/calls logged on Service Now Advice from HBL ICT, NHS Digital or other key organisations Cyber attacks on other HBL ICT organisations, other NHS organisations and/or wider organisations	HBL ICT have confirmed that all patches are up to date. As new patches are developed these will need to be installed. User awareness is as important as ever and so communications to staff have been maintained and detailed guidance is issued via all Trust emails when the specific threats are identified. HBL ICT March 2019 Service Statement presented at the IM&T/IG committee stated that there were no cyber security incidents during March 2019. Assessment for Cyber Essentials has been completed and we are now working with the Partner organisations to develop a plan for accreditation. Risk of cyber attack is ever present.	Ronke Akerele (Director Innovation and Transformati on)	16/04/2019	01/07/2019

				responses Information Governance mandatory training HBL ICT development of mirrored data centres Move to NHSMail Updated Paper Light processes							

Hertfordshire Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	6th June 2019	**Agenda Item:** 17
Subject:	Aston Ward – dormitory removal and refurbishment	**For Publication: Yes**
Author:	Keith Loveman, Deputy CEO and Director of Finance	**Approved by:**
Presented by:	Keith Loveman, Deputy CEO and Director of Finance	

Purpose of the report:

To:-

- Inform the Board of progress and next steps
- seek formal **approval** of a £1m 'not to be exceeded' capital budget

Action required:

To:-

- note progress to date and next steps
- approve a 'not to be exceeded' budget for delivery of single room accommodation on Aston ward

Summary and recommendations to the Board:

Background

As reported to the Trust Board on 7 March, we have moved to make our remaining five dormitory rooms on Aston ward single bed accommodation only, giving an immediate and substantial quality gain. Our plan is the reconfiguration of dormitory facilities to provide single room accommodation, which is estimated to take up to six months although phasing options are being explored. In order to maintain sufficient bed provision during the transition period we have procured five beds in the independent sector.

Progress

Programme

The high level programme timeline sets out completion by end October. Work is now progressing with the operational team to develop an appropriate work programme which can be facilitated safely whilst the ward remains in operation. Detailed design options have been developed and are currently subject to final sign off for suitability.

Finance

Revenue implications are an estimated cost of c.£375k which have been budgeted within the 2019/20 plan. Capital cost of refurbishment of the five dormitories is estimated at c£1m. This has been built into the 2019/20 capital programme as a budgeted sum. The Finance & Investment Committee agreed a 'not to be exceeded' capital budget of £1m at its meeting of 19 March 2019.

Recommendation

The Board is recommended to:-

- Formally approve a 'not to be exceeded' capital sum of £1 million for the refurbishment of the previous dormitory accommodation on Aston ward

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

Summary of Implications for:

1 Finance 2 IT 3 Staffing 4 NHS Constitution 5 Carbon Footprint 6 Legal

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

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

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

Trust Board 7 March 2019 FIC 19 March 2019

Hertfordshire

Estates Strategy – Inpatient Bed Provision – East & North Hertfordshire

Introduction

This paper introduces the developed thinking in relation to the provision of adult acute beds for east & north Hertfordshire and builds on the commitments made through Investing in Your Mental Health, Leading by Design and the Modernising our Estates programme from 2012-date. Initial options for delivery of a solution are noted.

The resulting proposals will form the basis of the forward inpatient reprovision strategy for east & north Hertfordshire.

Background

Investing in Your Mental Health was a strategy on the future mental health provision for Hertfordshire, which was written by the former Bedfordshire & Hertfordshire Strategic Health Authority. The strategy showed a need for a medium secure unit, psychiatric intensive care unit and ancillary accommodation in addition to those services already located at Kingsley Green.

It further recommended the closure of existing units at Lister Hospital, Stevenage, the mental health unit at Queen Elizabeth 2nd (QE11), Welwyn Garden City and the Shrodells Unit at Watford General Hospital; and re-locate to 2 purpose built facilities serving both sides of the county. This recommendation was further refined following public engagement and commissioner support to build a single purpose built facility at Kingsley Green.

Historically, the agreements that were consulted on were caveated by a commitment to secure a more local provision for the 'Far' East of the county; Bishops' Stortford and surrounding villages. At the time it was anticipated that this would be via 305 Ware Rd but in practice, the changing picture of clinical acuity has precluded the trusts ability to propose a standalone unit of that scale. Discussions have taken place with NEMHPT and more latterly EPUT about securing the ability to purchase acute beds at Harlow. However to date neither Trust has been in a position to release such capacity, albeit as part of the STP leadership there is a commitment to work towards such an outcome and to create 2 beds in Harlow that could be purchased by HPFT. The timescale for this is not yet set out and is dependent on a range of variables across the totality of EPUT's estate.

Current Position

There are four significant factors that shape the longer term requirements to complete a final stage of transformation of our adult acute inpatient environments.

(1) The commitment to relocate beds from the Lister site remains. It is well evidenced and certainly clear through service user and staff experience that MH beds on acute hospital sites is inappropriate. In addition, the nature and status of the environment/infrastructure within the Lister MHU means that significant quality improvement is not feasible. Until very recently this included the need to eradicate the only remaining dormitory provision within HPFT's inpatient estate.

(2) Stand-alone units such as Albany Lodge are not economically viable and present significant challenges in terms of workforce sustainability. Paramount in consideration however are current and future service requirements, including the acuity and presentation of admissions, which mean that the quality and safety of isolated units cannot be sustained in the longer term and these would no longer carry

clinical support as a viable solution. There is also a need to establish a second AAU function within HPFT that will be supplemented by a commitment to significant commissioner investment in the crisis pathways from 2019/20-21.

