Hertfordshire Partnership University NHS Foundation Trust
Board of Directors PUBLIC Meeting

The Colonnades

28 June 2018 10:45 - 28 June 2018 13:15

INDEX

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD OF DIRECTORS MEETING

A Public meeting of the Board of Directors
Thursday 28 June 2018 – 11:20- 1:15
VENUE: The Colonnades, Beaconsfield Road, Hatfield AL10 8YE, Da Vinci B+C

A G E N D A

Service User presentation **10:45-11:15**

	SUBJECT	BY	ACTION	ENCLOSED
1	**Welcome and Apologies for Absence:**	Chair		
2	**Declarations of Interest**	Chair	**Note/Action**	Verbal
3	**Minutes of Meeting dated May 24th 2018**	Chair	**Approve**	Attached
4	**Matters Arising Schedule**	Chair	**Review & Update**	Attached
5	**CEO Brief**	Tom Cahill	**Receive**	Attached
QUALITY & PATIENT SAFETY				
6	**Patient Safety Annual Report**	Dr Jane Padmore	**Receive**	Attached
7.	**Infection Control Annual Report**	Dr Jane Padmore	**Receive**	Attached
8.	**Safe Staffing Annual Report**	Dr Jane Padmore	**Receive**	Attached
OPERATIONAL AND PERFORMANCE				
9.	**Finance Report**	Keith Loveman	**Receive**	Attached
10.	**Workforce Quarter 4 report (plus)**	Jinjer Kandola	**Receive**	Attached
11.	**Organisational Development Stocktake**	Jinjer Kandola	**Receive**	Attached
GOVERNANCE AND REGULATORY				
12.	**Any Other Business**	Chair	**N/A**	None
13.	**QUESTIONS FROM THE PUBLIC**	Chair	**None**	None
14.	**Date and Time of Next Public Meeting:** **26th July 2018, 09.30 – 13.30, Da Vinci A+B** ***Annual General Meeting – 19 July 2018 from 5pm**			

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

Agenda Item: 3

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING
Held on Thursday May 24th, 2018
Da Vinci B – Colonnades

PRESENT:

NON-EXECUTIVE DIRECTORS	
Christopher Lawrence	Chair
Catherine Dugmore	Non-Executive Director
Sarah Betteley	Non-Executive Director
Michelle Maynard	Non-Executive Director
Robbie Burns	Non-Executive Director
Loyola Weeks	Non-Executive Director
Tanya Barron	Non-Executive Director
Simon Barter	Non-Executive Director
EXECUTIVE DIRECTORS	
Tom Cahill	Chief Executive Officer
Asif Zia	Director Quality & Medical Leadership
Jinjer Kandola	Deputy CEO & Director Workforce & Organisational Development
Jane Padmore	Director Quality and Safety
Ronke Akerele	Director of Innovation and Transformation
Jess Lievesley	Director Service Delivery & Customer Experience
Karen Taylor	Director Strategy and Integration
Keith Loveman	Director Finance
IN ATTENDANCE	
Allison Lerner	Board Secretary PA to Company Secretary (Minute Taker)
Jane Twelves	Minutes (Audit section)
Lisa Gazeley	Communications
MEMBERS OF THE PUBLIC	
APOLOGIES	
Sue Darker	Herts County Council

Item	Subject	Action
52/18	**WELCOME AND APOLOGIES FOR ABSENCE** Chris Lawrence welcomed all present to the meeting. Apologies received from Sue Darker, Herts County Council.	
53/18	**DECLARATIONS OF INTEREST** None declared.	
54/18	**MINUTES OF THE MEETING DATED** The Minutes of the meeting held 22nd March 2018 were approved as an accurate record.	
55/18	**MATTERS ARISING** There were no further matters arising.	
56/18	**Draft Annual Accounts 2017/18** **KL presented the Annual Accounts for 2017/18.** The final position is £3.5m surplus before STF and impairment. This is £2.7M above plan and in line with the expectations set out in February 2018. The statement of financial position shows	

	strong income and cash flow. The Trust assets are strong at £150M and cash levels are high at £56M; KL suggested a further discussion at Board to think through how to use this to best effect. The agency cap has been met. A large movement around provisions was noted with a number of significant Continuing Healthcare claims being settled although some provision has been retained. This has enabled the Trust to make a refund back to the CCG in Hertfordshire. For 2018/19 the position will be more challenging with consideration being given to different ways of working in order to field further efficiencies. **Audit Committee endorsed the accounts and recommended their adoption by the Board.** **RESOLVED** **That the Board received and ADOPTED the Annual Accounts 2017/18.**	
57/18	**Internal Audit Annual Report including:** • **Head of Internal Audit Opinion** • **Final Progress Report** Board received the Internal Audit Report. This is an important statement together with an overview of the work completed through the year and a key part of the Governance Framework. No issues around internal controls were found however there were 4 areas of partial assurance during the year. CD advised that Audit had asked for the Lead to attend to provide assurance to the Board. HPFT have been given the second highest opinion. KL advised that Audit had discussed progress and implementation of the actions arising from the reports. Areas in red were those areas not implemented which is less than in other organisations. Audit Committee would expect this to be zero in terms of our Good to Great journey. **Audit Committee endorsed the report and recommend approval by the Board.** **RESOLVED** **That the Board received and APPROVED the Internal Audit Annual Report which included the Head of Internal Audit Opinion and Final Progress Report.**	
58/18	**External Audit – Annual Governance Report** The findings and recommendations from the 2017/18 External Audit – Annual Governance Report were presented by the Chair of the Audit Committee. The work undertaken was summarised including the work on the significant risks and finalisation of the review process. The key risks in the audit process on the financial statement relate to; • Capitalisation of expenditure • The assumptions used in the revaluation of Trust property. Deloitte made comment on the information provided from our property value and were comfortable with the assessment and judgment made. A clean opinion was given on the controls. During the audit no issues were escalated through the Director of Finance. CD advised that no issues had been round the audit progress well; the transition of the general ledger was acknowledged by the Audit Committee and Deloitte had no	

	issues. Audit Committee had expressed congratulations to Paul Ronald and his team. The letter of representation was considered by Audit Committee; it is a standard letter and Audit noted the content related to the property valuation. Audit Committee recommended that Board accepts the letter. **Audit Committee endorsed the report and recommended approval to the Board.** **RESOLVED** **That the Board Received and APPROVED the External Audit Annual Governance Statement.**	
59/18	**Draft Annual Report including Annual Governance Statement** KL presented the Draft Annual Report including the Governance Statement which had been discussed at Audit Committee. Feedback from Deloitte had stated that the report was significantly improved with very little adjustment required. KL advised that the Board of Directors are collectively and individually responsible for the preparation of the Annual Report and Quality Report. Board noted the Annual Governance Statement which identifies the governance structure across the organisation. **Audit Committee endorsed the draft Annual Report including the Annual Governance Statement and recommended its approval to the Board.** **RESOLVED** **That the Board received and APPROVED the Annual Report and Annual Governance Statement.**	
60/18	**Draft Quality Account (Included in Annual Report)** AZ presented the draft Quality Report including Quality Accounts for 2017/18 which had been discussed at Audit Committee. The Quality report sets out the scope of the work undertaken including sample testing of 3 Indicators – two chosen by Deloitte and one chosen by the Council of Governors. Indicators selected are; • Early Intervention in Psychosis (EIP) • Inappropriate Out of Area Placements • Carers Question in the "Have Your Say" survey The scope of the testing including an evaluation of the key processes and controls for managing and reporting the indicators. The overall conclusion found an Unmodified Opinion for Inappropriate Out of Area Placements and a Modified Opinion for EIP. No issues were found for the Carers question. The findings are disappointing. KL advised that this will be addressed as part of the wider data quality plans. Following discussion it was agreed that a data quality Deep Dive will be included on the agenda for the Audit Committee meeting in September with a more robust follow-up process through Integrated Governance Committee. **Audit Committee endorsed the report and recommended approval at Board.** **RESOLVED** **That the Board received and APPROVED the Quality Account.**	

61/18	**Annual Report of the Audit Committee** CD summarised the work of the Audit Committee during the year. The Annual Report outlines how the Audit Committee has complied during the financial year 2017/18 with the duties delegated to it by the Trust Board. The Committee has an annual work plan with meetings timed to consider and act on regular and special items within the plan. There have been a number of deep dives during the year and two sessions on GDPR and Cyber Security. As part of the process Audit Committee had endorsed both the Annual Report and Quality Accounts and recommended approval to the Board. The Chair thanked members of the Audit Committee for all the work undertaken and the work with the other Committees. **RESOLVED** **That the Board received and noted the Annual Report of the Audit Committee.**	
62/18	**NHSI Declarations** • **Compliance with Provider License** Board received the report which provides evidence of compliance with the Trust's provider licence. Audit Committee is required to review the report and satisfy itself that the evidence of assurance provided are true, sound and accurate. Audit Committee endorsed the report and recommend it approval to the Board. **RESOLVED** **That the Board received and APPROVED the NHSI Declarations Compliance with the Provider Licence.**	
63/18	**Use of Waivers – 2017-18** The use of Waivers is reported quarterly. During the period 1st April 2017 to 31st March 2018 there were 36 Waivers. Board were asked to note the increase and value of the Waivers. All requests for Waivers are required to be authorised by either the Director of Finance or Chief Executive. Audit Committee endorsed the report and recommended approval to the Board. **RESOLVED** **That the Board received and APPROVED the use of waivers for 2017/18.**	
64/18	**Use of Corporate Seal** During the reporting period of 1st April 2017 to 31st March 2018, the Corporate Seal had been used for 15 transactions with no exceptions to report. Audit Committee endorsed the report and recommended approval to the Board. **RESOLVED** **That the Board received and APPROVED the Use of the Corporate Seal.**	
65/18	**Losses and Compensation Report 2017-18** KL reported financial losses/compensation reimbursements related to payments outside of normal NHS expenditure for the period 1st April 2017 to 31st March 2018. A number relate to the loss of service user property. There is a piece of working being taken forward around improving process and consideration is being given to the use of barcoding. In the meantime, this continues to be an area of focus. Audit Committee endorsed the report and recommended approval to the Board.	

	RESOLVED **That the Board received and APPROVED the Losses and Compensation Report 2017/18.**	
66/18	**Treasury Management Report** The Treasury Management activity was presented as part of the final accounts process and in accordance with the Treasury Management Policy. A total of £142K of interest was received during the financial year on surplus balances held. PR advised Public Dividend Capital funding had been received to fund some estates and cyber security costs. KL advised that the Trust regularly reviews its cash and loan requirements so that it can maximise the interest received on cash held and minimise the amount of interest paid on loans. Audit Committee suggested that the report is also shared with the Finance and Investment Committee. Audit Committee endorsed the report and recommended approval to the Board. **RESOLVED** **That the Board received and APPROVED the Treasury Management Report.**	
67/18	**CEO BRIEF** TC updated the Board on a range of issues both externally and internally. Highlights from the report included; The Government may put in place a "multi-year" funding plan for the NHS in England. NHS national bodies have broadly welcomed the announcement. NHS England (NHSE) and NHS Improvement (NHSI) have announced that they are to work more closely together. This will include creating seven single integrated regional teams to replace the five existing regions. Ian Trenholm has been appointed as CQC's new Chief Executive. He will take over the role from Sir David Behan when he leaves in July. Ian has been Chief Executive of NHS Blood and Transplant Service since 2014. Jackie Smith has announced her decision to step down as Chief Executive and Registrar of the Nursing and Midwifery Council (NMC) after six years in the role. John Wood, Chief Executive at Hertfordshire County Council had announced he will be retiring by the end of the financial year 2019. TC announced that Jinjer Kandola, Deputy CEO & Director of Workforce & OD has been appointed to the role of CEO for Barnet Enfield and Haringey Mental Health Trust, and will be leaving on 29th June. The recruitment process will be advised in due course. The process of recruiting a NED to replace Robbie Burns whose tenure expires on 31 July is under way with interviews scheduled for late July. The Board were made aware of the significant amount of work undertaken relating to GDPR and a full report would be brought to the next Public Board. JP informed The Board that this is now on the Trust Risk Register. **RESOLVED**	**RA**

	That the Board NOTED the CEO Brief.	
68/18	**REPORT FROM INTEGRATED GOVERNANCE COMMITTEE** The Board received the report of the Chair of the Integrated Governance Committee which met on the 10 May 2018. SBe reported that the committee had reviewed the CQC action plan noting the many areas of good and outstanding practice, together with areas that required improvement particularly in safety and effectiveness. The action plan would now be reported through QRMC to IGC and Board going forward. NHS Improvement had carried out a survey on nutrition and hydration and the trust had met two of the six highlighted best practice indicators for governance. Loyola Weeks agreed to be the Non-Executive Director champion. Bullying and harassment was raised and discussed, noting the Trust was not an outlier and levels of reporting were in line with the national average which was backed up with feedback from the Big Listen. However data from operational service surveys highlighted bullying and harassment as an issue for further discussion by the Executive. **RESOLVED** **That the Board received and noted the report for assurance.**	
69/18	**CARE QUALITY COMISSION REPORT** The Director of Quality and Safety presented the report which highlighted the high level comparisons with the 2015 CQC report. It was noted that there was an overall improving picture with improvements in two service lines, one improving by two bandings. It was noted that both safety and effectiveness were areas highlighted for further improvement. An action plan had been developed and would be audited by the Trusts Internal Auditors to ensure all actions had been captured. The Board noted that significant progress had already been made against the actions. Discussing the report LW welcomed the news that Broadlands had received an outstanding rating but noting that the unit was still on a regulation Section 29 with continued weekly reporting. She felt that this could leave staff feeling confused. CL asked about plans for a briefing pack for Governors, staff and the media, noting that a press release would go out. JK responded that staff were being written to and there would be local celebrations. The Board noted that the CQC would be attending its meeting in June. The Chairman, on behalf of the Board, thanked the Director of Quality and Safety and all staff for their hard work. **RESOLVED** **That the Board discussed and noted this report.**	
70/18	**REPORT OF THE FINANCE & INVESTMENT COMMITTEE** The Board received the report of the Chair of the Finance and Investment Committee which outlined the work of the committee at its meeting held on 15 May 2018. In particular SBa highlighted the Committee's deep dive on placements, a major element of the CRES program, Andrew Godfrey, Service Line Lead, provided an update. The Committee had requested a further report for its meeting in July to monitor progress. The Committee had also received reports on performance noting that the backlog in CAMHS was expected to have improved by June.	

	A report recommending the option to remain with CIVICA to host PARIS, at a cost of £1.5m for a five year period, and to upgrade the relevant infrastructure had been received. The Committee agreed to endorse the recommendation for approval by the Board. SBa reported that the Committee had a detailed discussion on a contract variation for Interserve and had endorsed the proposal for recommendation to the Board for approval. SBa reported that the Committee had received an update on progress with the estates transformation program particularly highlighting Prospect House and Elizabeth Court. An Estates Strategy was being developed and the draft would be brought to the Committee's meeting in July 2018. CL thanked SBa. **RESOLVED** **That the Board RECEIVED and NOTED the report.**	
71/18	**PERFORMANCE REPORT; QUARTER 4 2017/18** The Director of Innovation and Improvement introduced the regular performance report which set out performance for Quarter 4. It was noted that overall Q4 performance had been strong across five indicators including improvements in CPA reviews. Single access into adult community had improved to over 90% against target. CATT referrals performance was sustained during April achieving 100%. DTOC performance had improved throughout the year ending Q4 at 4.7%. Workforce performance indicators had improved during the quarter with statutory and mandatory training at 85.5% against Q3 performance of 80% and sickness absence rate reducing to 4.5%, however the turnover rate had increased to 14.2% against 13.3% in Q3. RA highlighted areas where performance had underachieved included CAMHS which had seen a decline following strong Q3 performance. Key issues affecting performance were around urgent referrals, staff vacancies and delays in SPA. During the discussion TB referred to workforce targets and asked if more achievable targets could be set, in response JK explained that the turnover rate target for next year was 11% as indicated in the NHSI Recruitment and Retention plan. **RESOLVED** **That the Board REVIEWED and ASSESSED the Trust's performance against both the NHS Improvement and Single Oversight Framework targets and Trusts KPIs for Quarter 4 2017/18.**	
72/18	**FINANCE REPORT; REVENUE SUMMARY TO 30 APRIL 2018** For 2017/18, the Trust is reporting an overall surplus of £9.0m. This represents a c. £1m underlying surplus with £2.5m non-recurring provision reversals and £5.5m STF. KL advised The Board April's financial position had been challenging, with an overall Trust position reported a deficit of (£240k), which is behind Plan by (£222k) (before STF). Key areas affecting financial performance are Placements particularly CAMHS Tier 4 and PICU along with significant bed pressures. Total pay was	

	above plan by £118k partly due to agency spend which was £42k above cap. The Board was reminded of the CRES program and noted the CRES program was behind plan The CRES level assumed within the Plan is £4.7m, and the NHSI Agency Ceiling is £7.3m, which is £1.4m below last year's actual spending. Further details on pay are provided in Item 16 - Finance Report. KL commented on additional measures to strengthen the overall growth approach including streamlining regular finance meetings with Managing Directors and Jess Lievesley to set a new tone and discuss rules and policy's to fit with this context taking steps now so that risks around operational performance are not undermined by finances. TC indicated he is looking for clear improvement by Q2. The detailed finance report goes to FIC end of Q1 for review. TC raised the issue that this position opened up the question of whether we are funded appropriately. Action: To be discussed at FIC, CL indicated he is looking forward to an update after Q1. **RESOLVED** **That the Board received and noted the report.**	
73/18	**ANNUAL PLAN 2018/19** The Director of Strategy and Innovation presented the report which set out the Trust's year end performance against the 2017/18 annual plan. Following discussion the Chair noted the report and advised the Board to not lose sight of the outstanding year that the Trust has had and that it was widely acknowledged that it is a high performing organisation with much to be proud of. KT reminded the Board that the Annual Plan 2018/19 had been approved at the last Board meeting and submitted to the Council of Governors at its meeting in May. A copy of the Plan would be available to the public via the Trust website. **RESOLVED** **That the Board noted and approved the end of year report.**	
74/18	**SUSTAINABILITY AND TRANSFORMATION PLAN** The Chief Executive presented the report which provided an update on recent and on-going developments within the Herts & West Essex STP (H&WESTP) since the last report to the Board. In particular the appointment of Deborah Fielding, as full time officer to lead the H&WESTP. A number of priorities going forward have been identified which include developing a sustainable financial framework for the STP, developing a coherent estates strategy, developing a coherent workforce strategy and a technology and digital strategy. This was in addition to developing an integrated care system that supported a population based health commissioning and population based health and social care provision. In recent months the Chief Executives Steering Group together with the Chairs Oversight Group had commissioned an external consultant, Carnall Farrah, to support the design and development of an integrated care structure. This system is designed to enhance the opportunities for further integrated working to achieve the three outcomes for the STP. Following discussion it was agreed that Ms Fielding be invited to attend a future	

	meeting of the Board. **RESOLVED** **That the Board received, discussed the update on recent developments.**	
75/18	**HERTFORDSHIRE HEALTH CONCORDAT** The Board received the report of the Company Secretary which set out the arrangements for joint working between the Hertfordshire County Council and Health Partners in Hertfordshire. The Board were reminded that this was a long standing agreement that had been in existence for about 12 years and was updated every four years in line with the new council. The Board noted the key changes to this iteration were that it now reflected the STP and the inclusion of the Princess Alexandra as a new partner. The Board approved the document for adoption and that the Chief Executive sign it on behalf of the Board of Directors. **RESOLVED** **The Board reviewed and agreed that the Chief Executive Officer sign the Hertfordshire Health Concordat on behalf of the Board of Directors**	
76/18	**ANY OTHER BUSINESS** LW queried the absence of a Q4 patient Safety report on the agenda, JP advised that Q4 reports would be coming to the next meeting of the Board.	
77/18	**QUESTIONS FROM THE PUBLIC** There were no further questions raised from the Public.	
78/18	**Any Other Business** No further business was noted	
79/18	**Date and Time of Next Public Meeting:** Thursday 26th July 2018 11:00 – 13.30 Da Vinci B&C, Colonnades	
80/18	**The resolution to hold remainder of meeting in private** **Approved by the Board.**	

Hertfordshire Partnership NHS
University NHS Foundation Trust

Agenda Item 4

PUBLIC BOARD OF DIRECTORS' MATTERS ARISING SCHEDULE – 24th May 2018

Date on Log	Agenda Item	Subject	Action	Update	Lead	Due date	RAG
22/03/18	**32/18**	Q3 Safe Staffing	JP to show the Safer Staff tool at a future Board Workshop	Date to be confirmed	JP	ongoing	A
24/05/18	**Item 11**	CEO Brief	Legislation Report came sooner than expected – JH to send report to all from the Kings website		JH	By next week	A
24/05/18	**Item 11**	CEO Brief	GDPR – 12 key points to achieve – bring back full report to the next Board		RA	July	A
24/05/18	**Item 16**	Finance Report	Report goes to FIC end of Q1 for review. The Board to receive an update after Q1		KL	September	A
24/05/18	**Item 17**	Annual Plan	Report has been signed off by both The Board and the Council of Governor's – Ready to share with the Public	Complete and published on website	JH	June 26	G
24/05/18	**Item 18**	STP	As TC is no longer involved with Sustainability and Transformation – Deborah Fielding to be invited to a future Board Meeting		TC	On-going	A

Hertfordshire Partnership NHS
University NHS Foundation Trust

PUBLIC BOARD MEETING

Meeting Date:	June 2018	**Agenda Item: 5**
Subject:	CEO Brief	**For Publication:** Yes
Presented by:	Tom Cahill, CEO	

National update

Government agrees NHS multi-year funding plan

On 18 June, the Prime Minister announced a new five year funding settlement for the NHS. This gives the health service real term growth of more than 3 per cent for the next five years. It will equate to £20.5bn more revenue in real terms compared with 2018-19. The funding is for the NHS England commissioning budget only, meaning that it does not include capital funding, public health or health education. Although the new funding does not cover social care (this area will need to wait until the spending review in 2020) the Government has confirmed that the adult social care budget would be set to not put further pressure on the NHS.