(3) Significant work has been undertaken since 2014 in relation to the potential long term provision of adult acute beds for east & north Hertfordshire. In particular, this has included exploring options for beds on the Hailey site (now sold) for east Hertfordshire residents and numerous searches for either land or existing buildings and consideration of potential alternatives. Discussions with the local authority have now concluded with no potential solution available. None of these have been viable and in particular, the feasibility of a stand-alone unit (as per 2 above) is not supported.

(4) Furthermore there is an opportunity to balance our inpatient provision across Hertfordshire and move away from an over dependence of provision in the West of the county improving experience. This enables us to provide services in geographical areas that have the additional potential benefit of attracting a larger pool of staff because of the lower cost of living.

The current relevant adult bed configuration for Hertfordshire is as follows:

Beds		
Location	**Beds**	**Status**
Stevenage (Aston ward, Lister)	20	Requires reprovision
Kingsley Green (Owl, Robin, Swift)	54	New build
St Albans (Albany Lodge)	24	Requires significant refurbishment with potential future reprovision
Total	**98**	

Future Requirements

Current occupancy rates for adult acute beds runs at an average of 97% but in practice are close to >100% because of the flexible use of leave beds.

Demand and capacity modelling undertaken with Mental Health Strategies suggests that any reprovision will need to replicate current bed capacity as a minimum and that to sustain this position in the longer term a number of significant community based service transformation initiatives would need to be progressed successfully. Whilst these are currently being taken forward, MH Strategies modelled the sensitivity of bed capacity to improvements within both inpatient and community based services on the basis that 'failures' resulted in bed 'overspill' into the private/independent sector. These improvements were modelled in terms of the level of optimisation achieved (gold, silver, bronze). The general findings in relation to the specific question:

'How many inpatient beds, of what types, should be commissioned for adults of all ages with mental health problems?' were reported as:

'It is clear from this modelling exercise that in the 'do nothing' scenario there will be significant pressure on inpatient beds over the next five years. This will rise as the population increases. In particular it should be noted that the number of people aged

65 and over is predicted by ONS to rise by 25% in the next 10 years. This predicted rise is similar for all four quadrants in Hertfordshire. HPFT would be faced with either commissioning increased placements with other providers or opening further in house capacity.

However, if the bronze optimisation scenarios were implemented and had the assumed effect, the average number of overspill beds required at any time would be 11 adult acute and 10 older adult functional beds. In the silver model this reduces to 6 adult and 5 older adult functional, and further reduces to 4 adult and 1 older adult functional in the gold model. This may be considered manageable by the Trust.

It is considered that further sophisticated modelling work will be required to confirm actual future bed numbers required. Whist current work suggests that with significant transformation of community based services, current bed capacity could be sufficient, when coupled with high occupancy rates and increasing demand and acuity, additional flexible bed capacity would potentially be appropriate.

Initial Scoping

To develop the potential for a permanent solution to bed provision for east & north Hertfordshire, given the lack of available land/buildings, initial scoping work has been undertaken looking at what options may be available within the current property portfolio.

These have focussed on what is required to:-

- Relocate Aston ward from the Lister Hospital site
- Address the issues associated with standalone units
- Increase AAU capacity to supplement the strengthened 24/7 Crisis and Home Treatment capability of the Trust
- Move forward with a solution to bed provision for east & north Hertfordshire

A range of options have been sketched out with potential benefits and issues/risks identified. Ballpark capital costs have also been drawn up. These range from ‘do nothing’ to ‘new build on a new site’. ‘Do nothing’ has been rejected as it does not meet the requirements of our Good to Great strategy and the principles we have set for the quality of our environments.

Affordability

The Trust currently carries a cash balance of c.£60m. Projecting cashflow forwards, recognising known liabilities and working to a policy of maintaining a minimum ongoing cash balance equivalent to two months payroll suggests that the Trust could fund an investment of c.£20-25m from current internal resources. This would indicate that the range of options to be developed and considered could require external borrowing in the range of £0-25m depending upon the desired solution. This would be impacted by:-

- Other development/innovation/transformation schemes and the need for investment
- Financial performance of the Trust across the relevant period

Interim Arrangements and Next Steps

The plan to provide a permanent solution for inpatient beds in east and north Hertfordshire has an estimated three year timeline and within the capital programme for 2019/20 we have included an estimated budget for the general refurbishment of both Aston ward and Albany Lodge.

As reported to the Trust Board on 7 March, we have moved initially to make our remaining five dormitory rooms on Aston ward single bed accommodation only, giving an immediate and substantial quality gain. To facilitate this arrangement and maintain sufficient bed provision through the transition, the five bed in-house reduction has been supplemented with a facility to access five beds in alternative units on a 'spot purchase' basis.

Our current plan is the reconfiguration of dormitory facilities to provide single room accommodation, which is estimated to take up to six months although phasing options are being explored. In order to maintain sufficient bed provision during the transition period it is proposed to procure five beds on a spot purchase or block basis depending on demand. Initial plans indicate that the five double dormitories may provide up to ten single rooms. However, more detailed work is required to confirm this and to then

Revenue - the estimated cost of a purchased general adult acute bed, based on prevailing rates, is c.£75k for six months, giving a potential six month cost for the of c.£375k which will be budgeted within the 2019/20 plan.

Capital - estimated cost of refurbishment of the five dormitories on Aston ward to provide up to ten single rooms c.£750k - £1m with a high level programme timeline of October to December completion dependent on configuration. This will be built into the 2019/20 capital programme.

The Committee is requested to approve a 'not to be exceeded' capital sum of £1 million for the refurbishment of the previous dormitory accommodation in order to optimize the potential for single bedded accommodation.

The Executive Team has reaffirmed the commitment to closure of Aston Ward and relocation of services to an appropriate location and agreed to the development of the options to Strategic Outline Case. A provisional budget is required to undertake this initial phase of planning and modelling work, including initial engagement with service users, carers, staff and external stakeholders and development of the business case.