In return, Theresa May has tasked the NHS with producing a 10 year plan to improve performance, specifically on cancer and mental health care. This 10 year plan will need to be delivered by the autumn budget.

Mental health is seen as a key area for investment. It is one of five priorities for the NHS set out by the prime minister, who has said she would like to see the 10 year plan set out ambitious “clinically defined access standards” for mental health.

A NHS Providers briefing is attached for further reading.

Spending on social care falls

A report by the Institute for Fiscal Studies has indicated that spending on social care is 9% lower per person than 10 years ago. This is despite extra government funding and councils trying to protect services by switching money from other budgets.

Local authorities’ spending on adult social care fell by 10 per cent in real terms between 2009-10 and 2014-15 according to the report (which is part of the IFS Green Budget). This was partially offset by extra funds from central government, the NHS and higher council tax receipts.

As mentioned above, the Government has said that social care funding will be addressed as part of the Government Spending Review.

Agenda for Change pay deal

The extra money in the five-year funding settlement includes cash for an increase in Agenda for Change salaries from next year. The settlement (which includes a three-year pay deal) has now been agreed with the NHS Staff Council. Trade union members voted to accept changes, which will be formally ratified at the end of June.

The new pay structure will increase starting salaries and reduce the number of pay points, meaning that many staff will reach the top of their pay band more quickly.

Visas for NHS staff

The prime minister has announced that doctors and nurses will be excluded from the tier 2 visa cap on skilled migration. The cap - introduced by Theresa May when she was Home Secretary - sets a limit for all non-EU skilled workers at 20,700 people a year. The move will allow NHS trusts to recruit more staff from outside the European Economic Area, following serious workforce pressure.

Lord Carter reports on productivity in mental health and community health services

At the end of May NHSI published its report '*NHS operational productivity: unwarranted variations in mental health and community health services'* following the review led by Lord Carter analysing the productivity and efficiency of mental health and community health services. Lord Carter makes 16 recommendations for improving productivity. He suggests that £1bn in efficiency savings can be achieved by 2020/21, largely from clinical and workforce productivity measures. The Trust will be working through the detail of the 16 recommendations in conjunction with SBU teams, focussing on the following four areas:

- Improving staff productivity
- Reducing contract management processes
- Increasing the use of technology
- More effective service delivery - Getting It Right First Time (GIRFT). One of the recommendations is that mental health is included in GIRFT from autumn 2018 with a focus on community mental health pathways.

Call for social media companies to help tackle children's mental health issues

Simon Stevens, Chief Executive of NHS England told the NHS Confederation that social media companies such as Google, which owns YouTube, and Facebook should face tough scrutiny around the role of technology and social media companies and the impact that they are having in creating 'an epidemic of mental health challenge for our young people". A third of young people aged 11 to 18 who use Facebook and YouTube are exposed to bullying or distressing content such as violence or self-harm, according to a survey by the NSPCC. The Government is pressing companies to introduce policies such as better enforcement of age limits on social media accounts and said that it may consider legislation to protect children if companies fail to act.

MH out of area placements

A report from the BMA has indicated that increasing numbers of mental health patients have had to travel out of area for inpatient treatment. According to figures provided to NHS Digital, February 650 patients had to travel for inpatient care,

Jeremy Hunt has pledged to reduce, and eventually ban, out-of-area placements by 2020.

Regional update

NHSI and NHSE reveal further detail of closer working

At the end of May NHS England (NHSE) and NHS Improvement (NHSI) announced that they are to work more closely together. This includes creating a new NHS Executive Group, headed by two new chief executives who will oversee all national and regional directors from the two arms of the NHS. Three new national director roles will be created, reporting to both CEOs, including an NHS medical director, nursing director and a chief financial officer. Part of the new organisation's role will include mobilising resources for the NHS 10-year plan. The body will introduce a single financial and operating process and a single performance process.

New regional working will include creating seven single integrated regional teams to replace the five existing regional patches. This would include our existing East region being split into two, with Hertfordshire being in the East of England region.

STP CEOs discuss the formation of ICS and ICAs

Leaders from the STP have been meeting regularly to consider how together we can form an integrated care system (ICS) that will oversee a strategic approach to health and care across the STP area. The ICS would then work with a number of integrated care alliances (ICA) on the commissioning and delivery of health services for children and adults. The exact number and type of these structures is still to be determined with an update due at the end of the summer.

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Trustwide update

Performance

Demand for our services remains high as we progress through the first quarter of 2018/19. The highest demand is within CAMHS and adult services. This is impacting on our ability to meet all our accessing performance measures, particularly in the East & South East and South West of the county. We have also seen a significant increase in clinical acuity across our acute and inpatient services, resulting in higher than average numbers of women being referred to our Psychiatric Intensive Care Unit (PICU). In spite of these pressures, we have seen higher numbers of service users recommending the Trust as part of the NHS Friends and Family Test, where we remain in the upper range of comparator trusts. This is a huge testament to the hard work of our teams. However, we will continue to work with commissioners to develop the way in which we work with primary care to improve the overall timeliness and effectiveness of our services.

Quality and safety

A number of initiatives are in place to ensure that we embed learning from deaths and serious events. This has included working with external bodies to improve our practice in a number of ways. The Trust's Mortality Governance Group is exploring how we learn from deaths, including participating in a RCPsych Care Review pilot for 3 months (June – Aug 2018).

We have commissioned Merseyside NHS to undertake an external review of our seclusion practice and the team from Merseyside will be visiting our inpatient services in Herts, Essex and Norfolk at the beginning of July. Additionally, in late June, we will begin working with NHS England on a work stream looking at recording data on restrictive practices.

A number of internal reviews are also underway to review our approach to serious incidents and the quality of our investigations; to better understand themes and lessons emerging from suicides and to strengthen our local governance for internal quality assurance visits.

Financial update

The financial position remains very challenging with an overall deficit reported of £25k for May and £266k year to date (before STF). This is worse than the plan for the month by £5k and for the year by £217k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating (the UOR) reports as a 2.

There are several key actions being implemented to address this. The level of financial risk is driven by the fact that we have a small surplus margin while managing a significant and volatile level of demand and workforce pressures. Whereas in previous years we have been able to offset costs against underspends within pay budgets this has reduced. The situation has been further impacted by the phasing of saving schemes and some seasonal spikes in activity. However, we are continuing to invest to support service user experience, performance improvement and data quality initiatives, and on information technology to support staff.

Interim Director of Workforce & OD appointed

Mariejke Maciejewski has been appointed as Interim Director of Workforce & OD. A permanent appointment will be made in the autumn. Jinjer Kandola will leave HPFT on 29 June to take up her role as CEO of Barnet, Enfield & Haringey NHS Trust.

West Herts Diabetes Service scoops regional NHS70 award

The West Herts Diabetes Service, run jointly by HPFT and West Hertfordshire Hospitals NHS Trust has been chosen from hundreds of applicants to represent the central midlands region in the NHS70 Parliamentary Awards marking the NHS's 70th birthday. The team was nominated by Watford MP Richard Harrington for their outstanding work in providing mental health support to people with diabetes. As regional champion in the 'Excellence in Mental Health Care' award category, they will now go forward to a final stage of judging. All of the champions will now be invited to the national awards ceremony, on Wednesday 4 July, the day before the NHS's 70th birthday.

NHS 70

Along with all Trusts in the UK, the Trust is planning a number of celebratory events and activities to mark the 70th birthday of the NHS on 5 July. These include: a musical event with the HPFT Choir on the evening of 4 June; a series of tea parties in all our main hubs on 5 July; a Windrush Walk on 13 July, in partnership with the National Workforce Race & Equality Standard (WRES) Programme and a NHS 70 marketplace at our AGM on 19 July. Further details are available from the Trust's Deputy Director of Communications.

Tom Cahill,
Chief Executive

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	28th June 2018	**Agenda Item: 6**
Subject:	Annual Patient Safety Report	**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 2017/19 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 its recommendations for 2018/19
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 the service users remain safe whilst under our care. It also identifies the patient safety priorities that the Trust implements to minimise the risks to service users.

In February 2018 the CQC undertook a core inspection of inpatient services in 4 service lines within the Trust. The inpatient learning disability services were moved from a rating of requires improvement to good for safety, the acute inpatients and psychiatric intensive care and Child and Adolescent Mental health in patient unit service lines remained as requires improvement for this key line of inquiry. The Trust was rated good overall but requires improvement for safety.

The 1st April 2017 and 31st March 2018 the Trust reported an increase of 13% in incident reporting compared to the same reporting period in 2016/17. There was a 25% (91) increase in reported Serious Incidents in comparison to those reported in 2016/17 although six were subsequently downgraded. There were no incidents reported that would meet Never Events criteria.

There was an increase in the number of suspected suicides (a number are still waiting conclusions). The Trust has not met its aspiration to reduce the number from the previous year.

A number of safety initiatives were implemented during the year including safety huddles, safety crosses and medication safety to address themes arising from incidents.

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

This report speaks to and provides assurance in relation to delivering safe care.

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:

Due to be seen at IGC on 5th July 2018

Executive Summary

Introduction

Delivering safe services to our service users is a key priority for the Trust. 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 and actions taken to manage this risk.

Overview of the 2017/18

The Care Quality Commission (CQC) visited the Trust this year and undertook an unannounced visit in one service and an inspection of 4 core services as well as the well led inspection. The safety Key Line of Enquiry (KLOE) was considered at each. Although the inpatient learning disability services moved from a rating of requires improvement to good for safety, the acute inpatients and psychiatric intensive care and the child and adolescent mental health in patient service lines remained as requires improvement. The Trust was rated good overall but requires improvement for safety.

The Trust reported no incidents that would meet Never Events criteria. Between 1st April 2017 and 31st March 2018 the Trust reported an increased number (by 13%) of incidents when compared to the same reporting period in 2016/17. It also reported 91 Serious Incidents in 2017/18, 6 of which were subsequently downgraded. This was an increase of 25% on the total number of Serious Incidents reported in 2016/17.

The number of reported falls has decreased during this period. Non-anchor ligatures incidents have increased, with clothing being the most frequent reported category. This is in line with the National picture and the Trust is working with a group of Trusts Nationally to develop practice in this area.

Actual assaults by service users against other service users and staff has decreased.

The Trust level of harm reporting bench marks well nationally, although some caution is required following the CQCs comments regarding the Trust rating of moderate harm. The next 6 monthly report from The National Reporting and Learning System (NRLS) will reflect the introduction of the moderate review panel in quarter 4.

The Trust's Mortality Governance Group was set up and began its work this year. This group has oversight of all deaths reported on Datix and those which are subject to a structured judgement review or a serious incident investigation, including those in the national Learning Disabilities Mortality Review (LeDeR) programme which aims to make improvements to the lives of people with learning disabilities.

The Trust aspired in 2017/18 to reduce the number of suicides by 10%, it is clear that there will be an increase, although there are still a number of unexpected deaths that are suspected to be suicides that are to be concluded at inquest. It is not yet possible to know whether this increase is reflective of the national picture. An important part of work in 2018/19 will be to understand this data better and work towards improving outcomes for our service users.

Key priorities for 2018/19

- The Trust is developing a new safety strategy in co-production with its staff, service users and carers.
- Further prevention of suicide and a deep dive into 2017/18 data to identify themes, trends and learning.
- Collaboration with Public Health in a Suicide audit and the suicide prevention strategy implementation.
- A review of seclusion practice and documentation by Mersey Care NHS Foundation Trust in July 2018.
- A review of the whole Serious Incident identification and investigation process, using Quality Improvement methodology.
- Embedding Human Factors into investigations.
- A review of the patient safety meeting, 'Clinical Risks and Lessons Learnt', to ensure all learning is not only identified but shared and acted on consistently.
- Co-production with service users and carers to deliver safe medicines management.

Conclusion

This annual report identifies and discusses the key data that informs the monitoring and activity in relation to safety. There has been a significant increase in all incident reporting and also in serious incidents reported. In particular there was a significant increase in quarter 4 of serious incident reporting. The majority of these relate to unexpected deaths, but some to self-harm.

It is clear that that there are a number of areas where evidence shows safety for our service users is improving.

The CQC visit identified much good practice in relation to safety, including good medication safety and evidence of staff reporting, escalating and learning from incidents. However the trust remains in 'requires improvement' for safety. The ongoing priority in 2018/19 must be to address the areas identified for improvement and develop a strategy that will make our service users, carers and staff not only receive safer care but feel safer too.

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 2017/18 with the use of safety metrics. Datix is a live data base; for the purposes of producing this report the data was taken from Datix on 11th April 2018 at 08:00am.

1.2. The report provides a summary of incident data reported between 1st April 2017 and 31st March 2018, alongside a review of trends and themes. The Board received quarterly patient safety reports in quarters 1 to 3, with quarter 4 included in the overall annual report.

1.3. It also includes a review of mortality data and serious incidents reported and investigated by the Trust.

1.4. The report is divided into the following sections:

- Part A CQC
- Part B Analysis of Incidents
- Part C Learning and Changing Practice
- Conclusion

1.5. The report gives an overview of Trust incident data, with comparison against 2016/17, this includes: falls, medication safety, ligature risk and violence and aggression.

1.6. 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.

Part A

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

2.1. The CQC undertook a core inspection of inpatient services in 4 service lines within the Trust this year–

2.1.1. Forensic in patient,
2.1.2. Acute in patient and Psychiatric Intensive Care Unit (PICU),
2.1.3. Children and Adolescent in patient,
2.1.4. Learning Disability.

2.2. Five Key Lines of Enquiry (KLOEs) were considered- Safety, Responsive, Effective, Caring and Well Led. This section of the report will give an overview of the findings in relation to the Safety KLOE.

2.3. The CQC also conducted an unannounced visit to the Broadland Clinic in September 2017 to specifically look at the Safe and Effective KLOEs.

2.4. The Trust was subsequently sent a Section 29A Warning Notice regarding The Broadland Clinic. The reasons given for the Commission's view were that the quality of healthcare provided at the Broadland Clinic required significant improvement in the following areas:

- Seclusion environments.
- Restraint practice.
- Risk assessments and clinical records.
- Ligature point management and environmental risks.
- Staffing.
- Supervision.

2.5 The Trust was required to make the significant improvements identified above regarding the quality of healthcare by 31 January 2018. This was achieved and the warning notice was lifted following the care and well led inspection.

2.6 The CQC raised a concern that the Trust's system for rating and recording serious incidents against the NHS framework was not accurate and therefore might led to serious incidents lacking full investigation, reporting and learning. In response to this, the process has been reviewed and a weekly moderate harm panel has been implemented. This panel includes the Deputy Directors of Nursing, Safer Care and Deputy Medical Director and SBU representation. The panel reviews 72hr reports for moderate harm incidents and considers whether they should be reported.

2.7 The acute inpatient and PICU services remained as requires improvement for safety. The Trust was identified as not meeting the following legal requirement - Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. This related to assurance around ligature risks and blind spots, physical health assessment on admission, adherence to the Mental Health Act code of practice in regards to recording of seclusion practices and the seclusion environment and proper and safe management of medicines.

2.8 These risks are being addressed and work is ongoing in the coming year that includes a review of seclusion practice and development of the ligature risk assessment audit. Other work includes a review of Safe and Supportive Observations practice and policy, and a standard operating protocol for medication expiry dates.

2.9 In patient child and adolescent services, Forest House Adolescent Unit, also remained as requires improvement. The Trust was identified as not meeting the following legal requirement - Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment.

2.10 The report said the trust must ensure that all ligature risks are identified, mitigated and managed. A number of actions have been taken to mitigate the risk, including ligature risk assessments in unsupervised in these areas. The young people are risk assessed on an individual basis with regards to access to the garden and whether they require an escort.

2.11 Forensic Inpatient Services moved from requires improvement to 'good' for safety. The CQC identified many areas of good practice including: robust ligature risk assessments, regular environmental risk assessments and well managed staffing levels across the service. Care records showed staff used a recognised risk assessment tool and individual risk assessments. All incidents of restraints were reported and all wards participated in the hospitals restrictive interventions reduction programme. Recording of seclusion was

effective and followed best practice. Restraint was used as a last resort when all other de-escalation techniques had failed.

2.12 The Trust's overall rating for 'Safety' remains as 'Requires Improvement' however the CQC found significant evidence of good practice, some are included below:

- Services used recognised risk assessment tools. Staff had completed personalised, holistic, recovery focused risk assessments for patients on admission in all wards. Staff were able to identify and respond to changing risks and updated patient risk assessments following incidents.
- Managers and staff demonstrated good understanding of safeguarding, reporting, and recording incidents and escalated concerns immediately.
- Managers shared learning from incidents across the Trust and disseminated this through team meetings on all wards. As a result of post incident analysis and learning from incidents, practice changed.
- All wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs.
- Restraint was used as a last resort when all other de-escalation techniques had failed.
- Staff managed medicines safely in most services. The Trust had made improvements in medicines management since the last inspection.
- Documentation was clear, staff completed competency assessments, and managers implemented systems to manage medication and completed regular audits.

2.13 The Trust has developed and is implementing an action plan in response to the concerns raised. In addition learning from good practise identified has been shared and built upon.

Part B

3. Overview Of Reported Incidents

3.1. Trust wide incident reporting

3.2. 'Patient safety incidents are 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.

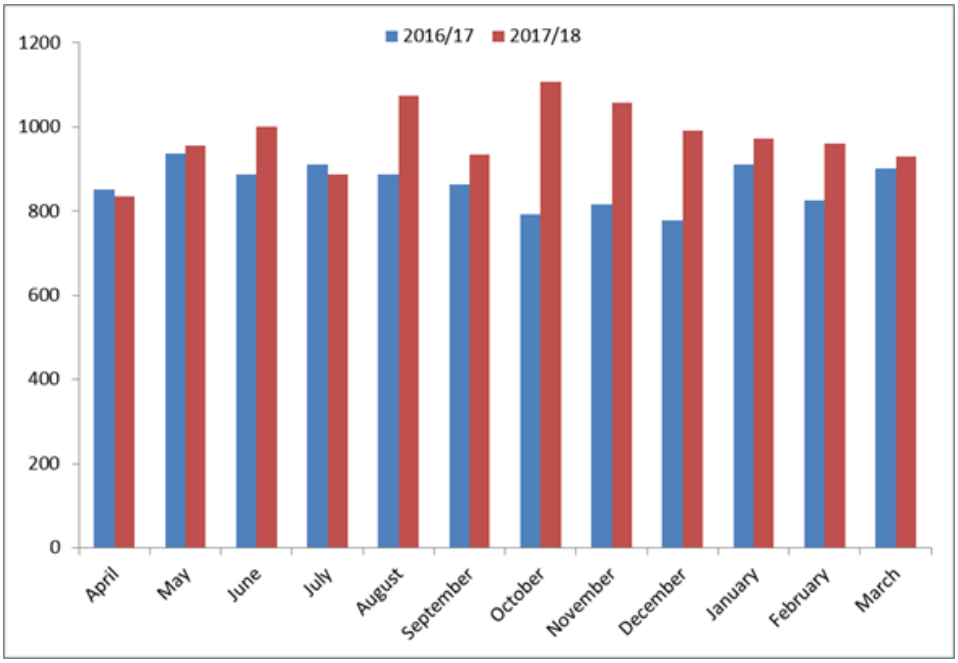
3.2.1. There has been an overall increase in incidents from 2016/17 to 2017/18 of 13% (chart 1). A trust with a safety culture committed to learning expects to have a high rate of no harm and low rate of harm reporting.

3.2.2. The increase in incidents can be seen across all the trust services, with the highest increases being in CAMHS Inpatient Services (43%), and Rehabilitation (46%) and Low Secure Services (LD) (39%). These services have seen a pattern of repeated incidents pertaining to the same service users.

3.2.3. The greatest increases were seen in the reporting period August to December 2017. This included the following incidents: data loss (39%), medication (37%)

practice/clinical care (36%), safe guarding adults/ children (37% and 27% respectively) and security (32%).