Recommendation

The Committee is recommended to:-

1. **Interim Arrangements**
    - **Approve a 'not to be exceeded' capital sum of £1 million for the refurbishment of the previous dormitory accommodation on Aston ward**

2. **Bed Reprovision**
    - **Confirm the commitment to closure of Aston Ward and relocation of services to an appropriate location**
    - **Approve an initial budget of up to £150k for the initial phase of development work to Strategic Outline Case**
    - **Advise the Trust Board as necessary**

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Trust Board

Meeting Date:	6th June 2019	**Agenda Item:** TBC
Subject:	Annual Speak Up & CQC Concerns Report 2018-19	**For Publication:** No
Author:	Kevin Hallahan, Freedom to Speak Up Guardian (FTSUG) Nick Egginton, Compliance and 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:

To provide the Board with the annual Speak Up report that details the activity and learning in relation to Freedom to Speak Up (FTSU) cases and CQC concerns from 1st April 2018 – 31st March 2019.

Action required:

The Committee is asked to consider and note the contents of the report and discuss any point requiring clarification. The Committee is also asked to receive assurance of the governance process for the Freedom to Speak Up Service.

Summary and Recommendations to the Committee:

1. Speak Up Summary

All Speak Up concerns are securely stored on the Datix system with restricted access.

The Speak Up Strategy Group continues to meet Quarterly. Its membership has recently been refreshed. This meeting is chaired by the Trust's Deputy Director of Safer Care and Standards.

The CQC inspection in February 2018 and the subsequent published report in May 2018 highlighted the need to actively recruit a Guardian rather than the post be attached to a role.

The Trust's Freedom to Speak up Guardian (FTSUG) Kevin Hallahan was appointed in August 2018, following a successful internal recruitment process. Prior to this the post was covered by the role of Deputy Director of Safer Care and Standards.

Through the year the Guardian and the Risk and Compliance team have actively promoted throughout the trust the role of the Guardian and how to access it and raise concerns. This has included visits to sites, attending the Big Listen, taking part in induction and ensuring wide marketing of the champion, through posters on wards and non-clinical areas.

Loyola Weeks is the Trusts Non-Executive Director Speak Up Champion.

A total of 18 concerns were raised in 2019/19, compared to 20 in 2017/18.
There were no themes identified.

Priorities for 2019/20 include the review of the FTSU committee and the process of raising a concern and how it is managed.

The Trust now reports data quarterly to the Freedom to Speak Up National Guardian Office – this data is provided in appendix 1.

2. CQC Concerns
In 18/19 there were 9 CQC concerns received, in comparison to 15 in 2017/2018. There have been no themes identified, or locations/ services of particular concern.

These concerns are investigated and a response provided back to the CQC. They are triangulated with any other intelligence the trust has, including incidents and complaints.

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

Relation to the Trust Risk Register: (Specific risks)
657-**Workforce:** The Trust is unable to retain sufficient staff in key posts to be able to deliver safe services
978-**Quality and safety:** The Trust fails to deliver consistent and safe care across its services resulting in harm to service users, carers and staff.

Relation to the BAF: (Strategic objectives)
1. We will provide **safe** services, so that people feel safe and are protected from avoidable harm
2. We will deliver a great **experience** of our services, so that those who need to receive our support feel positively about their experience
3. We will improve the health of our service users & support recovery through the delivery of **effective** evidence based practice
4. We will attract, retain and develop **people** with the right skills and values to deliver consistently great care, support and treatment

Summary of Financial, IT, Staffing & Legal Implications:

None

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

N/A

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

CQC Well Led W3: Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process.

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

IGC 22nd May 2019

Executive Summary

2019/20 has seen a renewed focus on The Freedom to Speak Up (FTSU) profile within the Trust alongside the process being refreshed and refocused. A new FTSU Guardian was recruited following the CQC visit in 2018 which has had a significant impact on the visibility and work in this area.

In 2018/19, 18 FTSU concerns were raised (20 in 2017/18), of which the investigation relating to 5 of these cases has not concluded. Since the new FTSU Guardian has been in post the number of anonymous concerns has reduced; this is of note as this is an indication of greater confidence in the processes and allows concerns to be investigated thoroughly. Outcomes can be fed back to staff.

The West Strategic Business Unit (SBU) received 7 concerns relating to 6 different service areas. Concerns are listed below and related to both in-patient and community services:

- Training opportunities for a staff member.
- A stolen address book from a secure staff area.
- Issues with progression with secondment.
- The misuse of CCTV.
- Staff behaviours following an incident with reception staff.
- A lack of support from a line manager following an incident of violence and aggression.
- Safety concern regarding timely referrals following a new pilot that has been launched.

The East & North Strategic Business Unit (SBU) received 5 concerns relating to 5 different service areas. Concerns related to both in-patient and community services.

- CAMHS community team regarding breaches of the 28 day target and the management of the demand for CAMHS services.
- Inadequate office space and working environment.
- CAMHS Service.
- A personal disagreement.
- Accessing IT equipment.

The Learning Disability & Forensic Strategic Business Unit (SBU) received 4 concerns relating to 4 different service areas. Concerns related to both in-patient and community services provided in the SBU.

- Staff morale and leadership.
- Working relationships.
- Unprofessional behaviour of a member of staff.

Corporate services received 2 concerns

- Sending group MDT notes to incorrect circulation lists.
- Lack of support for staff member.

Concerns are recorded on Datix and categorised by theme. The most common themes have been staff making allegations against other staff in relation to bullying and harassment, poor practice and quality of care.

During the year The FTSUG attended a number of trust events and visited services around the trust, including, Student Induction Day, monthly trust induction and The Big Listen. The National Guardian's Office launched Speak up month in October 2018, a national event for all Trusts to participate in. As part of this, the FTSUG facilitated six open sessions across Hertfordshire to enable staff to drop in and speak with the FTSUG.

The Speak Up priorities for the new financial year are as follows:

- Implement a responsive monthly Speak Up Operational Group, that reports to the FTSU Strategy Group, to ensure a more responsive and confidential service.
- Continue to engage with staff and teams about how to raise concerns.

- Implement ‘Drop in’ sessions for the FTSUG once a month at different sites.
- Consider inviting the National Guardian Dr Henrietta Hughes to the Trust to raise the profile.
- Continue to develop the FTSU Champion role.

There has been no significant change in the number of speaking up cases being reported but since the appointment of Kevin Hallahan as the FTSUG there has been a significant reduction in the number of concerns reported anonymously. In 2019/2020 the FTSUG will continue to streamline and improve the responsiveness of the process and promote the service more regularly and to a wider audience.

Speak Up Annual Report 1st April 2018 – 31st March 2019

1. Introduction

1.1 This report focuses on concerns made through the Speak Up process received from 1st April 2018 – 31st March 2019. The report provides information on themes, learning and actions taken by the trust's Freedom to Speak Up Guardian (FTSUG) in response to the concerns raised. The report also provides information on the engagement work of FTSUG in 2018/19. The report also provides information relating to individual concerns raised by CQC.

2. The CQC Inspection 2018

2.1 Following the CQC inspection of the Trust in February 2018, with the report published in April 2018, the trust was asked to review its process for appointing the role of FTSUG. The post, until this time, had been held by the Deputy Director of Safer Care and Standards.

2.2 The trust recruited through to the role through an internal competitive process and this person started in post in August 2018. The post holder has dedicated time to carry out the roles and responsibility, with the rest of his time undertaking his clinical role as a nurse.

3. Freedom to Speak Up Governance

3.1 The FTSU process ensures the anonymity of those raising a concern, if this is their preferred method. However, where possible staff are encouraged to share their details, so that concerns can be robustly investigated. There is a high level of confidentiality, with a restricted number of people able to see details about concerns. The access to the details of the concerns was reviewed in 2018/19 and the number of people involved was reduced.

3.2 The FTSU Strategy group meets bi-monthly and reports to the Integrated Governance Committee six monthly. In 2018/19, the FTSUG presented at the board, where the national FTSU self-review tool for NHS trusts was discussed, and areas for development identified. The Trust also identified non-executive board member for Freedom to Speak Up.

3.3 The FTSU guardian receives monthly supervision and meets the Trust CEO on a regular basis. The Trust also submits Speaking Up data to the national guardian's office quarterly.

4. Speak Up Concerns and Learning 2017/18

4.1 A total of 18 Speak Up concerns were received in 18/19, compared to 20 in the previous year this has not differed significantly since 2014, when this reporting commenced.

4.2 When considering whether this how this compares nationally, it is reported that, for any Trust with up to 5000 staff, the average number of concerns is 25. The National Guardian reported that 'there is no obvious correlation between the CQC rating of a trust and the number of cases that a Freedom to Speak Up Guardian might be expected to handle'. (National Guardian Freedom to Speak Up report September 2018).

4.3 The Trust reviews the number (Table1) and type from each SBU and considers themes.

Table 1– The number of cases received by Strategic Business Units

4.4 **West SBU** received 7 concerns, relating to 6 different service areas. Concerns related to both in-patient and community services. There were no themes identified but concerns raised included: training and secondment opportunities, misuse of CCTV, staff behaviours, lack of support from a line manager following a violence and aggression incident and a safety concern relating to waiting times increased through a new pilot.

4.5 **East & North SBU** received 5 concerns, relating to 5 different service areas. Concerns related to both in-patient and community services. Concerns raised included concerns about office space, breaching of targets and capacity concerns, access to IT equipment and a personal disagreement.

4.6 **Learning Disability & Forensic SBU** received 4 concerns relating to 4 different service areas. Concerns related to both in-patient and community services provided in the SBU. Concerns included: working relationships, unprofessional behaviour and staff morale and leadership in one service.

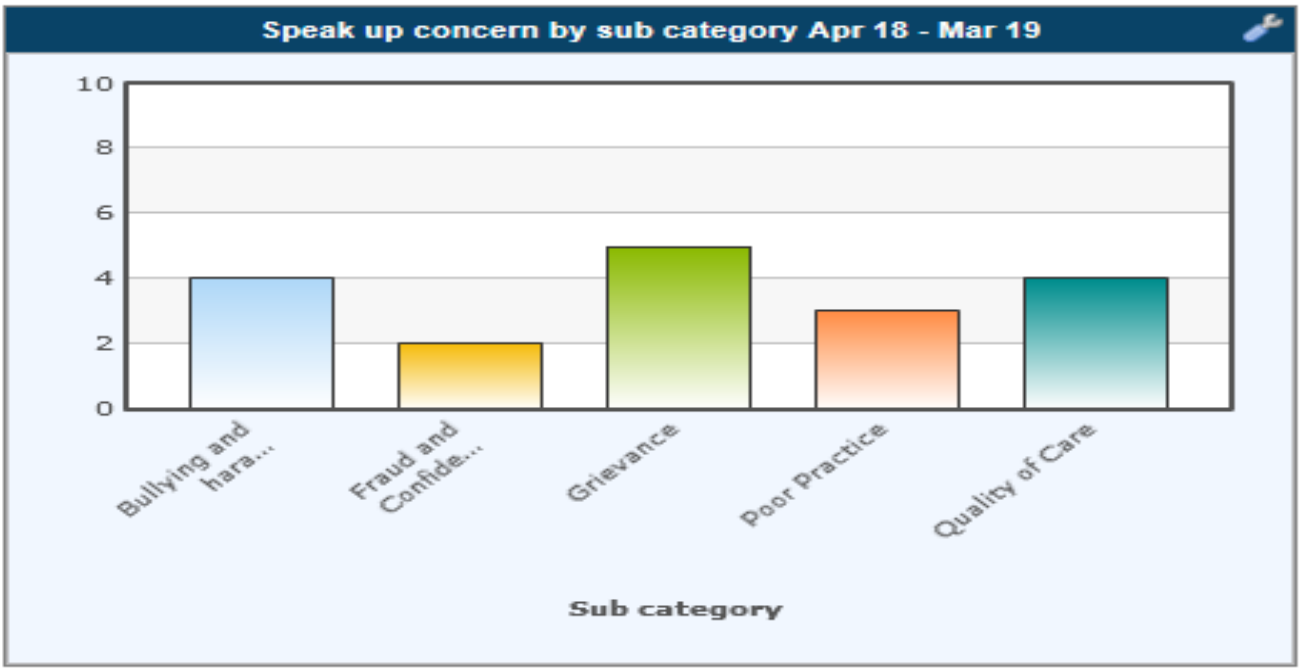
4.7 There were two concerns raised for **Corporate**, these included sending of MDT notes to the incorrect circulation lists and a lack of support for staff member.