Chart 1: The number of incidents reported across all Trust services from April 1st 2017 to March 31st 2018 compared to 2016/17



3.2.4. There was an increase in the incidents reported relating to concerns about staff shortages. They doubled in this reporting period compared with 2016/17. This was correlated with work done in the safe staffing committee, to encourage nursing staff to report when they had concerns about staffing levels or when service user activities had to be cancelled due to staffing challenges.

3.2.5. There is no indication that there were short falls in staffing when the data was analysed but the high acuity and a resultant increase of bank and agency may have had an impact on how staff felt. This information has been used during the regular review of safe staffing levels.

3.2.6. The trust has invested in 'SafeCare', a live view of staffing that takes into account the numbers and needs of service users. In 2018/19 this be built upon further to strengthen how we use staff to meet service user need. Also it will be used to give an overview of bank and agency and staff moves and how this impacts on staff morale.

3.2.7. Security incidents were low there was an increase last year from 69 to 191. The key reason was 'discovery of an inappropriate item or object on a award or unit'. A considerable amount of work has been done to improve the search guidance and to support staffing in being safety aware at all times. It is therefore positive that an increasing number of restricted items are found and reported by staff.

3.2 Duty of Candour

The Trusts Duty of Candour policy sets out the requirement to meet the Statutory Duty and this is assessed through the quality schedule. The Serious Incident investigation process will include the family and the report considers their concerns, questions and input into the terms of reference.

Where the family has engaged, they receive a copy of the report and the Trust ensures the report is shared ahead of inquests. Investigators meet with families in a number of cases but this is not always something the family wants. At inquest our representative always approaches the family to offer condolences and answer any questions the family may have. We have examples of families getting involved in suicide prevention work following the work we have done to engage them following the death of a service user.

Our head of patient safety emails commissioning managers when an SI investigation is about to begin reminding them of the need to ensure that the duty of candour is met.

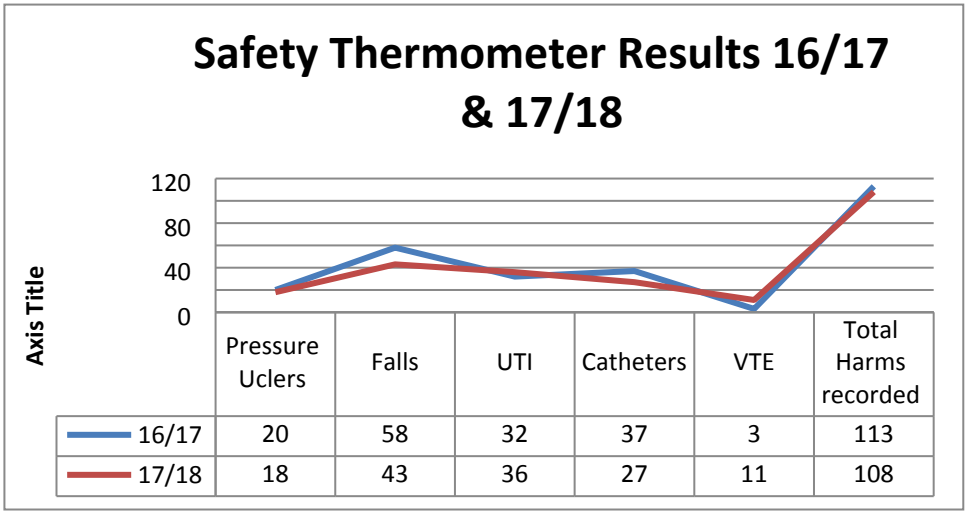
3.3 Safety Thermometer

The Trust submits its safety thermometer regularly, as required. The data for this reporting period is shown in the chart below. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The tool measures four high-volume service user safety issues:

- Pressure ulcers
- Falls in care
- Urinary infection (in patients with a catheter)
- Treatment for Venous Thromboembolism (Assessment & Treatment)

In 17/18 the Trust reported 108 harms on the Safety Thermometer, this is a 4% decreased compared to 16/17. However Venous Thromboembolism (Assessment & Treatment) have increased from 11 recorded on the safety thermometer in 17/18 compared to 3 in 16/17. A multi professional approach to tackling this challenge has been instigated through the Clinical Risk and Lessons Learnt committee.

Chart 2 Safety Thermometer 2016/17 and 2017/18

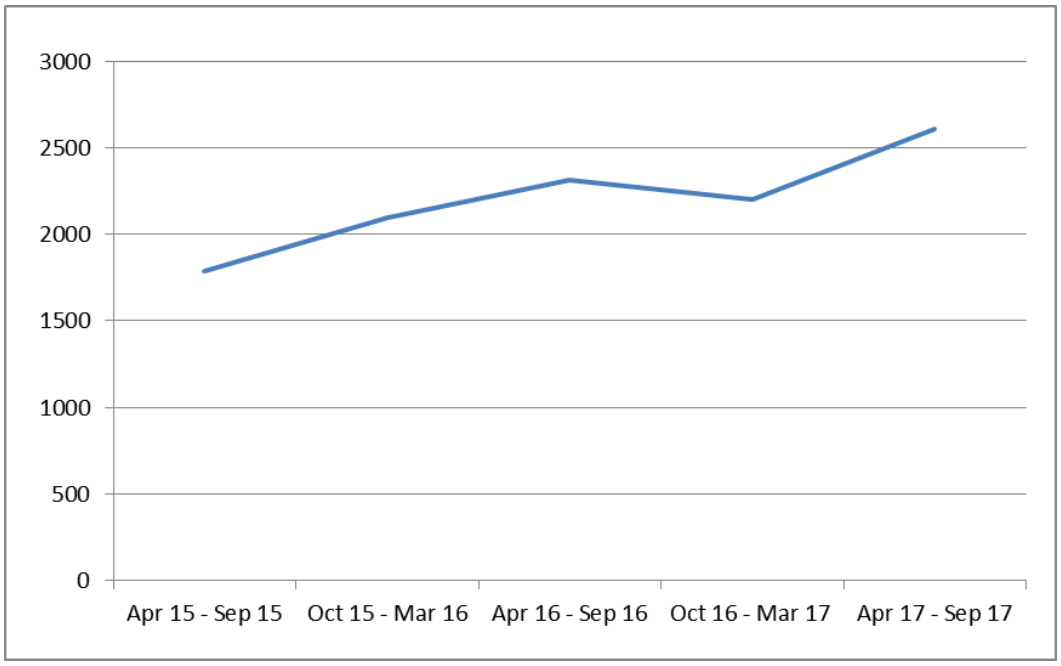


	Pressure Uclers	Falls	UTI	Catheters	VTE	Total Harms recorded
16/17	20	58	32	37	3	113
17/18	18	43	36	27	11	108

3.4 National Reporting and Learning System (NRLS)

3.41 The Safer Care Team reports relevant patient safety incidents to the National Reporting and Learning System (NRLS). The latest release of the Organisational Patient Safety Incident Report data for NHS organisations was published in March 2018. This release provided information about incident data reported by the Trust between 1st April 2017 and 30th September 2017. This demonstrated a steady increase in reporting of safety incidents over time.

Chart 3: Number of patient safety incidents reported to NRLS



3.4.2 The report details the degree of harm in comparison to other mental health trusts. This is shown in chart 3 and demonstrates the Trust has reported a lower level of harm in 2017 compared to 2016. This should be viewed with some caution as CQC found that the Trust may not be rating the level of harm resulting from incidents appropriately.

3.4.3 In comparison to all mental health Trusts the Trust has a lower than average reporting rate of moderate harm incidents, again this should be interpreted with some caution. A moderate harm panel is now in place to review incidents and ensure they are reported consistently and investigated appropriately.

3.4.4 It can be seen that although reported incidents have increased in the latest 6 month reporting (1st April 2017- 30th September 2017) to the National Reporting and Learning System (NRLS), there is a ratio of 72% of no harm compared to a bench mark against other mental health trusts of 66%.

3.4.5 The ratio of HPFT patient safety incidents resulting in Severe Harm to service users is down from 0.2% to 0.08%. The proportion relating to service user deaths has fallen from 1% to 0.8%. It is important to consider this data does not include quarter 3 and 4 where it is known there were increases in serious incident reporting and unexpected deaths. The next report from NRLS will reflect this and will be detailed in the appropriate quarterly report.

3.4.6 Chart 4 shows the level of harm reported by the Trust compared with the other mental health trusts in the East of England. This demonstrates a good reporting culture in relation to no harm incidents, ensuring lessons are learnt even when there is no adverse outcome.

Chart 4: Degree of harm: comparison against all Mental Health Trusts

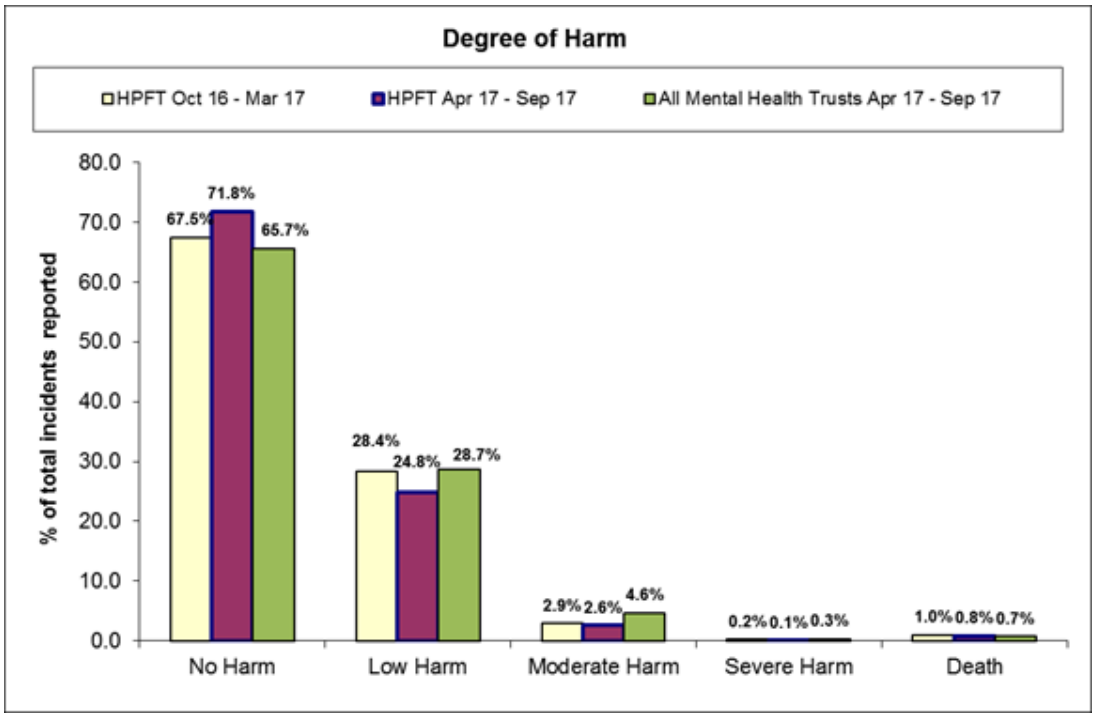
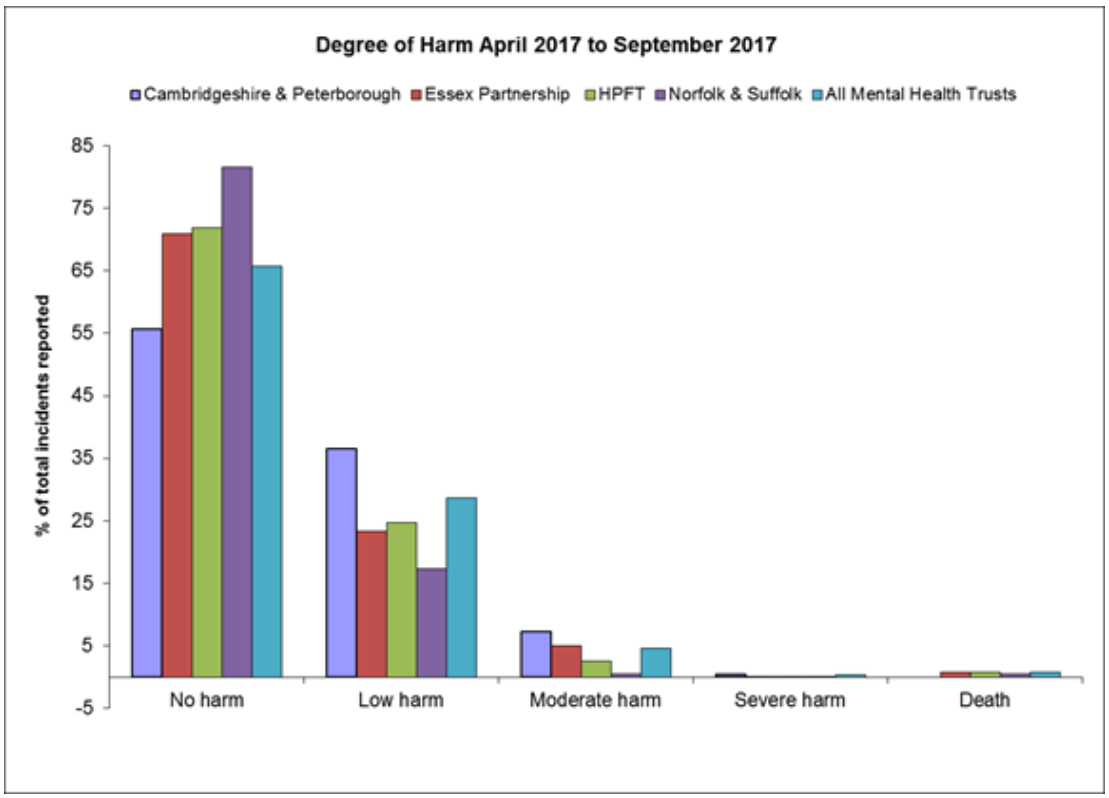


Chart 5: HPFT Comparison of degree of harm with other trusts in the East of England.



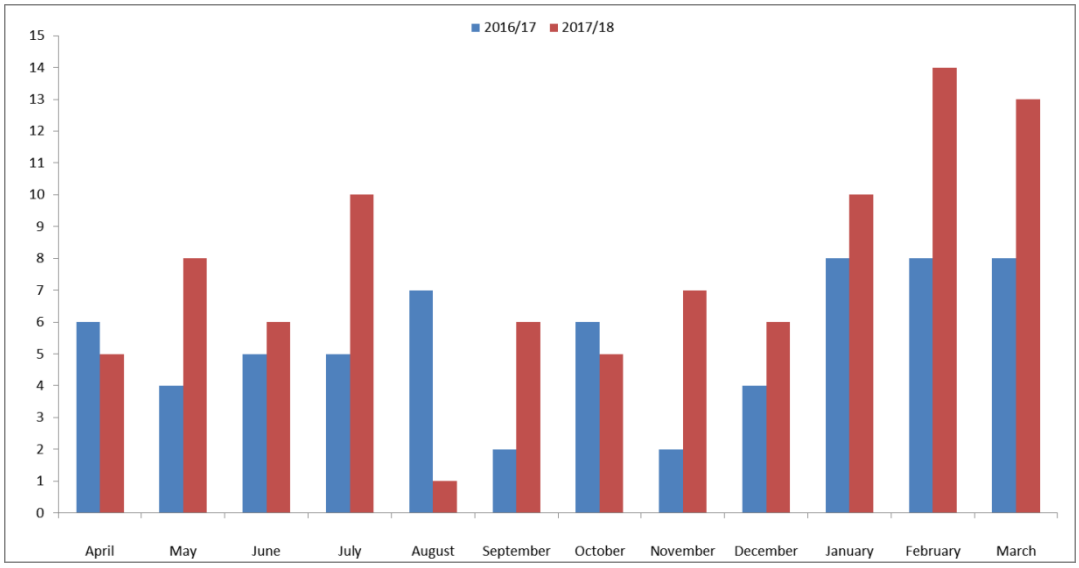
4 Serious Incidents Overview

4.3 ‘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).

4.4 Serious Incidents are reported externally via the national Strategic Executive Information System (StEIS). The Trust reported a total of 91 Serious Incidents in 2017/18 compared to 69 in 2016/17.

4.5 There were 24 Serious Incidents reported in Q4 2016/17 and 37 reported in Q4 2017/18. It is noted that there was a sharp increase in February and March, resulting in a 25% increase in reported serious incidents (chart 5). This appears to be multi-faceted. It is assumed that increased scrutiny and the review of ratings has resulted in an increase in SI reporting. In addition, the panel undertook a retrospective review of the previous 3 months and reported an extra 3 SIs, including one that the CQC had identified.

Chart 6: Serious Incidents by Reported Month, comparing 2016/17 to 2017/18



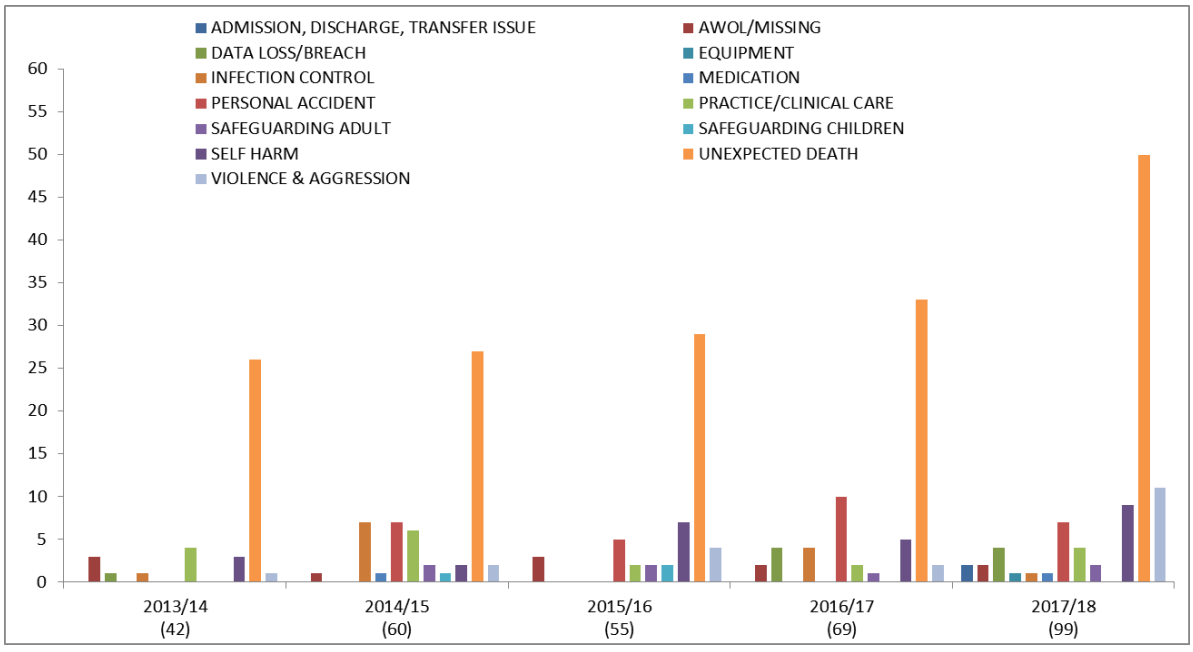
4.41 When the incidents are broken down by category in Chart 7, it is clear that unexpected/avoidable deaths and apparent/actual/suspected self-inflicted harm are the areas with the biggest increases as reported SIs.

4.42 Chart 8 gives greater understanding over a longer period of time. It demonstrates that unexpected deaths has steadily increased year on year. Also, that the range of type of incidents reported has increased.

Chart 7: The serious incidents reported in 2016/17 & 2017/18 by StEIS category

Category	2016/17	2017/18
Unexpected/avoidable deaths	39	49
Apparent/actual/suspected self-inflicted harm	3	11
Slip/trip/fall	10	9
Confidential information leak/information governance breach	4	6
Abuse/alleged abuse of adult patient by third party	1	3
Disruptive/aggressive/ violent behaviour	2	3
HCAI/Infection control	4	2
Unauthorised absence	2	2
Accident e.g. collision/scald (not slip/trip/fall)	0	1
Adverse media coverage or public concern about the organisation or the wider NHS	0	1
Apparent/actual/suspected homicide	0	1
Major incident/ emergency preparedness resilience and response/ suspension of services	0	1
Medication incident	0	1
Treatment delay	0	1
Commissioning incident meeting SI criteria	1	0
Abuse/alleged abuse of adult patient by staff	1	0
Abuse/alleged abuse of child patient by third party	1	0

Chart 8: Serious Incidents by Incident Date (April 2013 – March 2018)



5 Suicide

5.3 The Trust aspired to reduce suicides by 10% in 2017/18. A 10% reduction would be no more than 32 in the year if compared with the previous reporting year. Every suicide is one too many and the impact on the family and staff is great and the Trust is committed to zero suicides.

5.4 It is clear that number of suspected suicides have increased over the year although the inquests have not all be concluded yet. Table 9 and 10 shows the position at year end.

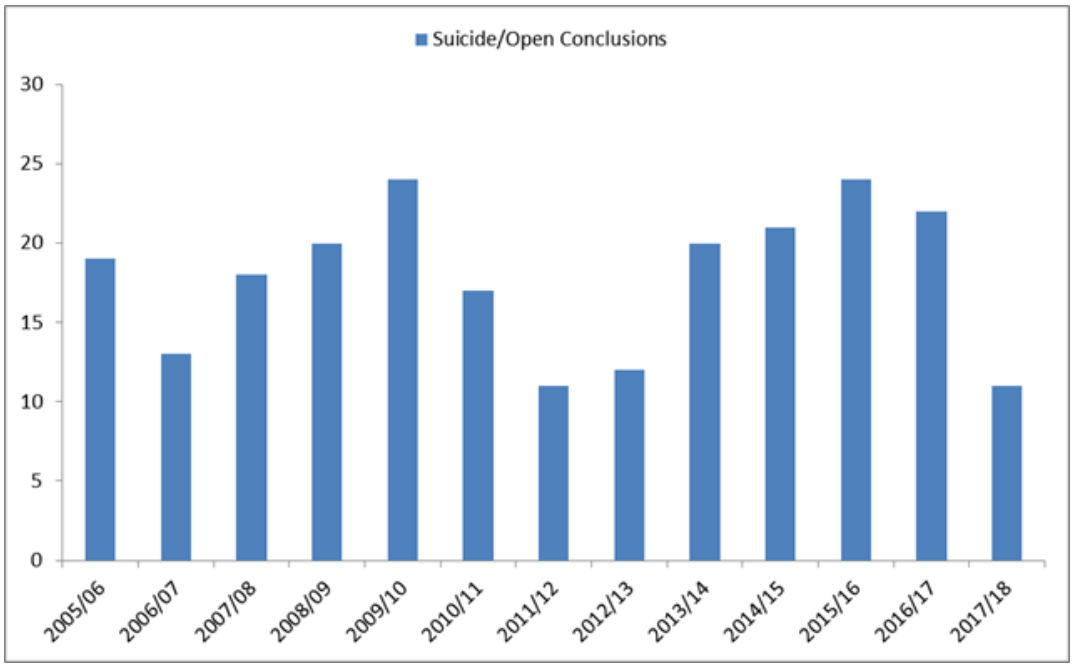
5.5 Suicides are only concluded when the coroner believes there is no reasonable doubt. A deep dive into the data and contributory factors will take place in 2018/19 and the Trust is working with public health, the CCGs and The British Transport police to undertake an audit across Hertfordshire.

Table 9 Number of unexpected deaths 2017/18, with current positon, including confirmed inquest outcome.

Q	Unexpected deaths initially considered	Still to be heard at inquest			Current possible end position	
		Unclear awaiting histology	Suspected Substance misuse	Suspected still to hear	min	Max
1	8	0	0	0	5	5
2	9	0	0	0	8	8
3	12 (+1 not HPFT)	0	2	9	9	11
4	18	2	4	12	12	18
Year end	44(+1)	**2**	**6**	24	35	43

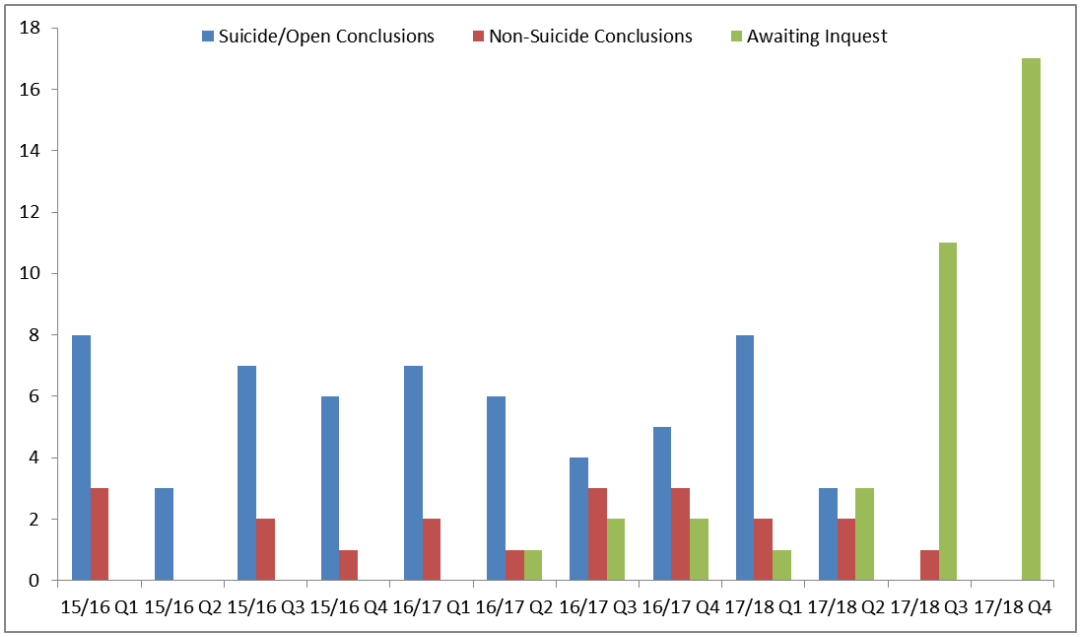
Q	Unexpected deaths initially considered	Confirmed Inquest Outcome				
		Inquest suicides	Inquest open verdict	Confirmed open/ suicide	Non suicide/ Narrative at inquest/no inquest needed	Not HPFT
1	8	4	1	5	3	0
2	9	8	0	8	1	0
3	12 (+1 not HPFT)	0	0	0	1	1
4	18	0	0	0	0	0
Year end	44(+1)	10	1	11	4	**1**

Chart 10: Suicide/Open Conclusions by Incident Date (April 2005 – March 2018)



The data in 2016/17 and 2017/18 will change as not all unexpected deaths will have coroner's conclusions, see chart below.

Chart 11: Unexpected Deaths by Incident Date (April 2015 – March 2018)



6 Suicide Prevention

6.4 HPFT's ambition is to have zero suicides. This ambition is reflected in the Hertfordshire wide suicide prevention strategy which HPFT contributed to developing and has signed up to. The strategy's vision is to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option.

6.5 HPFT have been an active participant in developing and delivering the resulting Hertfordshire Suicide Prevention Programme and the work undertaken by the Trust is delivered in line with this programme.

6.6 The Hertfordshire Suicide Prevention Programme is overseen by the Hertfordshire Health and Well-being Board. The aim is to deliver a wide range of actions in the relation to suicide prevention. A county wide suicide prevention action plan was develop by all partners across the county. This set out how we will work together across a broad range of initiatives.

6.7 A programme structure was developed to assist with co-ordinating the work and monitoring and evaluating delivery. A Suicide Prevention Programme Board, comprised of a small number of sector representatives, meets quarterly to maintain strategic direction, approve the action plan and take any major decisions. Hertfordshire's Suicide Prevention Programme Board aims:

- to reduce the rate of suicide within Hertfordshire.
- to provide strategic leadership and oversight of the suicide prevention programme being delivered across Hertfordshire.

6.8 A Suicide Prevention Working Group meets once every one or two months and oversees the work of the task and finish groups through structured highlight reports. Any major risks and issues are escalated to the Suicide Prevention Board.

6.9 The action plan is delivered though task and finish groups set up around specific actions or delivered through groups already in existence, such as Spot the Signs. These action areas were drawn from workshop sessions at the November 2016 multi-agency event.

6.10 HPFT are reviewing a suicide audit tool with public health to ensure it reflects the changing picture of suicides locally.

6.11 HPFT has representation in each of the work streams as well as on the programme board and working group:

- Men and boys
- Mental health transition
- Spot the Signs
- Medicines
- Communication, awareness and media
- Signposting and referral
- Support for bereaved families
- Support for young people
- Learning lessons and performance measures

7 Learning from Deaths

7.4 The Trust's Mortality Governance Group has oversight of all deaths reported on Datix and those which are subject to a structured judgement review or a serious incident investigation; this also includes those deaths meeting criteria for reporting to the national Learning Disabilities Mortality Review (LeDeR) programme which aims to make improvements to the lives of people with learning disabilities.

7.5 In 2017/18 a new process was developed to ensure a robust and collaborative approach to mortality reviews and the identification of learning.

7.6 In 2018 the Royal Collage of Psychiatrists are developing a morality screening tool specific to Mental Health and the Trust are to be one of the pilot sites implementing the new tool offering us the opportunity to input into the development but also gain early intelligence regarding our data.

8 Never Events

8.4 The Trust has had no Never Events in 2017/18.

8.5 The Never Events policy framework, March 2015 defines a Never Event as 'serious incidents that are entirely preventable… Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.'

8.6 The Trust has completed a gap analysis of the update Framework Never Event list (January 2018) to assure compliance in potential risk areas. The policy has been updated accordingly.

Part C

9 Learning from Incidents and Changing Practice

9.4 There are many learning opportunities relating to incidents, Serious Incidents (SIs) and mortality reviews, learning is captured for each team and shared across the Trust as 'Learning Notes'.

9.5 The Trust's patient safety committee 'Clinical Risk and Lessons Learnt' is the focal point for ensuring learning is embedded across the Trust in a number of ways.

9.6 In the quarterly patient safety reports to Board details of areas of learning are detailed. This report will detail the main areas of practice development that have been influenced by learning from incidents.

9.7 Learning is further support by the delivery of Schwartz Rounds, case study presentations, staff support and task and finish groups were safety concerns have been raised.

9.8 The Making our Service Safer Strategy (MOSS) saw its final year in 2017/18. This strategy focused on four key areas to support the management of positive, proactive and safe care:

- Data Informed Care: review of incidents and data for themes and learning
- Restrictive Intervention Reduction: use of approaches, such as Safe wards
- Support Planning: through Positive Behavioural Support, Wellbeing Plans
- Post Incident Support: to offer support post incident.

9.9 A number of 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, and supporting established activities such as 'Safewards' to support less restrictive approaches to care.

9.10 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.

9.11 Significant work was undertaken to ensure that the Managed Entry and Exit Policy (MEEP) was implemented effectively. Alongside this quality improvement project was developed that resulted in a significant reduction in the number of MEEP incidents. Lessons from this project were shared and implemented across the Trust.

10 Medication Safety

10.4 Full details of medication safety and management will be in the Annual Medication Management Report. For the purpose of this report the main safety themes are drawn out.

10.5 Between the periods of April 2017 to March 2018, there have been a total of 517 incidents relating to medication reported within HPFT. This is an increase of 20% when compared to 2016/17.

10.6 The top five common (based upon qualitative review) themes are as follows:

- Inappropriate/incorrect administration
- Delayed and omitted doses
- Incorrect documentation and record keeping
- Inappropriate/incorrect prescribing
- Inappropriate/incorrect dispensing

10.7 The pharmacy safety team have responded to these by increasing education and training to Trust staff. There have also been a number of actions taken:

- Development of a depot standard operating procedure and audit of practice against the SOP
- Lithium shared care guideline developed
- Re-design of the community depot prescription chart
- Re-design of the clozapine initiation and titration chart.

11 Ligature Incidents

11.4 Non-anchor ligature incidents represented an on-going challenge with regards to patient safety in 2017/18. The CQC identified concerns in relation to risk assessments and work continues to ensure rigorous risk assessments and robust audits. Chart 11 below gives a comparison of ligature incidents by type for 2016/17 and 2017/18.

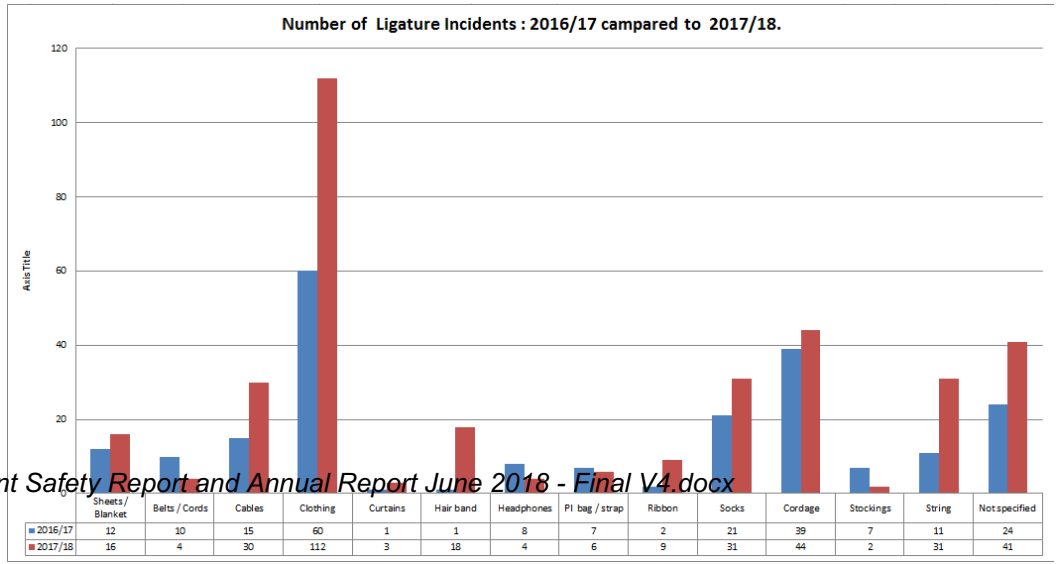


Chart 12: Number of Ligature Incidents: 2016/17 compared to 2017/18

11.5 Analysis of incidents shows an overall increase of 133 incidents in total, with the most significant increase in the use of clothing, which is freely available and can easily be modified.

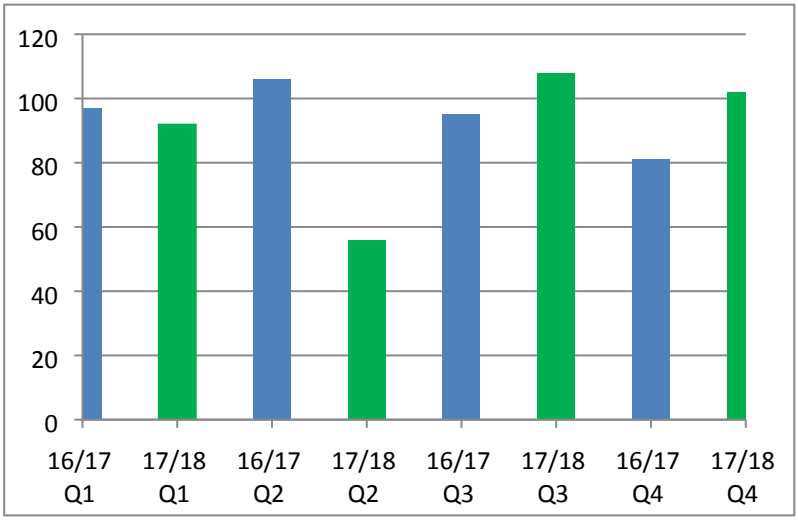
11.6 The Trust teams have analysed risks and continue to develop safe observations, search practice and appropriate seclusion as part of the mitigation. Staff share incidents and learning across the trust and a safety awareness culture supports safety of service users as they become more resourceful.

11.7 The Trust is also involved in a national piece of work across all mental health Trust to gain further understanding in relation to this and share good practice. This is in response to a National increasing trend that is being observed.

12 **Violence and Aggression**

12.4 This year has seen an overall decrease in service user to service user actual assaults by 5 %, although the last two quarters have seen increases, quarter 3 by 17% and Quarter 4 by 25%. See chart below.

Chart 13 Assault Service User to Service User 2016/17 and 2017/18



12.5 It is normal practice to see peaks and troughs in data as known service users are admitted and discharged from our services that are attributed to repeated assault on staff and other service users. In Learning Disability Services robust behavioural plans are in place for all service users, and these are particularly detailed, with attention paid to those service users who assault other service users or staff repeatedly. Staff in these services receive specific training by a psychologist in relation to developing these plans.

12.6 Assault by service user to staff has also decreased by 17.5%. However it is important to understand specific services where assaults are higher. There are higher incidents in dementia wards, i.e. Seward Lodge and Lanbourn Grove, where service users with dementia are admitted in acute presentations. It is known that a number of assaults happen during the giving of personal care to service users with dementia.

Chart 14 Assault Service User to Staff Assaults 6/17 and 2017/18

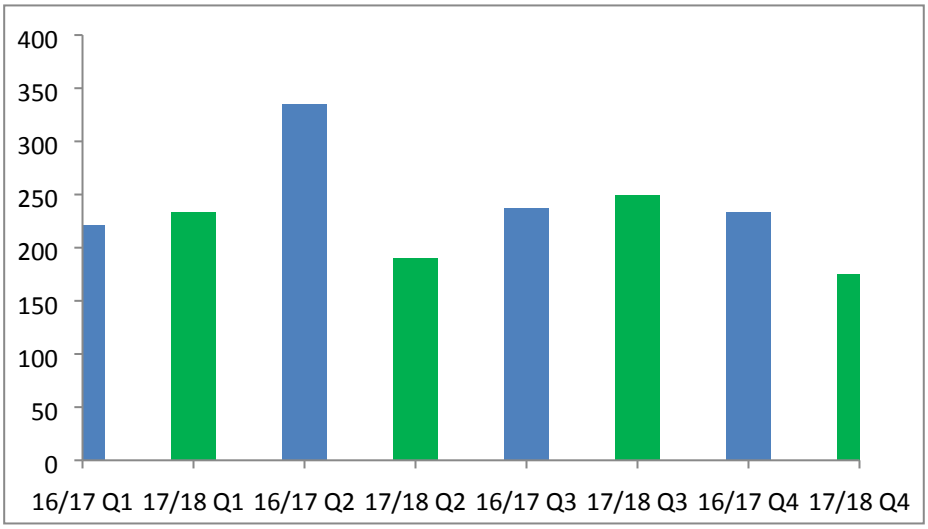
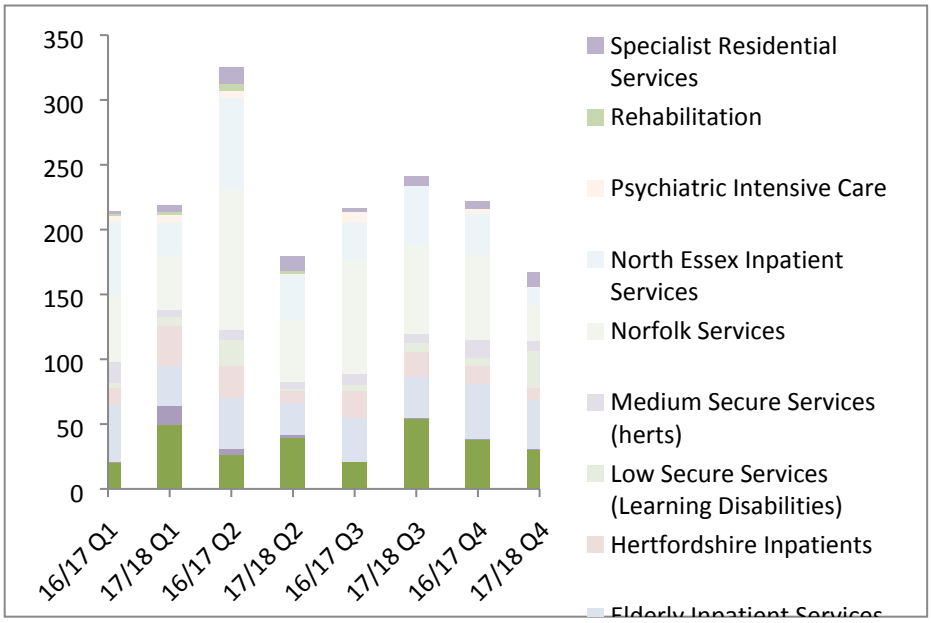


Chart 15 Service User to Staff Assaults by Service 2017/18



12.7 The implementation of the 10 MOSS interventions is likely to have had an effect on the reduction in assaults. These include bad news mitigation, clear mutual expectations and a set of values and rules that are agreed between the service user and staff. Following an incident datix requires information on the 10 interventions as to whether they were used, if they are effective and the use of physical intervention.

12.8 As the level of acuity increases in some services a review of RESPECT was carried out in 2017/18. Recommendations included the development of a training manual regarding disengagement and teamwork skills and the addition of new techniques for training. The Trust has also joined a multi Trust collaborative that shared learning and trouble shoots when challenges and new presentations arise.

13 **Prevention of Future Deaths (PFDs)**

13.4 Prevention of future death reports offer a significant opportunity for learning. During this reporting year The Trust received no Regulation 28 Prevention of Future Deaths reports from HM Coroners in 2017/18.

13.5 Despite that, all future death reports issues nationally are analysed and those relevant to the trust are shared in a quarterly update to the Clinical Risk and Lessons Learned committee. Any reports felt to be critical to the safety of our service users or carers are shared immediate with the relevant services through a cascade from the Safer Care Team.

14 **Falls Prevention**

14.4 The Trust Falls Group has focused in the last 18 months on falls occurring within Older People's Inpatient Services which is where the majority of the falls or found on floor incidents occur. There has been a decrease in falls in this service and across the Trust, see Charts 12 and 13.

14.5 The group meets quarterly and reports into the Health and Safety Scrutiny Committee.

14.6 Completed serious incident reports for falls or suspected falls resulting in a fracture are reviewed by the group to consider whether any targeted action is required.