4.8 It can be seen that there is a variety of reasons for staff raising concerns; as far as possible concerns are managed by facilitation and discussion with the parties involved. Where learning is identified this is shared in a general way through the normal learning routes for the trust, e.g. team meetings, learning notes. Feedback is given to staff regarding outcomes, when the concern is not anonymous.

5. Themes

5.1 Concerns are recorded on Datix and categorised by theme. The most common themes are bullying and harassment, quality of care and grievance. As the numbers are small it is hard to draw conclusions from this data. However, the National Guardian data shows that Bullying and Harassment accounts for 45% of all concerns nationally. These relate to 22% of the concerns raised within the Trust.

Table 2 Speak Up Concerns by sub category April 2018-March 2019

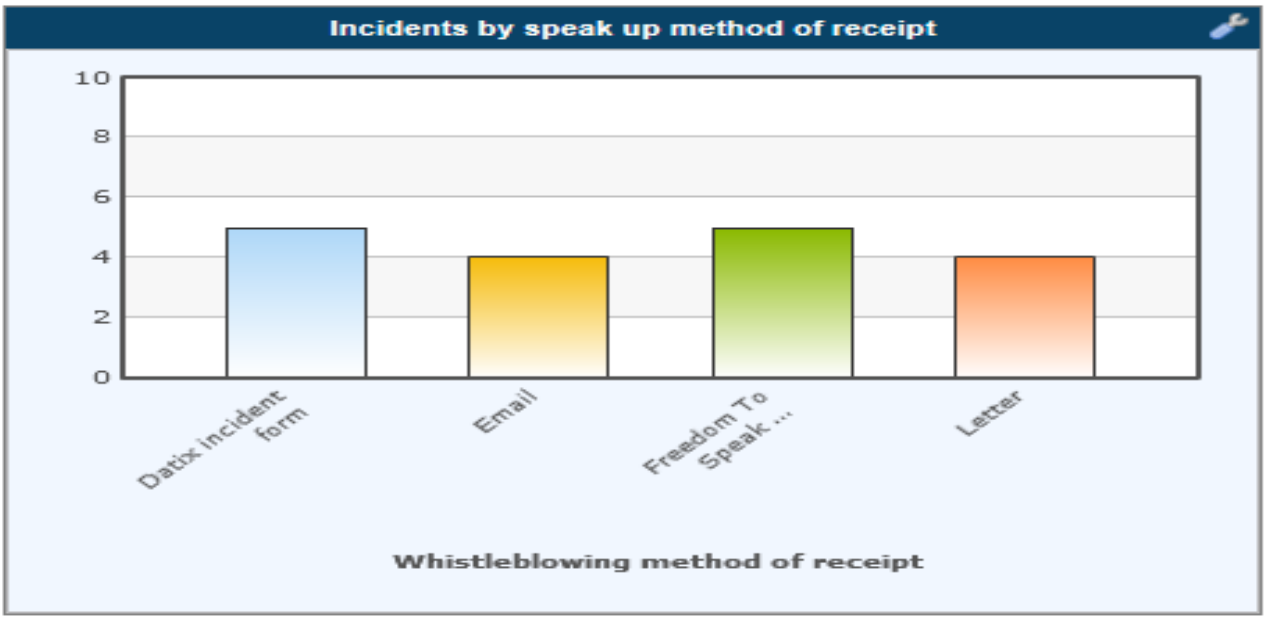


6. Method of raising a concern

6.1 The trust has a number of mechanisms by which concerns can be raised (Table 3). One of the aims of 2018/19 was to reduce the number of anonymous concerns raised. Only 2 out of the 18 concerns raised were reported anonymously which is a significant improvement from the previous year.

6.2 It is believed the new Guardian has had an impact on this, as he is visible and staff find him approachable and are confident of their anonymity.