Chart 16 Service User Falls Older People Services 2016/17 and 2017/18

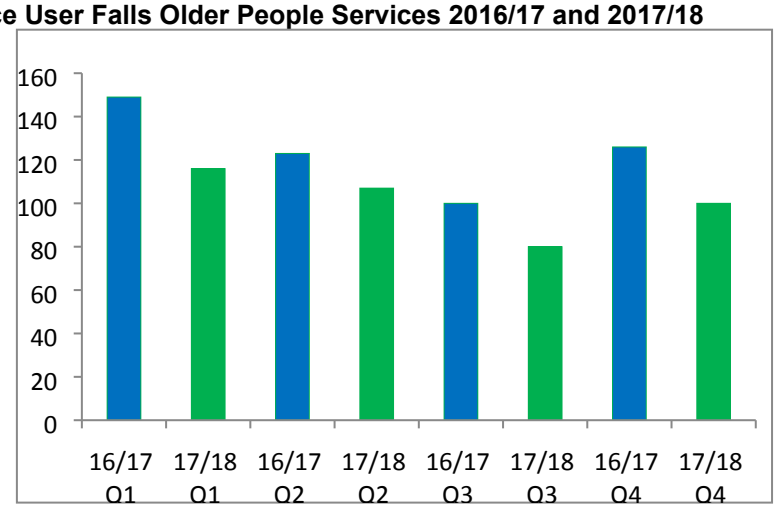
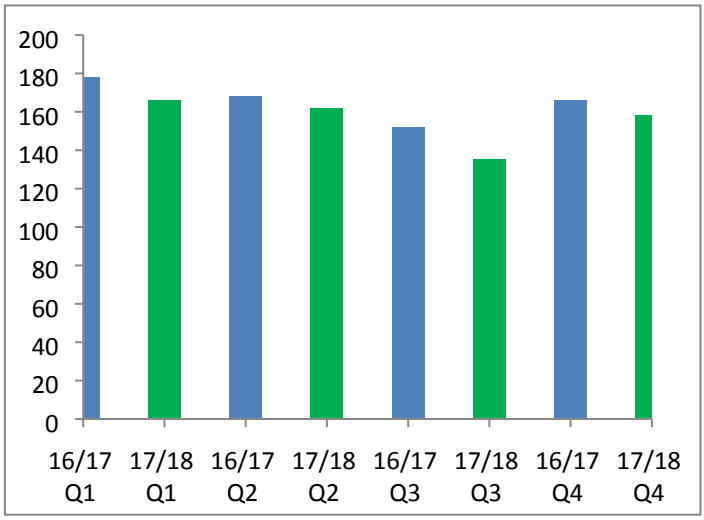


Chart 17 Service User Falls all Services 2016/17 and 2017/18



15 Education and Training

15.4 The Trust continues to develop and offer a number of training opportunists including: datix, route cause analysis (RCA), investigation skills and staff support. The training and education initiatives were recognised as by CQC as positive when they inspected the Trust.

15.5 A greater focus on human factors this year is beginning to be embedded investigations and this will be built on in the coming year.

15.6 A number of trust staff have completed the LeDeR investigation training and are part of the Hertfordshire team of investigators.

16 Conclusion

16.4 This annual report identifies and discusses the key data and initiatives that inform the monitoring and activity in relation to safety. There has been a significant increase in all incident reporting and also in serious incidents reported. In particular there was increase in quarter 4 of serious incident reporting. The majority of these relate to unexpected deaths, but some to self-harm.

16.5 It is clear that that there are a number of areas where evidence shows safety for our service users is improving.

16.6 The CQC visit identified much good practice in relation to safety, including good medication safety and evidence of staff reporting, escalating and learning from incidents. However the trust remains in 'requires improvement' for safety. The ongoing priority in 2018/19 must be to address the areas identified for improvement and develop a strategy that will make our service users, carers and staff not only safer from harm but continue to feel safer.

Appendix 1

Glossary and definitions of terms used in the report

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

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

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	28th June 2018	**Agenda Item: 7**
Subject:	Infection Prevention and Control Annual Report	**For Publication:** Yes
Authors:	Debbie Pinkney, Consultant Nurse Infection Prevention and Control, and Jacky Vincent, Deputy Director of Nursing & Quality	**Approved by:** Dr Jane Padmore, Executive Director for Quality and Safety (Chief Nurse), DIPC
Presented by:	Dr Jane Padmore, Executive Director for Quality and Safety (Chief Nurse), 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 2018/19
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:

Due to be seen at IGC on 5th July 2018 and at Infection Prevention and Control Committee on 19th July 2018

Executive Summary

Introduction

The annual report gives an overview of the reporting year 2017/18 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 2017/18

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 ongoing concerns regarding the service received by Interserve. The Trust also did not meet the target for staff flu vaccinations. Lessons learned from this year's campaign have been taken forward and included within the planning of the campaign for 2018/19.

Prioities for 2018/19

2018/19 will focus on developing and implementing a reporting procedure to monitor practices within the community setting. It will also see a renewed focus on monitoring and improving the standard of cleanliness from Interserve. A review of the service provision within the infection prevention and control team with the aim of ensuring sufficient resources will take place, which will include the agreement and implementation of a Trust wide Service Specification. Also an increased focus on working with the Trust's Occupational Health provider and Human Resources in ensuring that the Trust meet the flu vaccination target.

Conclusion

The annual report on infection prevention and control 2017/18 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 servcie 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 2017 to March 2018.

1.2 The report will give an overview of the healthcare associated infection, the audit programme and results.

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 infection prevention and control (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 2017/18.

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 2017/18, 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 related to the level of cleaning within the in-patient and community areas. The actions that were either non-compliant or partially completed will be incorporated into the IPC Programme for 2018/19.

2.5 **Incidents.** Monthly data has been collected on the incidence of MRSA (Meticillin resistant *Staphylococcus aureus*), MSSA (Meticillin sensitive *Staphylococcus aureus*), E-coli bacteraemia and *Clostridium difficlie*. There were no reported cases of MRSA bacteraemia or MSSA bacteraemia. There have been 2 reported cases of MRSA colonisation/infection (not bacteraemia).

2.5 There has been 1 case of pulmonary *Tuberculosis, one of* vancomycin resistant *enterococci* and 1 of *Clostridium difficile.* There have been no confirmed reported cases of E coli bacteraemia.

2.6 All cases were investigated by the IPC Team 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.

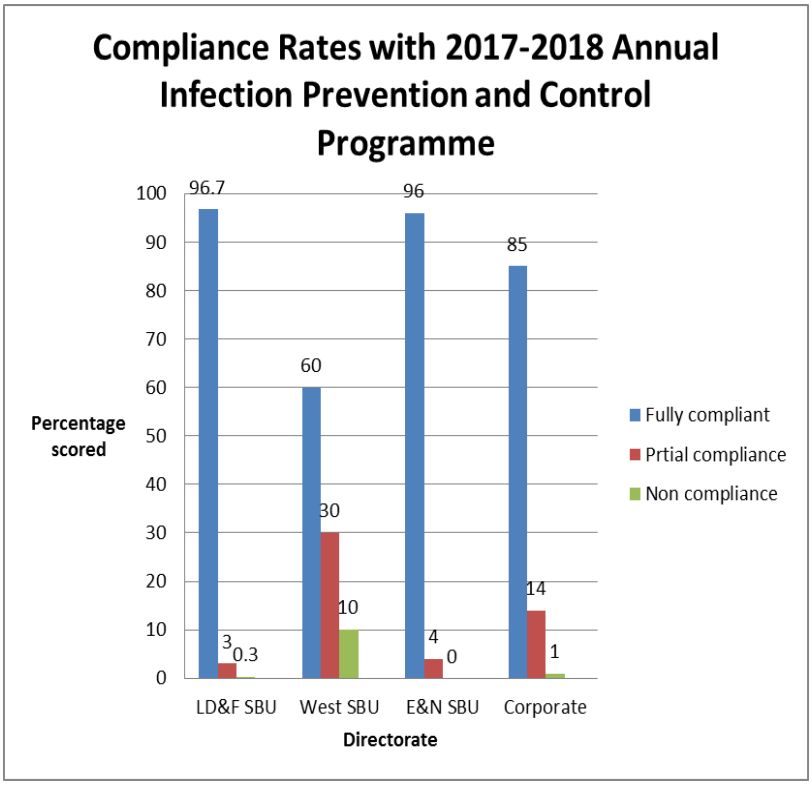


Table 1

3 Assurance

3.1 The IPCC oversees the quality assurance for this area of work. During the year CQC inspected the Trust, undertaking a core and a well led inspection as well as MHA assessments throughout the year. 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 support worker 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.
    - Staff not reporting cleaning concerns to the Helpdesk consistently.
    - Sharps containers not being labelled correctly.

  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. Improvements with how the audits were undertaken within some of the units within the West SBU. The IPC healthcare support worker and Head of Nursing have put in place a plan to address this and will provide support to the link practitioners on the completion of the audits.

- *Essential steps infection prevention and control 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.

- *Antimicrobial prescribing audit.* This audit measured the Trust performance against 5 standards **(Appendix 2).** The analysis identified areas of good practice in the following areas:
    - The completion of the allergy status and the appropriate duration of treatment.
    - All clinically reviewed antibiotic outcomes were documented in the notes.
    - There was limited prescribing of antibiotics in the community on FP10s.

  Areas for improvements identified were:
    - Antibiotic use being noted on the prescription chart as well as in the service user's notes.
    - The anticipated course length or review date being clearly documented in the service user's medical records and on the prescription chart.
    - Evidence of a clinical review being implemented at least 48-72 hours after initiating an antibiotic.
    - The use of Co-amoxiclav being reviewed within the local acute Trusts.

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 complaint with the national guidance.

4.2. A new policy has been written in relation to Carbapenamase Producing Enterobacteriaceae. This was written in response to a national screening programme being introduced for all patients being admitted to the acute general hospitals. There has been an increase in the number of cases being reported within the acute hospitals and the Trust needed to have a clear policy about how to manage any incidence if it were to present in our services.

4.3. There were 104 deep cleans during the year 2017/18. In addition, IPC deep cleans were undertaken at 5 sites in response to suspected or confirmed outbreaks of infection or periods of increase in incidence of infection.

4.4. Due to the ongoing concerns in relation to the service received by Interserve, Directors from both Interserve and the Trust have met several times to negotiate Interserve's claim for outstanding Compensation Events. An Action

Plan for Service Improvement (with agreed time lines) has been developed and is closely monitored.

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 year end of quarter 4, the overall compliance was recorded at 83**%** for level 1 and 82% for level 2.

5.2. IPC link practitioners are also offered additional training and development opportunities and legionella training was undertaken by Estates and Facilities as well as Interserve.

5.3. This year we have continued to raise the profile of IPC and the role of the IPC team. This has resulted in an increase in the number of designated IPC link practitioners and closer working relationships between the Community Clinical Nurse Leads and the IPC Team.

5.4. The Trust used national awareness weeks to promote this work further including 2017 International Infection Prevention and Awareness week at the Colonnades and at ward and team level and the European Antibiotic Awareness week.

5.5. The Consultant Nurse IPC worked jointly with the Matron from West SBU and the Sepsis Lead Nurse at East and North hospital Trust to deliver a presentation which identified the causes and signs and symptoms of sepsis**.** Posters from the Sepsis Trust have also been distributed to the units/sites and are available on the IPC page on *Trustspace*.

6. Incidents

6.1. 90 IPC incidents were reported on Datix and followed up by the IPC Team and then 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 place of incident taking place. The majority of suspected/confirmed outbreaks of infection or periods of increase in incident of infection occurred within the Mental Health Services for Older People. However, this is likely to be due to the increase in vulnerability of these service users and early reporting of symptoms to the IPC Team.

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

7. Legionella

7.1. Water Risk Assessments have been carried out for the entire Trust Estates portfolio. This year, work has focused on improving the monitoring of flushing, ensuring the appropriate level is maintained. As a result, there has been a significant improvement demonstrated across all sites.

7.2. During routine testing of the water systems at Albany Lodge, positive Legionella results were recorded. Following extensive investigations and remedial works, the water systems were cleaned chlorinated and re-sampled. As a result of the lessons learnt, improvements to the flushing procedures were also identified and implemented on this site and shared, where relevant, with other sites.

7.3. The Water Safety Group (WSG) has met regularly. The terms of reference for this group are currently being reviewed as a result of the restructuring of the Facilities and Estates Team. The Estates and Energy Manager has regularly met up with Interserve to monitor the water safety procedures

8. Flu campaign

8.1. Despite the Trust implementing an extensive flu campaign, the overall total of staff uptake was recorded at 59% (national target of 70%).

8.2. Lessons have been identified and the planning for next year's campaign has already started which will include increased involvement from Senior Management Staff with the SBU, increased peer vaccinators, earlier staff training and earlier provision of equipment.

9. Summary of key progress and challenges

9.1 Key Progress over the year:

- The incidence of alert organisms remains low.
- Audit implementation has improved due to the input of the IPC healthcare support worker. Actions plans were developed and implemented post audits and improvements were monitored at the quarterly IPCC meetings.
- IPC policies have been updated and reviewed in line with Trust format and national guidance.
- Training compliance levels have gradually increased – reporting at 83% for level 1 and 82% for level 2, at the end of Q4.
- 90 IPC incidents reported via datix.
- Increase in awareness of IPC at several promotional events including International IPC Awareness week and European antibiotic awareness week.

9.2 Key Challenges over the year:

- Ongoing concerns in relation to the service received by Interserve. This continues to be monitored.
- The Trust did not meet the set 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 2018-2019.

10. Priorities for 2018/19

10.1. Following the review of 2017/18 performance and the national priorities, the priorities have been set for 2018/19.

10.2. The Infection Prevention and Control Annual Work Plan will be discussed and approved, on behalf of the Board, by IGC. This will be a full a detailed plan but 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 of the staff resources within the IPC team, to ensure sufficient resources available to secure the effective prevention and control of infection. This will include liaising with the Trust's Contracts team in the agreement a Trust wide Service Specification.
- Work with the Trust's Occupational Health provider and Human Resources to ensure that the Trust meet the flu vaccination target.
- Manage and monitor the use of anti-microbial prescribing.
- Develop and implement the *'dip or not to dip'* campaign within all inpatient areas
- Implement the Infection Prevention and Cleanliness Programme 2018/19 (see **Appendix 3**) – 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 IPC Team, the DIPC, the Trust's Deputy Director of Nursing and Quality, Heads of Nursing, Matrons and Community 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 2017/18. The target was to fully complete 100% of the action points identified in the 2017/18 IPC programme; those actions which were either not completed or partially completed will be incorporated into the IPC priority schedule for 2018/19.

11.4 The IPC Team 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	Criteria
Standard 1	The allergy status of the service user 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 user's medical records.** *
Standard 3	Appropriate total duration of treatment - unless a clear indication is present antibiotic therapy should be stopped after 5-7 days
Standard 4	a) The anticipated course length or review date should be clearly documented in the service user's medical records **and** on the prescription chart. b) Was there evidence of a clinical review of antibiotic use at 48-72 hours? c) Outcome of review
Standard 5	Appropriateness / Adherence to Local and Trust guidelines. Expert advice from medical microbiologist

Hertfordshire Partnership NHS
University NHS Foundation Trust

Appendix 3

INFECTION PREVENTION AND CLEANLINESS PROGRAMME

April 2018 - March 2019

1. Background

1.1 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). 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.

1.2 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 sets out the 10 criteria against which the Care Quality Commission (CQC) will assess the Trust.

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 & Objectives

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.

3.2 Overall, to ensure compliance with the 10 criteria as highlighted within the *Health and Social Care Act, 2008,* revised 2015, as detailed in table 1 below.

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 and *Clostridium difficile*
- To ensure that all Trust staff acknowledge the importance of their role in terms of 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.

4. Infection Prevention & Control Arrangements

4.1 The Trust's designated DIPC is accountable directly to the Chief Executive Officer (CEO) and the Board; this role is undertaken by the Executive Director of Quality and Safety. The Trust also has a designated Non-Executive Director responsible for Infection Prevention and Control (IPC).

4.2 The Trust's IPC Committee meets 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).

4.3 Service level agreements (SLAs) continue with West Hertfordshire Hospital Trust and with Norfolk and Norwich Microbiology; these ensure Trust staff have further access for IPC advice via the IPC Nurses, Infection Control Doctors and microbiology staff working within these establishments.

5. Key Priorities

5.1 The Trust's key priorities are included within the action plan which also identifies the *responsibilities of key personnel*, for each individual action **(Appendix 1).**

5.2 The action plan also identifies

- **<u>Alert Organism/Condition Surveillance (Criteria 1)</u>**
  - Inform the Trust IPC nurses 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

- Database on alert organisms/conditions to be maintained by the Trust IPC nurses, including information on the incidence of MRSA, MSSA, ESBLs, E-*coli* bacteraemia and *Clostridium difficile*
- Matrons provide a quarterly, written report which identifies the incidence of all alert organisms/conditions that have been isolated within their units
- Post Infection Reviews and/or root cause analysis completed on any new MRSA bacteraemia, MSSA bacteraemia/*Clostridium difficile* cases/ Carbapenemase Producing Enterobacteriaceae
- Develop and implement post infection review form identifying lessons learned following the reporting of suspected or confirmed outbreaks of infection or periods of increase in incidence
- 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 report surveillance statistics to the Trust's IPC Committee and the Board via the Strategic Performance Report
- Include all alert organism/condition surveillance information in the annual report.

Action by: IPC team, MMs, Laboratory staff

- **Assessing and reducing the risks of infection (Criteria 1)**
  - 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 routinely complete the Risk Assessment Form regarding HCAIs – on all admissions/transfers into and out of Trust units. Matrons to report on the frequency of use of the form on a quarterly basis
  - Staff educated on the specific criteria regarding infection prevention and control incidents and report incidents via the Datix system
  - 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 implemented on all suspected or confirmed outbreak situations and periods of increase in incidence of infections
  - Monitor and review the IPC Risk Register on a quarterly basis and report at the IPC Committee
  - Implement the "Dip or not to dip" campaign launched within the Hertfordshire Nursing and Residential Homes
  - Review the Water Safety Steering Group & for the group to monitor all Trust sites, ensuring compliance is met with the Health and Safety Executive (HSE) guidance regarding water systems
  - Complete Water Safety Plans which require clinical input and clinical assessments
  - Report progress of the Water Safety Steering group at the IPC Committee and the Health Safety and Security meetings
  - Provide Legionella training to Matrons and Team Leaders
  - Monitor 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: -
  - Demonstrates compliance and assurance with the Code and to receive quarterly reports on IPC matters
  - 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 IPC
  - Have sufficient resources available to secure the effective prevention and control of infection, including 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.
  - Has a water safety group and that a water safety plan is in place.

  Action by: *CEO, DIPC, DDN&Q, Board Members, Consultant Nurse-IPC, Estates and Energy Manager*

- **Audit (Criteria 1)**
  - IPC nurses implement a minimum of 5 Infection Prevention Society environmental audits per annum
  - Inpatient IPC link persons work with the Matrons and implement regular IPC audits within their workplace
  - Community Clinical Nurse Lead to oversee the completion of 6 monthly environmental audits within the Community Hubs
  - Ensure that a minimum overall percentage score is above 85% on the environmental audit tool
  - Ensure the appropriate action plans are developed and implemented post all IPC audits
  - Complete Patient-Led Assessments of the Care Environment (PLACE) assessments
  - Matrons complete weekly walkabout IPC checklist
  - Matrons ensure monthly cleaning audits are completed and poor cleaning standards are reported; also that poor standards are actioned in a timely manner
  - Monitor the use of the Bristol stool chart when assessing the bowel movement of service users
  - Monitor the correct use of food and fluid chart on all service users with a suspected/confirmed infection.

  Action by: IPCNs, ICLPs, MMs, Monitoring Officers

- **Hand Hygiene (Criteria 2)**
  - Ensure staff complete the hand hygiene audit tools and that compliance is above 95%
  - Staff make use of the hand hygiene training equipment to monitor the effectiveness of staffs hand hygiene
  - Staff complete two yearly mandatory training
  - Staff carrying out direct service user contact to ensure that alcohol hand gel is available at the point of care
  - Encourage hand hygiene amongst visitors entering/leaving the units

- Replace the detergent wall mounted dispenser at all entrances/exit to Trust units

Action by: IPCT, MMs, Infection Prevention & Control Link Persons, Estates Team

- **Clean and Appropriate Environment for Health Care (Criteria 2)**
  - IPC issues taken into consideration at planning and design stage of all refurbishments/new builds
  - Lead personnel check units are kept clean and in good physical repair and condition
  - Cleaning concerns reported to the Interserve help desk
  - Cleaning standards and auditing arrangements implemented as per the NHS cleaning standards
  - Monitor the SLA agreement with Interserve and report the findings to the Board and IPCC
  - Matron implement and monitor the responsibilities for cleaning
  - Service users and visitors provided with the appropriate information regarding healthcare associated infection and 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)**

- Manage and monitor the use of antimicrobials

- SLA include access to timely microbiological diagnosis, susceptibility testing and reporting of results. Prescribers have access to a suitably qualified individual who can advise on appropriate choice of antimicrobial therapy
- Prescribers receive induction and training in prudent antibiotic use
- Display anti-biotic awareness materials during anti-biotic awareness week
- Encourage staff to download and make reference to the antimicrobial app on their mobile 'phone
- Pharmacy carry out an annual audit regarding anti biotic prescribing.

Action by: Pharmacy Team

- **Training (Criteria 6)**
  - Planned programme of training to be implemented
  - Staff who deliver direct service user contact attend minimum two yearly level 2 IPC training. 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
  - Non-clinical staff complete level 1 IPC training
  - New Trust staff require completing the IPC training
  - Continue enhancing IPC within the community setting
  - IPC link persons provide feedback from training to colleagues
  - Database regarding attendance collected. Non-attendees to be followed up by the Learning and Development department
  - Link practitioners celebrate achievements made during the International IPC and Awareness Week
  - Training action plan implemented ensuring IPC training compliance is maintained at a minimum of 92%

- Matrons monitor training compliance within their areas and report rates.

Action by: IPC nurse, IPC Link Person, MM, HoN, Learning and Development Team

- **Policies (Criteria 9)**
  - Ensure all IPC policies are in date
  - Ensure all staff aware of the IPC policies and how to access them
  - Ensure paper copies of the policies are the most up-to date copy within the IPC Manual.

- **Healthcare Workers (Criteria 10)**
  - Staff access to Occupational Health services
  - Record kept of all relevant immunisations
  - Staff acknowledge importance of their role in terms of IPC
  - Staff have access to the IPC team
  - Trust and Occupational Health provide annual seasonal influenza programme for staff in line with Department of Health guidance
  - Human Resources monitor Occupational Health service provision regarding management of exposure to HCAIs and 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 29		
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 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 bacteraemia, Clostridium difficile, CPE incidence to be reviewed and reported	IPCT
9.	To report all cases of MRSA bacteraemia, MSSA bacteraemia, 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 and to ensure that poor cleaning standards are reported to the help desk and copied to the HoN and IPC Consultant Nurse, and that the poor standards are actioned in a timely manner	MM,Team Leader, HoN, IPCT
16.	Infection Prevention and Control Nurses to implement a minimum of 5 environmental audits – concentrating on high risk areas and the community hubs.	IPCN
17.	HPFT to have a designated Director of Infection Prevention and Control who is responsible for the organisations Infection Prevention & Control team. The DIPC is accountable directly to the CEO.	CEO
18.	HPFT to have a designated decontamination lead.	DIPC/Head of Facilities and Estates
19.	HPFT to have a water safety group and a water safety plan in place which is to be regularly monitored.	Estates and Energy Manager, IPCC
20	To complete the Water Safety Plans which will require clinical input and clinical assessments.	Estates and Energy Manager, IPCC
21	Water Safety Steering Group to be reviewed to include new members of staff who have joined the Trust.	Estates and Energy Manager, IPCC
22	Report the progress of the Water Safety Steering group at the IPC Committee and the Health Safety and Security meetings.	Estates and Energy Manager, IPCC
23	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.	Estates and Energy Manager, IPCC
24	Legionella training to be provided to the Modern Matron and Team Leaders.	Estates and Energy Manager, IPCC
25.	To ensure that sufficient resources are available to secure the effective prevention and control of infection.	DIPC, HoN, Board Members
26.	To develop and implement the dip or not to dip campaign within all inpatient services	
27.	To develop, agree and monitor a Trust wide Infection Prevention and Control service specification	DDN&Q, Contracts Manager, CN- IPC, Service Providers
28.	Implementation of unannounced visits by the Deputy Director of Nursing and Quality, DIPC, HoN and Consultant Nurse – Infection Prevention and Control	DDN&Q, HoN, CN - IPC
29	To monitor and review the Infection Prevention and Control Risk Register on a quarterly basis and to report at the IPCC.	Safer Care Team, IPCC members

Criteria 1 – Objective 30 to 38		
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 :
30.	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
31	To ensure that staff record the infection risks on the Alert system on PARIS	Unit staff, MM, HoN
32.	Ensure the appropriate screening mechanisms are being implemented	All HPFT Staff
33.	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
34	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
35.	Staff to implement guidance laid out in the infection control policies/procedures	All HPFT Staff
36.	Staff to record accurately the steps that they have taken to reduce or control the risks of infection	All HPFT Staff
37	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
38	Staff to accurately report the food and fluid input on all service users with a known/suspected infection.	All HPFT staff

Criteria 1 – Objective 39 to 48		
Implementing an Appropriate Assurance Framework		
		Action to be taken by :
39.	Demonstrate that infection prevention and control is an integral part of clinical and Corporate Governance.	IPCC

40.	Regular presentations from the DIPC to the Board which includes trend analysis for infections, antimicrobial resistance and antimicrobial prescribing and compliance with audit programmes	DIPC, Chief Pharmacist
41.	Quarterly reports to the Board via the Strategic Performance Reports identifying compliance with the Code. Data to be collected via the Modern Matrons reports, incident reports etc.	DIPC, IPCT, MM,HoN
42.	Review of statistics on incidence of alert organisms (MRSA, MSSA, *Clostridium difficile*) and conditions, outbreaks and Serious Incidents	IPCT, DIPC
43.	Review monthly cleaning scores and PLACE scores.	Head of Facilities and Maintenance, Monitoring Team
44.	Review anti-microbial prescribing and training	Pharmacy 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 develop and implement a post infection review form identifying 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 to 2		
There are policies for the environment that make provision for liaison between the members of the infection control 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 Facilities and Maintenance
2.	Staff are aware and implements all infection prevention & control and cleaning policies. All are available on the staff intranet	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 – Objective 3 to 9	
Cleaning Services	
	Action to be taken by :
3. Allocation of a clear definition of specific roles and responsibilities for cleaning to be written	Head of Facilities and Maintenance, Monitoring Manager, Contract Managers, Modern Matrons, Site Managers.
4. All cleaning routines to be clear, agreed and available.	Head of Facilities and Maintenance, Monitoring Manager, Contract Managers Modern Matrons, Site Managers.
5. To have sufficient resources dedicated to keeping the environment clean and fit for purpose	Head of Facilities and Maintenance, Monitoring Manager, Contract Manager, Modern Matrons, Site managers, Service Managers
6. Interserve to appoint a Compliance Manager	Head of Facilities and Maintenance, Monitoring Manager
7. Named on-call manager outside office hours to be provided. Interserve to appoint an additional Estates Manager and Domestic Supervisor.	Head of Facilities and Maintenance, Monitoring Manager
8. The IPCT to be consulted regarding any cleaning protocols when internal or external contracts are being prepared	Head of Facilities and Maintenance, IPCT
9. Staff to be aware of how additional urgent cleaning can be requested	HPFT staff, Head of Facilities, Monitoring Managers, Modern Matrons, Site managers, On Call Managers

Criteria 2 ***Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of HCAI***		
Criteria 2 – Objective 10 to 27		
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 :
10.	The DIPC and the Head of Facilities and Maintenance to continue with the role of environmental cleaning and Decontamination Lead	Executive Director of Nursing and Quality, Head of Facilities and Maintenance
11	The Trust to have the following decontamination policies available and in-date:- • Decontamination of the environment • Decontamination of linin and laundry • Decontamination of equipment.	Head of Facilities and Maintenance, IPCN
12.	Correct implementation of the Decontamination Policy.	All HPFT staff
13.	Single use items to be used, were possible	All HPFT staff, procurement group, medical devices group
14	To ensure that staff are trained in cleaning and decontamination processes and hold appropriate competences for their role	All HPFT staff, IPCT, MM, HoN
16.	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 Facilities, Monitoring Manager, DDN&Q, HoN, MM, IPCT
17.	MM to have personal responsibility and accountability for maintaining a safe and clean care environment	MM
18.	MM to provide written evidence that appropriate cleaning of the environment/medical equipment takes place on a regular basis. The cleaning schedule to be available on request.	MM
19.	Person in charge of a unit to have direct responsibility for ensuring that cleanliness standards are maintained throughout the shift.	Person in charge of the unit/site

Criteria 2 ***Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of HCAI***		
20.	All lapses in cleaning procedures to be reported as a complaint to the Interserve help desk.	
21.	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 HPFT staff
22.	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 Facilities, Monitoring Manager
23.	The Trust to ensure there is adequate provision of suitable hand washing facilities and antimicrobial hand rubs.	All HPFT staff
24.	To replace the detergent wall mounted dispenser at all entrances/exit to HPFT sites	Head of Facilities
25.	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
26.	To have appropriate provisions of linen and laundry, including the storage and supply of this equipment.	All HPFT staff
27.	To have written documentation of the different types of deep cleans that are implemented	Trust Monitoring Manager/Interserve

Criteria 2 – Objective 28 to 35		
Decontamination • There is adequate provision of suitable hand wash facilities and antibacterial hand rubs.		
28.	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
29.	Staff to manage the risks associated with the use and storage of alcohol based hand gel	Health Safety and Security Team, IPCT, MM, Ward Manager, Service Line Lead, direct patient care staff
30.	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

Criteria 2 ***Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of HCAI***		
31.	Implement hand hygiene audits to ensure all staff complies with the Hand Hygiene Policy. Compliance rates should be a minimum of 95%	All HPFT staff
32.	Ensure hand hygiene posters and alcohol gel posters are clearly displayed in the unit.	MM, IPCLP, Site Manager
33.	To monitor hand hygiene compliance at Trust events e.g. Infection prevention and control awareness event.	All staff, IPCLP
34.	Provide evidence, through hand hygiene audits that staff are complying with the Hand Hygiene Policy. Staff to utilise the hand hygiene resource equipment to evidence compliance.	IPCLP, IPCN, MM, Site Manager
35.	Ensure all staff has received the necessary training in hand hygiene techniques.	IPCT, MMs, Unit Managers, All HPFT staff
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 antimicrobial stewardship policy	Pharmacy Team, IPCC
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	To encourage staff 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 • The prevention of spread of infection poster from Essential steps to safe, clean care • 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	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 11		
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 the 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	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 infection to be placed on a food and fluid chart/Bristol Stool Chart as appropriate	ALL Clinical Staff
11.	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 Facilities, 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 8		
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
4.	Clostridium difficile policy to be reviewed	CN-IPC,IPCC
5.	Last Offices for the Suspected/Known Infectious Service User to be reviewed	CN-IPC,IPCC
6.	Healthcare Associated Infection Risk Assessment Guidelines (Admission, Transfer and Discharge to be reviewed	CN-IPC,IPCC
7.	Aseptic Technique Guidelines to be reviewed	CN-IPC,IPCC
8.	Infection Prevention & Control Issues for Staff Health to be reviewed	CN-IPC,IPCC, OH

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,	PAM Occupational Health , HR

Criteria 10 ***Providers have a system in place to manage the occupational health needs of staff in relation to infection***		
	or when advice on patient tracing, notification and offer of BBV testing may be needed	
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

Criteria 10 ***Providers have a system in place to manage the occupational health needs of staff in relation to infection.***		
Criteria 10 – Objective 15 - 18		
There is a record of staff attending infection control training.		
		Action to be taken by :
15.	The names and dates of all staff who attend infection control training to be placed on the relevant database	IPCNs, MMs. Service manager, Learning and Development Department
16.	The principles and practice of prevention and control of infection are included in induction and training programmes for new staff.	Learning and Development Department, IPCNs
17.	All staff to carry out 2 yearly mandatory infection prevention and control training which should incorporate the principles and practice of prevention and control of infection.	IPCNs, All staff carrying out direct patient care.
18	The responsibilities of each member of staff for the prevention and control of infection are reflected in their job description and in any personal development plan or appraisal	HR, MM, HoN

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 NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	28th June 2018	**Agenda Item: 8**
Subject:	Safe Staffing Annual Report	**For Publication:** Yes
Authors:	Jaya Hopkins, Head of Nursing, Learning Disability & Forensic Services and Jacky Vincent, Deputy Director of Nursing & Quality	**Approved by:** Dr Jane Padmore, Executive Director of Quality & Safety
Presented by:	Dr Jane Padmore, Executive Director of Quality & Safety	

Purpose of the resolution:

To give assurance to the Board in relation to safe staffing requirements for 2017/18.

Action required:

To Approve: To formally agree the receipt of report and its recommendations for 2018/19.
For Assurance: To appraise the Board that controls and assurances are in place.

Summary and recommendations:

This annual Safe Staffing report is before the Board to report on the position over 2017/18 and for assurance purposes. Every NHS Trust needs to ensure safe staffing levels across inpatient services, publishing levels delivered against the minimum requirements set.
This report demonstrates that in 2017/18, the Trust ensured for the majority of the time inpatient staff levels matched or exceeded the minimum levels required. There were times when services were unable to meet minimum levels, managed through movement of staff, Team Leaders and Matrons working on shift.
The report recommends the pilot work undertaken in 2017/18 relating to care CHPPD and *SafeCare* is rolled out in 2018/19 enabling further analysis and immediate response to need.

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

This report speaks to the safety and workforce domains of the strategy ensuring an adequate balanced of staffing against acuity and service user numbers to ensure a positive impact on clinical outcomes, patient (service user) safety and experience.

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

Adequate staffing numbers were in place to meet demand on a shift by shift basis inpatient services. There were financial implications of this in relation to the use of bank and agency when there were staff vacancies or high acuity resulting in increased demand for staff.

Equality & Diversity /Service User & Carer Involvement implications:

N/A

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

Safety KLOE for CQC

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

Due to be seen at IGC on 5th July 2018. The quarterly data and reports have been to IGC and Board throughout the year.

Executive Summary

Introduction

This annual report gives an overview of the reporting year 2017/18 in relation to safe staffing in inpatient services across the Trust. It details the challenges as well as the achievements and then sets out the priorities for 2018/19.

Overview of 2017/18

The year has built on the work that took place in 2016/17; strengthening the method of assurance and ensuring that the right staff are in the right place undertaking the right task at the right time. Over the year, there was generally a safe level of staff in our inpatient services; Team Leaders were able to flex their staffing to meet the clinical demands of their services.

The Broadland clinic has fluctuating fill rates; however, when they were short in one band of staff, they compensated with an increase in another band, ensuring the delivery of safe services. There were many services which used more staff than their establishment to meet clinical demands.

The CQC visited during this financial year and generally highlighted positive practice in relation to safe staffing levels. Their report detailed two areas, SRS and Forest House Adolescent Unit that required further strengthening.

Challenges remain with high vacancy rates in nursing as well as a significant number of individuals who are at retirement age. A number of initiatives have been undertaken over the year and these have mitigated the risks on a shift by shift basis. Initiatives have been tried to address the recruitment and retention challenges, with limited success.

Priorities for 2018/19

2018/19 will focus on maintaining the improvements from last year and building on them further to ensure the challenges presented from the vacancy rate are mitigated and service users receive the safest and most responsive care.

This will be achieved through prioritising:

- Safe Sustainable Staffing guidelines recently published by NHSI and being reviewed and learning implemented
- Mental Health Model Hospital implementation
- Increased use of *SafeCare* and review of eRoster, Bank Bureau and Bed Management functions to support this
- Care Hours Per Patient Data (CHPPD) to aid analysis and impact of temporary staffing on each unit.

Work will also continue to address the recruitment and retention challenges.

Conclusion

The annual report on safe staffing 2017/18 demonstrates that safe staffing levels have been maintained and managed throughout the year in inpatient services. This is despite the high vacancy rates and the challenges that are faced through having a high proportion of nursing staff that are eligible for retirement. 2018/19 will see the further work to address the challenges and the risks.

1. Introduction

1.1. This annual report serves to provide the Board with information and analysis of in patient nurse staffing. This enables Board members to scrutinise and have assurance in relation to the nurse staffing in Hertfordshire Partnership NHS University Foundation Trust's (the Trust) inpatient services.

1.2. This report initially sets out the Trust's expectations in relation to inpatient nurse staffing levels before giving an overview and analysis of 2017/18.

2. Expectations

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 Board 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. 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.

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

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

2.6. All inpatient services are implementing *SafeCare* module and this will be expanded to include implementation in the Crisis Assessment and Treatment Teams (CATT) in Quarter 1, 2018/19.

3. Analysis

3.1. Safe staffing levels have been reported to the Board quarterly (Quarters 1-3) throughout the year. **Appendix 1** provides the narrative and data in relation to quarter 4 and, as with previous quarters, demonstrates a generally safe level of staffing across the services.

3.2. The Broadland Clinic had a fluctuating staffing fill rate over the year. However, when the service was short on one band of staff, this was compensated with a higher fill rate in the other band to ensure safe service delivery. In addition, the Broadland Clinic is co-located with Astley Court who provided support as required.

3.3. Many services used more staff than their established numbers. This was to meet clinical demands of the services, for example Dove, Robin and Aston wards had high

acuity resulting in increased safe and supportive observation levels. Victoria Court was undergoing refurbishment during quarters 1 and 2 and staffing levels were increased to ensure delivery of safe services.

3.4. Staffing levels have been reviewed on a 6 monthly basis by the Heads of Nursing with the Deputy Director of Nursing and Quality. This is reported to the Trust's Safer Staffing Group for agreement before being approved by the Executive Director of Quality and Safety (Chief Nurse).

3.5. As a result of the staffing establishment review, the following changes were made to meet localised change in demands and acuity:

- Aston Ward –revised skill mix to take account of the daily ward reviews and need for RNs to support these.
- Swift Ward –to support with transfers, discharges and ward activities
- Specialist Residential Services (SRS) – Reviewed and Band 6 Charge Nurse posts have been increased to increase local leadership. In addition Associate Practitioners posts have been introduced following the successful implementation and evaluation of such roles in the Forensic services. These posts have been recruited to.

3.6 The Trust continues to have some challenges with recruitment, with a 21% vacancy rate for RNs and 20% for HCAs at the year end. This is a slight decrease over the year of 2.34% for RNs and increase of 0.85% for HCAs.

3.7 Thumbswood data has been scrutinised throughout the year. The range of fill rates is predominantly due to there being a low number of staff on shift and the need to be flexible in relation to both mother and baby needs. A meeting was been held with finance and the SBU to review the establishment and it was decided that the current level should remain the same, with the ability to flex to meet demand.

4. Challenges

4.1. A significant risk remains for the Trust regarding the profile of nursing staff who are able to retire. The year-end position was that 138 RNs (55 years old or over) and 158 HCAs (unregistered nurses – URN) were eligible to retire, totalling 296 nursing staff, as detailed in **Table 1**. Work continues to support them and explore their options to remain in the workforce.

	55-59			60-64			65+		
SBU	RN	URN	Total	RN	URN	Total	RN	URN	Total
LD & F	23	45	68	11	11	22	3	3	6
East and North	30	34	64	19	19	38	7	6	13
West	25	20	45	17	17	34	3	3	6
Trust	78	99	177	47	47	94	13	12	25

Table 1

4.2 The turnover rate for RNs over the year was 16% and 12% for HCAs. The Trust participated in the NHS Improvement (NHSI) 90 day initiative to address the retention of staff which focused on the nursing workforce. The work will continue into 2018/19.

4.3 In quarter 3, the Care Quality Commission (CQC) completed an unannounced visit the Broadland Clinic, looking at safety and effectiveness of the service. This resulted in the service being issued a warning notice under section 29A of the *Health and Social Care*

Act (2008). The warning notice cited concerns in relation to staffing - staffing levels were not safe to ensure safe care and treatment of patients (service users).

4.4 The staffing levels and skill mix on the unit were reviewed in relation to the number of service users and the acuity. The warning notice was lifted following the core and well led inspection in quarter 4. The report noted significant improvements in the service and the service line was rated as outstanding.

5. Care Quality Commission

5.1. The CQC undertook a core inspection of inpatient services in 4 service lines within the Trust - Forensic, Acute and Psychiatric Intensive Care Unit (PICU), Children and Adolescent and also Learning Disability.

5.2. The report following both the core and the well-led inspection indicated that the Trust generally had a favourable staffing position and was working hard to recruit and retain staff. The majority of the service areas that were visited reported their staffing levels as good. Leaders said they managed staffing effectively and that whilst bank and agency staff were used, they were often regular staff who knew the wards and service users well.

5.3. The CQC report acknowledged that the Recruitment and Retention Strategy had delivered innovative ways to recruit staff, such as career events, links with universities, bank work for those who had retired, and wellbeing packages for staff.

5.4. The use of *SafeCare* was also acknowledged as an innovative way of enabling the review of staffing instantly and in real time, based on service user numbers and levels of safe and supportive observations. As a result, staff were able to be moved between wards and service areas where necessary, helping to manage staffing effectively.

5.5. Despite the positive points raised in the report there were some areas that required improvement. This resulted in two ***should do*** actions:

- Forest House Adolescent Unit – the Trust should employ adequate numbers of permanent staff with the appropriate qualifications, competence, skills and experience. Low staffing may have impacted on the frequency of one to one keyworker sessions
- SRS – the Trust should provide sufficient staffing levels of RNs at all times as there were insufficient staffing levels.

5.6. Appropriate actions have been taken to address these concerns and are reported through the Quality and Risk Management Committee (QRMC) into the Integrated Governance Committee (IGC).