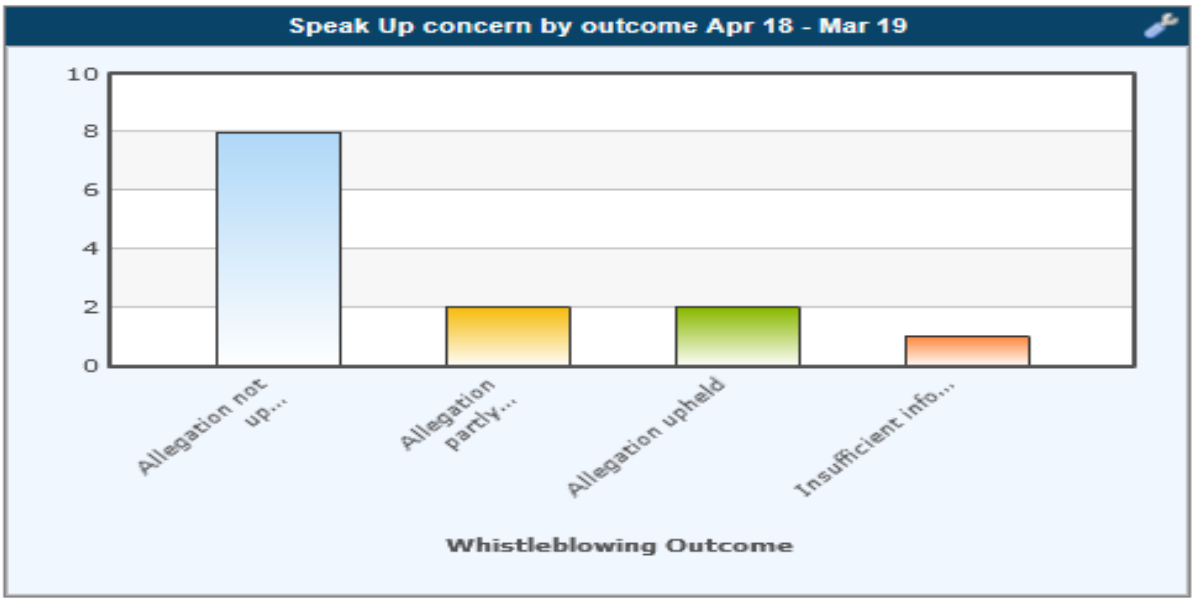
Table 3 Concerns raised by method of receipt



7. Speak Up Investigations and Outcomes

7.1 During 2018/19, thirteen investigations were completed, 2 of which were fully upheld (Table 4). 62% (8) were not upheld, 15% (2) were partially upheld and 8% (1) was not able to be concluded due to insufficient information.

Table 4 – Speak Up concerns outcomes (for the cases investigated)



8. Freedom to Speak Up Guardian (FTSUG) and staff Engagement

8.1 Since the new FTSU Guardian has been in post, time has been dedicated to engaging with staff, including student and staff induction days. The FTSUG has also attended The Big listen and visited the different services across the 4 counties.

8.2 The Trust celebrated Speak Up month in October 2018, a national event for all Trusts to participate in. As part of this the FTSUG set up 6 open sessions across Hertfordshire on the 2nd and 3rd October 2018 to enable staff to drop in and speak with the FTSUG. The FTSU has engaged with staff outside of Hertfordshire to ensure there are champions of FTSU in the trusts most remote services.

9. Priorities 2019/ 2020

9.1 The Speak Up priorities for the new financial year have been developed from the work undertaken in this reporting period and are as follows:

- Development of a monthly Speak Up Operational Group, to improve the responsiveness and decision making process.
- 'Drop in' sessions for the FTSUG once a month at different site.
- Invitation to the National Guardian Dr Henrietta Hughes to the Trust to raise the profile.
- Continue to develop the FTSU Champion role and increase visibility.

10. Care Quality Commission (CQC) Concerns

10.1 The CQC receive concerns directly from the public, service user, carers or staff. Although not formerly FTSU concerns, they are included in this report so that they are considered as a whole. The CQC shares the concern and the trust acts on the information provided. The Trust investigated and provided a response on the concerns raised to the CQC. These are discussed at the quarterly relationship meeting with the CQC.

10.2 Nine concerns were raised in this reporting period, the majority of these came from service users/families and 7 were from West SBU. There were no themes identified within the concerns and in most cases the trust was aware of the concern through another route (i.e. Complaint). All concerns raised in 2018/19 have now been closed by CQC.

11. Conclusion

11.1 There has been no significant change in the number of speaking up cases being reported but since the appointment of the new FTSU Guardian there has been a significant reduction in the number of anonymous cases. In 2019/20 the engagement started by the new FTSUG will be further developed to ensure that all staff know who the Guardian is and have the confidence to raise concerns if needed. The most common themes are bullying and harassment, quality of care and grievance, however with such small numbers it is difficult to draw conclusions.

Hertfordshire Partnership University
NHS Foundation Trust

Trust Board

Meeting Date:	6th June 2019	**Agenda Item:** 19
Subject:	Guardian of Safe Working quarterly report	**For Publication:** Yes/No
Author:	Dr Shane Ryan	**Approved by:** Prof Asif Zia
Presented by:	Dr Billy Boland, Deputy Medical Director	

Purpose of the report:

Quarterly report for the Board to **note**.

Action required:

This report is for noting. There are no exception reports raised by Junior doctors

Summary and recommendations to the Executive:

This is the Q4 Guardian of Safe Working Report, covering January- March 2019. During this quarter there were nil exception reports raised by trainee doctors.
Concerns have been raised regarding the level of cross covering on the 1st on call rota and details of the trends are included in this report. In summary:
Pressures on the On-call system for Junior Doctors are due to national level recruitment difficulties. There are currently 10.5 WTE gap in the rota due to vacancies and maternity leave.
There are 3 main areas to note in relation to vacancies:

1) Number of higher trainee vacancies (SpR/ST4-6) has slightly increased and is a grade which is having most difficulties in relation to national recruitment.
2) Rota gaps at the 1st on-call levels are due to sickness rather than vacancies
3) Use of Bank to cover the shifts and the financial cost associated with this cover.

Additions have been made to this report to add context under different headings. These additions were made for clarity. No data or illustrations have been edited. This was done as the guardian of safe working was on leave. Guardian of safe working has been made aware of these changes.