6. Initiatives

6.1. Work continues with the local universities ensuring that student nurses feel part of the Trust family at the start of their training. They meet with the Trust's senior nurse leaders during their training and are offered mentoring throughout by our clinicians. 27 offers have been made to student nurses finishing their training in August 2018 (Cohort September 2015).

6.2. The 10 trainee Nursing Associates continue with the programme. A celebratory event took place in April 2018 to mark the end of their first year. Plans are in place for further cohorts during 2018, with the first of two starting in May 2018.

6.3. The Trust held a successful recruitment fair in March for nursing staff in Hertfordshire. At the event, 21 offers were made which are being progressed through the recruitment process. Recruitment fair and events have also taken place in Norfolk with some success, particularly for HCA recruitment.

6.4. The overseas recruitment initiative reported in last year's annual report had limited success. The first nurse arrived in November 2017 and has successfully completed his Objective Structured Clinical Examination (OSCE) and is now an RN with the NMC.

6.5. The Trust was an active participant in the development of the *Care Hours Per Patient Day* (CHPPD) work that was undertaken by NHSI. CHPPD is calculated by taking the actual hours worked (split into RNs/midwives and HCAs) divided by the number of service users at midnight. This valuable opportunity allowed the Trust to have early sight of more meaningful data in relation to safe staffing.

6.6. Our data showed that smaller and stand-alone units use more CHPPD when compared to larger units. High clinical demands also increase CHPPD. This allows the Trust to look at eRoster efficiency and *SafeCare* and will be a priority for 2018/19.

6.7. CHPPD submission became mandatory from April 2018. The first set of data will be published nationally in September 2018, allowing comparison with similar Trusts. These national comparisons are not currently available.

7. Priorities for 2018/19

7.1. **Safe Sustainable Staffing.** In January 2018, NHSI published a number of improvement resources, including learning disability and mental health staffing resources, under the *'Safe Sustainable Staffing Guidance'* programme.
Dr Oliver Shanley, the previous Executive Director of Quality and Safety, led the Learning Disability work stream and Dr Jane Padmore, the current Executive Director of Quality and Safety/Chief Nurse, was a member of the Mental Health work stream; both work streams were tasked with developing these resources.
These will be used as part the staffing establishment reviews across all inpatient services during quarter 1, 2018/19.

7.2 ***Mental Health Model Hospital.*** The Trust is involved in the development of the *Model Hospital* with meetings set up in quarter 1, 2018/19. Working with NHSI, this will provide an easy-to-navigate tool that can be used across the NHS from Board to ward where productivity, quality and responsiveness data can be explored and compared, identifying ways to improve.
The *Model Hospital* is broken down into five 'lenses' offering different perspectives to review activity:

- Board-level oversight
- Clinical service lines
- Operational
- People
- Service user services.

7.3 ***SafeCare.*** *SafeCare* is now embedded and working effectively in the inpatient services and will be rolled out to Crisis Assessment and Treatment Teams (CATT) in the coming year.
Work has taken place to review the use of eRoster, *SafeCare* and how they work with the Trust's Bank Bureau and also the Bed Management Team. A new model will be implemented in 2018/19 with a view to increasing productive, effective and efficient use of how staffing is managed, reviewed and scrutinised locally and Trust wide.

7.4 ***Care Hours Per Patient Day*** **(CHPPD)**. The CHPPD work will be rolled out and used to analyse the Trust position, comparing wards internally but also against comparator Trusts from September 2018.

8. Conclusion

8.1. This annual report sets out to brief the Board in relation to the safe nurse staffing within inpatient services. In addition, it details the work the Trust is currently undertaking in order to run safe and effective services, whilst being compliant with the safer staffing requirements, ensuring the Trust has the right staff, in the right place, with the right skills, at the right time.

8.2. The Trust has been able to consistently deliver a safe level of staffing across the inpatient services over 2017/18.

8.3. There continue to be challenges in relation to the recruitment and retention of nursing staff alongside high vacancy rates. Multiple initiatives are used to address this with a varying degree of success.

8.4. *SafeCare* is embedded within all inpatient services; CATT are the next service area to implement.

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

Appendix 1 - Nurse Staffing fill rate data; quarter 4

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. The details are included below and overleaf.

The Broadland Clinic and Thumbswood had a fill rate below 80% in January which were compensated with a higher fill rate in the other staff group. For example, in January, the RN night fill rate was 71% compared with an HCA night fill rate of 138% at the Broadland Clinic. Thumbswood had a higher night RN fill rate of 138% and HCA night fill rate of 79%.

Astley Court had low bed occupancy in February and March which accounted for the low staffing fill rate. Also in March, both Dove ward and Thumbswood had high RN fill rate to compensate for the low HCA fill rate.

Many services had used staffing above their establishment in January and February to meet the clinical needs and demands of the services. For example, West SBU had high acuity levels; mental health services for older people (MHSOP) had used additional HCAs due to refurbishment work, so to maintain a safe environment and also to support service users at the acute general hospitals. They also had service users prescribed continuous safe and supportive observation.

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.

Services	RN Day Fill rate	HCA Day Fill rate	RN Night fill rate	HCA night fill rate
January 2018				
Sovereign House	100	100	100	100
Gainsford House	100	108	97	116
Hampden House	102	110	100	103
SRS	84	104	100	100
Dove	121	96	97	156
The Beacon	100	102	100	100
Lexden	92	112	100	127
Astley Court	90	98	103	106
Broadland Clinic	88	100	71	138
Warren Court	95	103	102	103
Beech	112	115	92	159
4 Bowlers Green	102	103	100	100
Oak	96	147	100	191
Swift	107	124	101	210
Robin	101	170	100	287
Owl	99	123	102	142
Albany Lodge	100	134	100	164
Aston	94	200	103	200
Thumbswood	132	87	138	79
Elizabeth Court	95	98	98.	130
Victoria Court	96	130	100	208
Wren	101	218	102	202
Lambourn Grove	116	94	100	248
Logandene	102	95	103	113
Seward Lodge	98	202	100	203
Forest House	98	129	100	176
The Stewarts	99	255	100	364
February 2018				
Sovereign House	100	100	100	100
Gainsford House	101	111	96	111
Hampden House	102	100	100	100
SRS	89	84	100	100
Dove	110	92	100	134
The Beacon	100	104	100	100
Lexden	84	106	100	86
Astley Court	63	83	100	88
Broadland Clinic	140	128	69	122
Warren Court	96	104	95	101
Beech	116	112	95	112
4 Bowlers Green	93	103	107	104
Oak	97	183	100	163
Swift	108	121	100	202
Robin	100	130	100	243
Owl	96	139	100	102
Albany Lodge	101	94	100	112
Aston	117	153	120	192
Thumbswood	113	92	125	93
Elizabeth Court	100	96	91	99
Victoria Court	94	182	100	104
Wren	102	122	107	104
Lambourn Grove	111	96	100	125
Logandene	106	104	100	127

Forest House	95	**123**	100	**152**
Seward Lodge	99	**156**	102	**216**
The Stewarts	98	**124**	100	111
March 2018				
Sovereign House	100.5	100.3	100.0	99.4
Gainsford House	96.8	97.0	100.0	100.0
Hampden House	100.4	97.7	101.5	96.6
SRS	83.5	106.0	98.3	100.5
Dove	**120.1**	**75.7**	96.6	93.9
The Beacon	99.7	100.1	98.6	103.4
Lexden	103.6	93.0	101.5	97.2
Astley Court	**72.0**	95.2	**54.0**	105.2
Broadland Clinic	96.1	**132.9**	**66.7**	**146.8**
Warren Court	103.8	90.6	100.0	97.4
Beech	109.0	88.5	74.7	113.8
4 Bowlers Green	93.2	104.4	109.0	98.7
Oak	102.5	99.4	100.0	99.9
Swift	99.2	90.1	97.9	97.7
Robin	92.4	87	98.3	95.8
Owl	100.1	95.8	100.0	97.9
Albany Lodge	101.1	100.2	100.0	100.1
Aston	105.3	90.6	113.8	90.1
Thumbswood	103.8	81.6	**148.3**	**73.5**
Elizabeth Court	97.1	87.4	91.8	93.6
Victoria Court	94.8	94.0	98.4	99.2
Wren	98.6	90.4	100.0	94.0
Lambourn Grove	105.9	94.0	94.2	99.3
Logandene	103.6	86.0	97.9	94.9
Forest House	96.4	85.1	95.2	96.4
Seward Lodge	97.8	89.1	96.7	96.7
The Stewarts	90.1	97.2	98.3	99.0

Hertfordshire Partnership NHS
University NHS Foundation Trust

Trust Board

Meeting Date:	28th June 2018	**Agenda Item: 9**
Subject:	Finance Report for the period to 31st May 2018	**For Publication:** No
Author:	Sam Garrett, Head of Financial Planning & Reporting	**Approved by:** Paul Ronald, Deputy Director of Finance and Performance Improvement
Presented by:	Keith Loveman, Director of Finance	

Purpose of the report:

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

Action required:

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

Summary and recommendations to the Board:

The financial position remains very challenging in May with an overall deficit reported of £25k for May and £266k Year to Date (before STF). This is worse than the Plan for the month by £5k and worse than the Plan for the year by £217k. The overall NHS Improvement (NHSI) Use of Resources Framework Rating, the UOR, reports as a 2. Key figures are summarised below and show adverse variances in all main areas:

UOR	2	In Month Plan £000	In Month Actual £000	YTD Plan £000	YTD Actual £000	Full Year Plan £000
Overall Surplus (Deficit)		(31)	(25)	(49)	(266)	360
Pay Overall		12,477	12,657	24,948	25,232	149,703
Agency		611	786	1,221	1,440	7,327*
Secondary Commissioning		2,597	2,585**	5,123	5,692	30,667

*NHSI Ceiling
** £625k CHC Provision released in month 2 without this figure would be £3,210k

In relation to the above and the wider financial performance:

1. Total Pay is reported above Plan by £180k (1.4%) in the month and by £283k (1.1%) for the year to date. In particular, Agency spend is above Plan by £176k in the month and £219k for the year to date; the Plan was based on the NHSI Ceiling so this is being breached.

2. Secondary commissioning is reported above Plan by £569k for the year to date, in the month it is below Plan by £12k but this is due to the release of £625k of the CHC Provision, without this it would be £613k above Plan in the month (24%) and £1.2m for the year to date (23%). This is largely due to increases on CAMHs Tier 4 NCM, and External PICU placements.

3. The immediate areas of focus are in relation to the CRES programme where a number of schemes are still in development; reducing agency spend; and addressing the additional level of bed pressures in the areas identified above.

This position is not sustainable and there are several key actions being implemented to address this. The level of financial risk is driven by the small surplus margin with significant demand volatility and workforce pressures. Whereas in previous years there was some degree of offset within Pay budgets this has reduced. This general level of risk has been further impacted by the phasing of saving schemes and some seasonal spikes in activity. In addition the Trust has continued to make additional spend to support performance improvement and data quality initiatives, and on Information Technology to support staff.

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

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

Summary of Implications for:

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

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

1. Background to Financial Plan 2018/19

1.1 Whilst a significant surplus was achieved in 2017/18 the final position in Quarter 4 was c. £250k and was dependent upon addressing cost increases in placements and CAMHS Tier 4 NCM plans being implemented as planned. In addition there are new investments and cost increases emerging for 2018/19 as well as the ongoing issue of addressing service pressures and the operational stretch being consistently reported.

1.2 The CRES level assumed within the Plan is £4.7m, and the NHSI Agency Ceiling is £7.3m, which is c. £1.4m below last year's actual spend. The Plan is summarised in Fig. 1a below:

Description	2017/18 Plan	2017/18 Actual	2018/19 Plan
Income	221.7	225.6	229.8
Pay	147.8	147.1	149.8
Other Direct Costs	28.2	32.2	33.9
Overheads	35.6	34.8	36.7
EBITDA	10.1	11.5	9.4
EBITDA margin	4.6%	5.1%	4.1%
Financing	9.3	8.1	9.0
Surplus	**0.8**	**3.4**	**0.4**

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

2. Performance Summary and Risk Rating

2.1 The year to date has been very challenging, with an overall deficit reported of £25k for May and £266k for the year to date. This is worse than the Plan for the month by £5k and worse than the Plan for the year to date by £217k.

2.2 The four main variances within this position are:

2.2.1 Pay overall worse than Plan by £180k for the month and £283k for the year to date.

2.2.2 Income better than Plan by £152k for the month and £170k for the year to date.

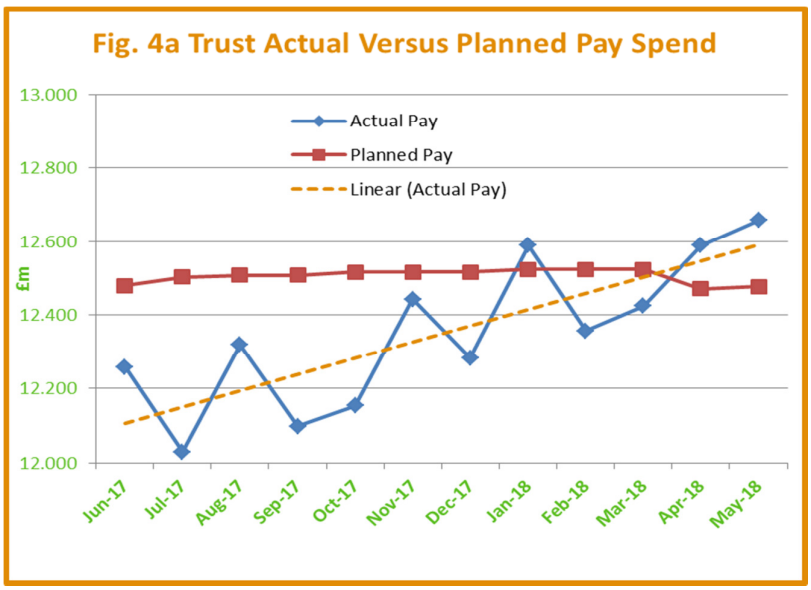
2.2.3 Secondary commissioning better than Plan by £12k for the month and worse than Plan by £569k for the year to date (£613k and £1.2m respectively excluding the £625k of CHC Provision released in Month 2).

2.2.4 Other Direct Costs, Overheads and Financing better than Plan by £21k.

2.3 The Trust's Use of Resources (UOR) framework rating for month 2 reports as a 2.

3 Trading Position

3.1 The Appendix Statement of Comprehensive Income, (SOCI), gives the full position and comparison to the Plan. Despite the challenging position currently, it is fully expected that the Trust's Control Total for the year will be met at the end of the year, but this will need significant focus on key areas.

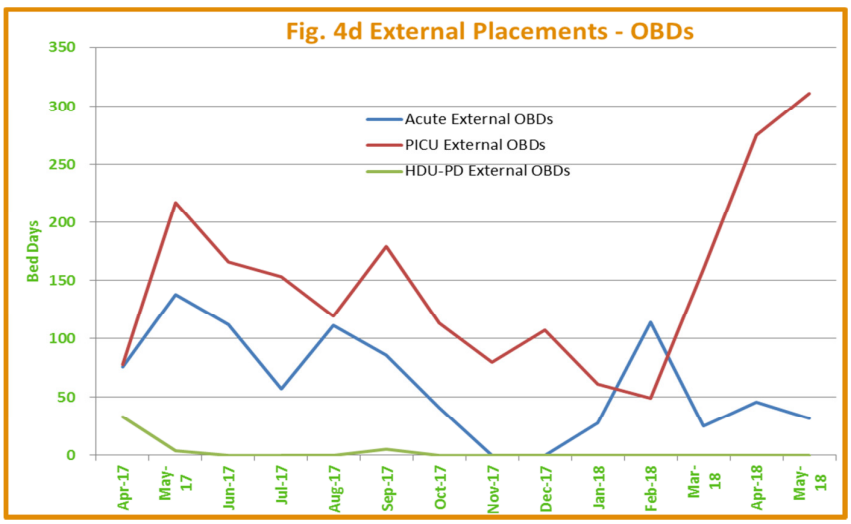


3.2 Fig. 4a shows the actual against planned pay spend over the last 12 months. Pay Costs totalled £12.7m in May, £180k worse than Plan. The trend line shows that overall pay has increased steadily over the 12 months, despite small decreases some months.

3.3 The most significant area of non-pay spend above Plan is Secondary Commissioning, which reports for the month at £2.6m against a Plan of £2.6m, and for the year to date at £5.7m against a Plan of £5.1m. However as explained above £625k of CHC Provision was released in May to support the position, without this adjustment spend would have been £3.2m for the month and £6.3m for the year to date.

3.4 Expenditure in all areas is being actively reviewed and monitored with several schemes to step service users down as soon as appropriate. For long term placements, as at end of May, 20 new placements had started during the year and 36 had ended, a net reduction of 16 placements. These have not yet resulted in significant reductions in spend in part due to high observation costs in April and May (£168k year to date).

Fig. 4c Long Term Placements	01/04/2018	Started	Ended	31/05/2018
MHSOP	74	0	1	73
Main Health	47	1	12	36
Social Care	430	19	23	426
Total	551	20	36	535



3.5 PICU External Placements tend to have seasonal demand in March – May each year, however activity this year has been much higher than usual – see Fig. 4d below.

4 Income and Major Contracts

4.1 Total income planned for the year is £231.6m, including £215.5m from Main Commissioners, of which £170.5m was planned in respect of Hertfordshire. It is not expected that the values for current commissioners will change significantly during the year, other than if the pay award is funded in this way.

4.2 CQUIN income is included in the position at 90% for Hertfordshire, and 100% for all other contracts. Final quarter CQUIN for 2017/18 has not yet been agreed.

5 CRES

5.1 In terms of deliverability there is clearly more work required to be confident. In particular:

5.1.1 Whist there has been some initial good progress with a number of schemes mainly focussed around bed requirements (both number and type), progress in several areas appears to have slowed.

5.1.2 In relation to the Agency cap more detailed plans are required.

5.1.3 Further work is required in relation to Social Care and Corporate services.

6 Capital and Revenue Projects

6.1 The sale of land at Kingsley Green has now occurred therefore the £6.79m Bridging Loan falls due. Cash has been received and the loan repaid on the same date 18th June 2018.

6.2 The Capital Programme for the year is outlined in Appendix F6. The Programme comprises actual capital spend and revenue spend associated with the programme.

6.3 Cumulative net capital spend year to date for 2018/19 is £600k.

6.4 There is a further £82k of revenue spend in month. This primarily relates to the running costs for empty buildings and dilapidation costs.

6.5 Capital spend has reduced since the completion of the major construction project of the Hemel Hempstead Hub. Work continues to be undertaken as part of the fire safety improvements, and works are progressing with the Forest House Place of Safety Suite.