Relationship with the Business Plan & Assurance Framework:

Mandated report to the Board. To be presented to IGC in May and then report to Board

Summary of Implications for:

No exception reports raised by Junior Doctors. No safety concerns raised by Junior Doctors

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:

There are no safety concerns raised by Junior Doctors in this quarter

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

IGC – 22/5/19

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Guardian of Safe Working Hours Quarterly Report April 2019

1. Executive summary

Guardian of safe working (GOSW) was put in place at the end of junior doctor contract negotiations in 2016 to ensure Junior Doctors work safe hours, get regular breaks, have protected time for training, and have adequate supervision to ensure safe patient care. GOSW is an independent clinician with a specific role to support the junior doctors. Junior Doctors can report any concerns about their working practice through the guardian of safe working as 'exceptional reports'. Procedures were also put in place for the junior doctors to report their concerns through a national portal as part of contract negotiations

GOSW writes a quarterly report to the board for assurance and report any concerns that they have received during the quarter.

Following is the Quarterly report by the GOSW, covering a period January- March 2019. During this quarter there were nil exception reports raised by our trainee doctors. Concerns have been raised regarding the level of cross covering the 1st on call rota and details of the trends are included in this report.

All these training posts are recruited to through national recruitment and national recruitment remains a challenge, especially in psychiatry. These posts are linked to the East of England Deanery for their education and training purposes. Posts that remain unfilled followed two cycles of national recruitment are recruited to through local recruitment.

Note – the government's Migration Advisory Committee has advised in May 2019 that all medical specialities, including psychiatry of all levels, be added to the Shortage Occupation List.

This report describes the current vacancy levels, rota gaps and sickness levels. The following report highlights difficulties in national recruitment to the senior trainee grade (specialist trainees) in most specialties of psychiatry. Secondly, gaps in the on-call rota appear at the 1st tier on-call due to sickness which is difficult to fill at a short notice.

2. High level data

Number of doctors in training on 2016 TCS (total):	
January- March 2019	**58 trainee doctors (including LTFT doctors)**
Amount of time available in job plan for guardian to do the role:	**No protected time**
Admin support provided to the Guardian (if any):	**Nil**
Amount of job-planned time for clinical supervisors:	**0.25 PAs per trainee**

January 2019

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	2016 contract
Core trainees	21	1	0	0	20
Specialist Registrars	8	1	0	2	7
FY2 trainees	7	0	0	0	7
FY1 trainees	8	0	0	0	8
GP	13	0	0	0	13
Innovative GP	2	0	0	0	2
total	**59**	**2**	**0**	**2**	**57**

February 2019

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	2016 contract
Core trainees	21	1	0	0	20
Specialist Registrars	8	1	0	2	7
FY2 trainees	7	0	0	0	7
FY1 trainees	8	0	0	0	8
GP	13	0	0	0	13
Innovative GP	2	0	0	0	2
Total	**59**	**2**	**0**	**2**	**57**

March 2019

No. of Trainees	Hertfordshire	Buckinghamshire	Norfolk	Essex	2016 contract
Core trainees	21	1	0	0	20
Specialist Registrars	7	1	0	2	6
FY2 trainees	7	0	0	0	7
FY1 trainees	8	0	0	0	8
GP	13	0	0	0	13
Innovative GP	2	0	0	0	2
total	**58**	**2**	**0**	**2**	**56**

3. Vacancies

During this quarter there were a total of 10.5 on average overall trainee WTE vacancies. The main reasons for vacancies was a shortage of applicants nationally and maternity leave. There were 4.5 vacancies at senior trainee grade level. National recruitment to this grade remains a challenge and is unlikely to improve in the short to medium term. All other vacancies are in line with previously reported trends.

January 2019

Grade	Vacancies	Maternity Leave	Total (FTE)
GP	1	0	1
FY 1	0	0	0
FY2	0	0	0
Core Trainee	1	2	2
Senior Trainee	4.5	1	5
Total	**6.5**	**3**	**9.5**

February 2019

Grade	Vacancies	Maternity Leave	Total (FTE)
GP	1	0	1
FY 1	0	0	0
FY2	0	0	0
Core Trainee	1	2	2
Senior Trainee	5.5	1	5
Total	**7.5**	**3**	**10.5**

March 2019

Grade	Vacancies	Maternity Leave	Total (FTE)
GP	1	0	1
FY 1	0	0	0
FY2	0	0	0
Core Trainee	1	2	2
Senior Trainee	5.5	2	6
Total	**7.5**	**3**	**10.5**

4. 1st on call Rota Gaps

There are three 1st on call rota's that run simultaneously to cover three different parts of the county- east, west and central rota covering the King Fisher Court. First tier on-call gaps can be due to the short or long term sickness and maternity leave. Due to the rota patterns, a single doctor going off sick can have a significant impact on the on-call cover. Sickness is having most impact on the day/ night shift with increasing vacancies during the month of March when junior doctors leave their post to take on new jobs either in the trust or with other organizations.

January 2019

Rota	Sickness		Vacancies		Restricted duties due to medical conditions	maternity leave	total
	Day Shift	Night Shift	Day Shift	Night Shift			
East	3	3	0	0	0	0	6
West	1	5	4	0	0	0	10
Central	1	0	0	0	0	0	1
Total	5	8	4	0	0	0	17

February 2019

Rota	Sickness		Vacancies		Restricted duties due to medical conditions	maternity leave	total
	Day Shift	Night Shift	Day Shift	Night Shift			
East	5	7	0	0	0	0	12
West	0	2	0	0	0	0	2
Central	3	3	1	0	0	0	7
Total	8	12	1	0	0	0	21

March 2019

Rota	Sickness		Vacancies		Restricted duties due to medical conditions	maternity leave	total
	Day Shift	Night Shift	Day Shift	Night Shift			
East	1	4	1	5	0	0	11
West	2	0	1	4	0	0	7
Central	0	3	3	0	0	0	6
Total	3	7	5	9	0	0	24

5. 2nd on call Rota Gaps

There is a single senior trainee on-call on the day/night shift. Night shift is a resident on-call based at King Fisher court. Where there are vacancies identified in the rota, a specialty doctor or another senior trainee is slotted in to cover that shift. High level of vacancies at this grade is reflective of national shortage and difficulties in recruitment to this grade.

January 2019

Second on call rota	Sickness		Vacancies		Restricted duties due to medical conditions	maternity leave	total
	Day Shift	Night Shift	Day Shift	Night Shift			
	2	1	4	0	0	0	7

February 2019

Second on call rota	Sickness		Vacancies		Restricted duties due to medical conditions	maternity leave	total
	Day Shift	Night Shift	Day Shift	Night Shift			
	1	1	4	4	0	0	10

March 2019

Second on call rota	Sickness		Vacancies		Restricted duties due to medical conditions	maternity leave	total
	Day Shift	Night Shift	Day Shift	Night Shift			
	0	0	5	2	0	0	7

Exception reports
Nil

Work schedule reviews
During this quarter there were no recorded requests for work schedule reviews by either trainees or clinical supervisors.

Fines
No fines were issued during this quarter

Locum Cover:
Locum posts are appointed to locally by the trust, either to cover a short or long term vacancy.

January 2019

Rota	Grade	Shifts	Hours	Cost
1st on call	CT =	13	158.5	£6023
	F2 =	2	25	£950
2nd on call	SAS =	1	4.5	£171
	ST =	5	30.5	£1159

February 2019

Rota	Grade	Shifts	Hours	Cost
1st on call	FY2 =	1	12.5	£475
	CT =	13	146.5	£5,567
2nd on call	SAS =	4	50	£1,900
	ST =	5	46.5	£1,767
	CT3 =	1	4.5	£171

March 2019

Rota	Grade	Shifts	Hours	Cost
1st on call	FY2 =	1	12.5	£475
	CT =	11	129.5	£4921
2nd on call	CT3 =	1	4.5	£171
	ST =	6	59	£2,242

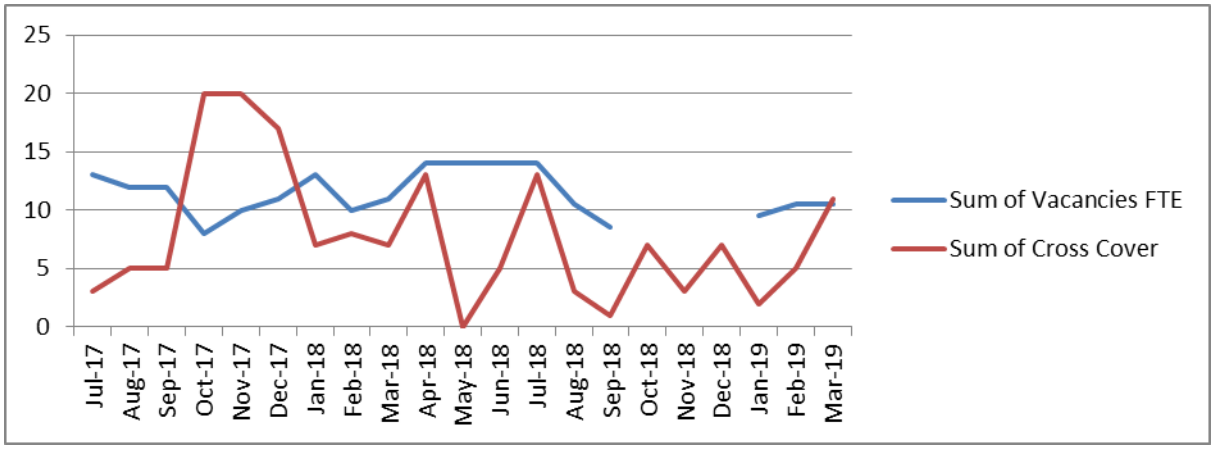
During this quarter the total cost for bank locums for the 1st on call rota was £18,411 and £5,871 for the second on call.

Out of a total on shifts in the rotas, 65 were successfully covered by using bank & Agency locums, 19 were covered by cross covering with other on-call doctors.

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

6. Summary

Concerns have been raised about the frequency of 1st on call cross cover. The graph below shows the relationship between vacancies and cross cover usage. There is a recent increase in the use of cross cover between Jan and March 2019. This will be monitored and medical staffing has been asked to attend the Junior Doctors meeting to discuss. Otherwise most of the gaps have been covered by Bank locums with a few agency bookings. Medical staffing has informed the Junior Doctors that Cross Cover has only been implemented when we have been unable to source internal bank or agency doctors.



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Trust Board

Meeting Date:	6th June 2019	**Agenda Item:** 20
Subject:	Chair's Action	**For Publication:**
Author:	Chris Lawrence, Chair	**Approved by:** n/a
Presented by:	Loyola Weeks, Non-Executive Director	

Purpose of the report:

To inform and seek agreement for Chairs action to be carried out for Marion Morse to become an MHAM Chair for the Norfolk Team.

Action required:

To approve the Chair's action.

Summary and recommendations to the Board:

Mental Health Act Manager – Marion Morse

Marion has successfully completed her required training sessions to become MHAM Chair for the Norfolk Team with positive feedback.

The Board is asked to **approve** the Chairs action for appointing Marion as the MHAM Chair for the Norfolk Team.

Relationship with the Business Plan & Assurance Framework:

N/A

Summary of Implications for:

N/A

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

N/A

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

N/A

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

N/A

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