Actual in month May-17	Actual YTD to 31-May-17	Description	2018/19 Plan	Month May - 18 Actual	Plan	Variance	Year to Date May - 18 Actual	Plan	Variance	Year to Date E&N	West	LD	Support	Other	Total
31	31	Number of Calendar Days	365	31	31		61	61							
0	0														0
13,890	27,780	Contract #1 Hertfordshire IHCCT	170,486	14,207	14,207	(0)	28,414	28,414	(0)	(0)	(0)	(0)	(0)	28,414	28,414
1,531	3,062	Contract #2 East of England	22,876	1,822	1,906	(84)	3,665	3,813	(148)	(0)	(0)	(0)	(0)	3,665	3,665
794	1,588	Contract #3 North Essex (West Essex CCG)	9,539	796	795	1	1,591	1,590	2	(0)	(0)	(0)	(0)	1,591	1,591
170	339	Contract #4 Norfolk (Astley Court)	2,166	181	181	0	361	361	0	(0)	(0)	(0)	(0)	361	361
561	1,107	Contract #5 IAPT Essex	6,579	534	548	(14)	1,068	1,097	(28)	(0)	(0)	(0)	(0)	1,068	1,068
317	634	Contract #6 Bucks Chiltern CCG	3,807	317	317	0	635	635	0	(0)	(0)	(0)	(0)	635	635
17,262	34,510	Contracts	215,453	17,857	17,954	(97)	35,734	35,909	(174)	(0)	(0)	(0)	(0)	35,734	35,734
116	209	Clinical Partnerships providing mandatory svcs (inc S31 agrmnts)	1,085	81	90	(10)	159	181	(22)	159	(0)	(0)	(0)	(0)	159
341	562	Education and training revenue	3,096	374	257	117	689	514	175	20	152	0	163	353	689
211	386	Misc. other operating revenue	2,453	384	204	179	716	409	307	173	120	58	314	51	716
397	826	Other - Cost & Volume Contract revenue	5,332	412	444	(32)	821	889	(68)	(0)	(0)	821	(0)	(0)	821
223	403	Other clinical income from mandatory services	1,975	178	165	13	318	329	(11)	25	49	209	35	(0)	318
15	28	Research and development revenue	403	15	34	(18)	30	67	(37)	(0)	(0)	(0)	30	(0)	30
63	126	Sustainability and Transformation Funding	1,775	89	89	(0)	178	178	(0)	(0)	(0)	(0)	(0)	178	178
(0)	(0)	Other block	(0)	(0)	(0)	(0)	(0)	(0)	(0)	9,105	8,757	10,051	3,672	(31,586)	(0)
18,628	**37,050**	**Total Operating Income**	**231,572**	**19,390**	**19,238**	**152**	**38,646**	**38,476**	**170**	**9,482**	**9,079**	**11,139**	**4,215**	**4,731**	**38,646**
(10,135)	(20,200)	Employee expenses, permanent staff	(126,428)	(10,543)	(10,535)	(8)	(21,133)	(21,064)	(69)	(5,910)	(6,084)	(5,903)	(2,597)	(639)	(21,133)
(1,271)	(2,445)	Employee expenses, bank staff	(15,948)	(1,328)	(1,332)	4	(2,659)	(2,663)	5	(814)	(939)	(771)	(129)	(6)	(2,659)
(739)	(1,452)	Employee expenses, agency staff	(7,327)	(786)	(611)	(176)	(1,440)	(1,221)	(219)	(609)	(544)	(169)	(126)	8	(1,440)
(32)	(62)	Clinical supplies	(279)	(36)	(23)	(13)	(75)	(46)	(29)	(34)	(16)	(19)	(5)	(1)	(75)
(2,493)	(4,697)	Cost of Secondary Commissioning of mandatory services	(30,667)	(2,585)	(2,597)	12	(5,692)	(5,123)	(569)	(1,714)	(726)	(3,877)	(0)	625	(5,692)
(29)	(48)	GP Cover	(288)	(23)	(24)	1	(49)	(48)	(1)	(17)	(0)	(32)	(0)	(0)	(49)
(209)	(421)	Drugs	(2,646)	(259)	(221)	(39)	(508)	(441)	(67)	(249)	(220)	(38)	(1)	(1)	(508)
(14,908)	**(29,326)**	**Total Direct Costs**	**(183,583)**	**(15,560)**	**(15,342)**	**(218)**	**(31,556)**	**(30,607)**	**(949)**	**(9,348)**	**(8,529)**	**(10,809)**	**(2,857)**	**(13)**	**(31,556)**
3,720	7,724	Gross Profit	47,990	3,830	3,896		7,090	7,869		135	549	331	1,358	4,717	7,090
19.97%	20.85%	Gross Profit Margin	20.72%	19.75%	20.25%		18.35%	20.45%		1.42%	6.05%	2.97%	32.23%	99.72%	18.35%
		Overheads													
(78)	(145)	Consultancy expense	(615)	(74)	(51)	(23)	(93)	(103)	10	(0)	2	(5)	(66)	(24)	(93)
(20)	(66)	Education and training expense	(1,029)	(77)	(83)	6	(150)	(166)	15	(16)	(23)	(26)	(93)	8	(150)
(227)	(561)	Information & Communication Technology	(4,080)	(343)	(340)	(3)	(669)	(680)	11	(11)	(29)	(56)	(563)	(9)	(669)
(345)	(679)	Hard & Soft FM Contract	(5,238)	(454)	(437)	(17)	(910)	(874)	(36)	(0)	(0)	(0)	(0)	(910)	(910)
(574)	(971)	Misc. other Operating expenses	(8,273)	(478)	(708)	230	(935)	(1,482)	547	(117)	(149)	(220)	(295)	(152)	(935)
(482)	(977)	Other Contracts	(5,778)	(510)	(481)	(28)	(983)	(963)	(20)	(117)	(304)	(315)	(184)	(62)	(983)
(53)	(103)	Non-clinical supplies	(279)	(46)	(23)	(23)	(93)	(47)	(46)	(23)	(15)	(37)	(17)	(1)	(93)
(491)	(959)	Site Costs	(5,546)	(589)	(462)	(127)	(991)	(924)	(66)	(12)	(0)	(4)	1	(975)	(991)
(204)	(672)	Reserves	(2,205)	(100)	(184)	84	(200)	(368)	168	(0)	(0)	(0)	(0)	(200)	(200)
(271)	(568)	Travel, Subsistence & other Transport Services	(3,700)	(294)	(308)	15	(619)	(617)	(2)	(149)	(246)	(139)	(100)	16	(619)
(2,744)	**(5,702)**	**Total overhead expenses**	**(36,744)**	**(2,966)**	**(3,079)**	**113**	**(5,643)**	**(6,222)**	**579**	**(447)**	**(765)**	**(804)**	**(1,318)**	**(2,310)**	**(5,643)**
976	**2,023**	**EBITDA**	**11,246**	**864**	**818**	**47**	**1,447**	**1,647**	**(200)**	**(312)**	**(216)**	**(473)**	**41**	**2,407**	**1,447**
5.24%	5.46%	EBITDA Margin	4.85%	4.45%	4.24%		3.74%	4.28%		-3.28%	-2.37%	-4.24%	0.97%	50.88%	3.74%
(411)	(830)	Depreciation and Amortisation	(5,025)	(439)	(419)	(20)	(855)	(838)	(17)	(0)	(0)	(23)	(0)	(831)	(855)
(36)	(72)	Other Finance Costs inc Leases	(354)	(35)	(29)	(5)	(69)	(59)	(10)	(0)	(0)	(0)	(69)	(0)	(69)
(0)	(0)	Gain/(loss) on asset disposals	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
7	18	Interest Income	168	(3)	14	(17)	37	28	9	(0)	(0)	(0)	37	(0)	37
(307)	(613)	PDC dividend expense	(3,900)	(325)	(325)	(0)	(650)	(650)	(0)	(0)	(0)	(29)	(0)	(621)	(650)
229	**525**	**Net Surplus / (Deficit)**	**2,135**	**63**	**58**	**5**	**(88)**	**129**	**(217)**	**(312)**	**(216)**	**(526)**	**9**	**955**	**(88)**
1.23%	**1.42%**	**Net Surplus margin**	**0.92%**	**0.33%**	**0.30%**		**-0.23%**	**0.33%**		**-3.29%**	**-2.38%**	**-4.72%**	**0.22%**	**20.19%**	**-0.23%**
166	**399**	**Net Surplus / (Deficit) before STF**	**360**	**(25)**	**(31)**	**5**	**(266)**	**(49)**	**(217)**						

Hertfordshire Partnership NHS
University NHS Foundation Trust

BOARD MEETING

Meeting Date:	24th May 2018	**Agenda Item: 10**
Subject:	Workforce & OD Key Performance Indicators – Q4 Results	**For Publication: Yes**
Author:	Mariejke Maciejewski – Deputy Director of Workforce and OD	**Approved by: Jinjer Kandola**
Presented by:	Jinjer Kandola – Director of Workforce & Organisational Development	

Purpose of the report:

To update the Trust Board on the Q4 performance against the key workforce metrics and organisational development activity agreed in the Annual Plan.

Action required:

To note the report and recommend any additional measures required.

Summary and recommendations to the Board:

The key performance indicator for the vacancy rate has increased slightly in Q4 from 13.43% to 13.71%. The turnover rate currently stands at 14.16% showing an increase this quarter from 13.27% in Q3. The sickness absence rate has decreased to 4.63% this quarter from 4.72% in Q3. The PDP rate has increased slightly in Q4 to 87.17% from 87%. Mandatory training rates have made improvements this quarter reaching 85.55% A significant amount of work has been undertaken to review statutory and mandatory training including the use of more e-learning packages, using 'Go To' meetings and producing a statutory and mandatory training matrix for staff. A task and finish group met on a weekly basis during Q4 to monitor progress.

Recruitment and retention remains a key focus for the Trust. An annual recruitment activity plan is currently in place to address difficulties in recruiting to key posts and in hot spot area. The Trust has continued to be involved in work on recruitment and retention on a national basis with NHS Employers and NHS Improvement during the quarter.

Delivery against the activity in the OD Strategy has continued in Q4. The national staff survey results were announced in Q4. The overall staff engagement score was above average compared to other mental health trusts. The results demonstrate a continuing positive position for the Trust. Just over 90% of our scores are in line with or above the national average (when compared to other mental health and learning disability Trusts). Feedback from the Q4 pulse survey saw an improvement or maintenance in the friends and family test scores, with 75% of staff recommending the Trust as a place to receive care, a significant improvement on Q3 at 67%. There has been a slight decline in staff saying they would recommend the Trust as a place to work at 64% in Q4 from 67% in Q3.

A significant amount of engagement activity continued in Q3 including the Big Listen, Local Listens, Senior Leaders Forums, and a number of health and wellbeing initiatives. Q4 saw the end of the flu campaign with 58% of frontline staff being vaccinated.

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

Summary of Financial, IT, Staffing & Legal Implications:

1 Finance
2 IT
3 Staffing
4 NHS Constitution
5 Carbon Footprint
6 Legal

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

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

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

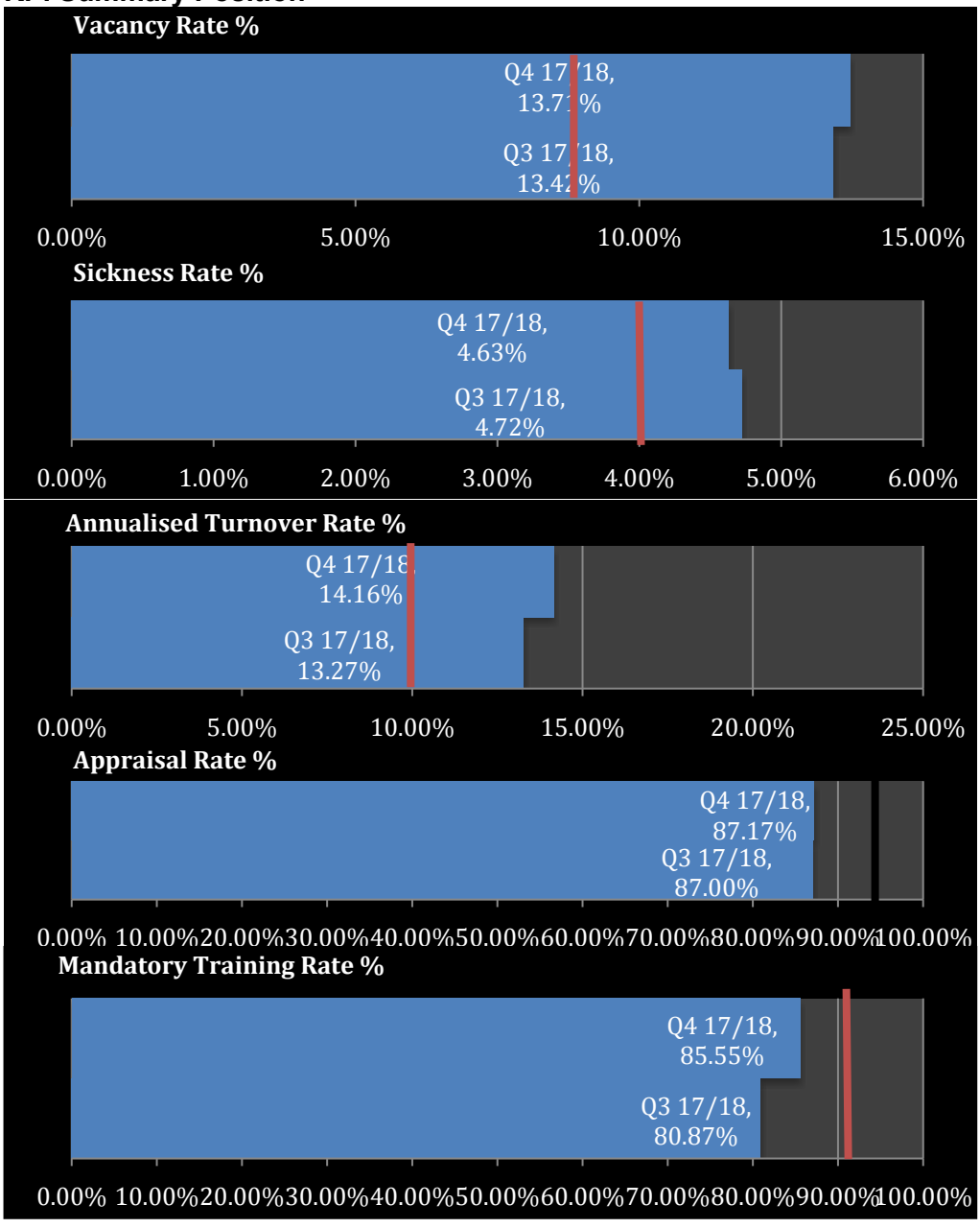
Workforce and Organisational Development Report
Quarter Four: January – March 2018

1.0 Introduction

The purpose of this report is to appraise the Trust Board on the Q4 performance of the key workforce metrics and organisational development activity as agreed in the Annual Plan. The report summarises the activities undertaken to improve performance against the agreed targets and outlines the planned activities for the next period. Detailed below is the Q4 summary position.

2.0 Executive Summary

KPI Summary Position



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Delivery against the activity in the OD Strategy has continued in Q4. The national staff survey results were announced in Q4. The overall staff engagement score was above average compared to other mental health trusts. The results demonstrate a continuing positive position for the Trust. Just over 90% of our scores are in line with or above the national average (when compared to other mental health and learning disability Trusts). Feedback from the Q4 pulse survey saw an improvement or maintenance in the friends and family test scores, with 75% of staff recommending the Trust as a place to receive care, a significant improvement on Q3 at 67%. There has been a slight decline in staff saying they would recommend the Trust as a place to work at 64% in Q4 from 67% in Q3.

A significant amount of engagement activity continued in Q3 including the Big Listen, Local Listens, Senior Leaders Forums, and a number of health and wellbeing initiatives. Q4 saw the end of the flu campaign with 58% of frontline staff being vaccinated.

3.0 Key Workforce Metrics

3.1 Establishment Data

The establishment data as at 31st March 2018 is as follows:

Funded Establishment =	**3345.26**
Staff in post =	**2886.45**
Vacant posts =	**458.81**
% Vacancy rate =	**13.71**
% Turnover rate =	**14.16**
% Stability rate =	**87.43**

3.2 Turnover Index

The turnover rate continues to increase this quarter to 14.16% from 13.27% in Q3 and 13.14% in Q2. Work continues in the SBUs to understand the reasons for staff leaving and staff are being encouraged to develop their careers at HPFT. We continue to work closely with NHS Improvement on our retention improvement plans. The Trust is working on four key areas of focus with a view to reducing turnover to 11% over the next 12 months.

3.2.1 Analysing the leavers data

There were 132 leavers during Q4 compared to 100 leavers in Q3. There were 32 leavers in nursing and 22 starters this quarter in comparison to Q3 where there were 23 leavers and 20 starters in this group.

Analyisis of the reasons for leaving in Q4 show that the top reasons given were relocation, promotion, retirement and work life balance. Promotion is the second highest reason for staff leaving the Trust. Initiatives such as the internal recruitment process, to make it easier for staff to move internally within the Trust and streamlining the retire and return process should support this as well as other initiatives.

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

3.3 Stability Index

This data shows the number of staff with more than one year's experience at two points in time, usually a year apart. These results are compared to give a reflection of the increase or decrease in experience in the organisation. A target of 75% - 85% represents a good balance of new ideas and organistional memory. The stability index at the end of Q4 is 87.43% this shows a decrease on the previous quarter when it was 89.38%. A stability index of 87.43% is outside the target but higher than recommended which continues to be positive and shows that experience is being retained in the organisation.

3.4 Key Recruitment Activity

Recruitment activity has continued during Q4. There are a total of 151 wte posts at offer and starting stage of which 23.83wte are due to start in Q1. Recruitment activity has increased in Q4 compared to Q3 where there were 138.6wte posts at offer stage.

The current time to hire is 55.87 days (11.1 weeks) which has reduced slightly from 57.5 days (11.5 weeks) at the end of Q3. The time to hire is measured from advert to the unconditional offer and excludes notice periods. These parameters are aligned to the Midlands and East Recruitment Streamlining Sector. Breaches to the parameters set in the SLA are communicated to managers and the recruitment process is continuously evaluated to consider streamlining processes further. The recruitment team continues to work with recruiting managers across the Trust to support them to meet the targets set in the SLA and recruitment training has been organised to take place throughout the year to reflect feedback from the recruitment audit.

During Q1 representatives from the Trust will participate in the NHS Employers Innovate, Engage and Exchange Network with a view to making changes and engaging with staff which will aid retention and good practice across the Trust.

The CAMHS recruitment project is one area where lead nurses and HR professionals are working in partnership to address recruitment difficulties.

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

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

A review of the recruitment and retention payments is being carried out to better understand if they are having a positive impact on our turnover and reducing agency costs.

There were three recruitment events in Q4 staring with the Brent Cross Jobs Fair on the 22-28 January which generated interest from 238 members of the public. All the potential candidates have been followed up in order to support and encourage them to apply and gain employment within the Trust. The recruitment team attended the University of West Herts on 31 January were 16 students registered their interest in working at the Trust. This was followed by the Recruitment Day which took place on 13th March which resulted in 21 nursing and HCA job offers being made on the day. The annual recruitment activity plan has been reviewed adding forth coming events and recruitment days to the end of 2018.

Four students from the February 2015 cohort are about to commence employment with the Trust with another eight students in the pipeline.

The Trusts recruitment processes received partial assurance from auditors in September and recommendations from the audit have been completed and are in place pending a further audit in Q1.

Work is also being undertaken with STP colleagues to look at new initiatives with regards to recruitment, attraction and retention. A STP recruitment day has been organised to take place on 12 May 2018.

3.5 Junior Doctor Recruitment

The difficulty faced by Health Education East of England in the recruitment of junior doctors into psychiatry continues. The February changeover saw 5 overall vacancies. The 2nd on call rota was underpinned from 7th February by 4 Specialty Doctors; this has helped significantly with cover. Rotas became the important topic during March as discussions took place with Junior Doctors Rep and 1st on call Medical Lead to agree a way forward with a compliant rota working to an increased frequency from a 1:13 to 1:11 effective for April rotation. Further interviews have been scheduled throughout April and adverts in the BMJ continue to draw in applicants. The task and finish group are meeting weekly to report and highlight any risks established with Clinical Directors and to take forward actions raised and will continue to send reports through Workforce Board, WODG and TMG to give assurance to the board on the steps being taken to minimise risks to service delivery.

In preparation for the August rotation, approximately 79 trainees are required to fill all junior vacancies. We have been successful in recruiting to 4 substantive Consultants vacancies. At the end of March we had 13 consultant vacancies in the following specialities; CAMHS, Community Eating Disorders, Early Intervention Psychosis. All adverts for vacant posts are live and interviews are scheduled for May 2018.

3.6 Number of starters

There were a total of 133 new starters and 132 leavers this quarter which resulted in a net gain of 1 member of staff.

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

3.7 Vacancy Trend

The number of vacancies has increased in Q4 to 458.81 wte from 448.03 wte in Q3 which has resulted in the vacancy rate increasing to 13.71% from 13.42% in Q3. The increase was as a result of 43 wte additional posts being added to the establishment this quarter which makes a total increase in establishment of 125.06 wte in this financial year. The vacancy rate would have been 9.7% if there were no additional posts added to the establishment during the financial year. During Q4 work has been undertaken on establishment control which will lead to an overall ratification of all the vacancies throughout the Trust.

Whilst the vacancy rate is 13.71% it is important to note that 17.59% of our staff are bank workers who work for us on a regular basis directly engaged on HPFT's bank and 1.45% are agency workers. 76.20% of HPFT are permanent staff and 4.77% of staff are on fixed term contracts.

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

3.8 Temporary Staffing

During Q4 bank and agency fill rates have increased slightly to 93.11% from 92.13%. The bank and agency fill rate is as follows; Nursing 93.29%, Admin 95.93%, Social Workers 77.64% and OT/AHP 90.79%. All these areas have increased on Q3 rates.

A total number of 32,163 shifts were requested to be filled in Q4 and 29,946 shifts were filled**.** 76.30% of shifts requested were filled by bank staff and of these 16.81% were filled by agency staff. In Q3 71% of shifts requested were filled by bank staff and 21% of shifts were filled by agency staff.

The % FTE of the workforce covered by bank in Q4 was 17.59% compared to 16.99% in Q3 and 4.77% for agency in Q4 compared to 4.30% in Q3.

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

3.9 Sickness Absence

The sickness absence rate for the Trust has decreased from 4.72% in Q3 to 4.63 % in Q4. There has been a decrease in the sickness absence rates for East and North and West SBUs with LD&F increasing slightly by 0.05 % and Corporate by 0.83 %. Sickness boards within the SBUs continue to focus on reducing the number of long term sickness absence cases and managing short term sickness absence cases for staff who have high bradford scores. Corporate sickness remains below the Trust target of 4% with a Q4 sickness absence rate of 3.60 %. East and North SBU sickness absence rate reduced from 4.93 % to 4.72 % in Q4 and a long term sickness case was closed. The rate for the West SBU reduced from 4.92 % to 4.47 %. In LD&F the rate is still high at 5.01% with some outlying services including the Broadland Clinic, Warren Court, Beech Ward, Gainsford House and SLDS Community A&T Team West.

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

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

The estimated costs to the Trust of sickness absence for Q4 has been calculated in excess of £1 million which is an increase of almost £11k in comparison to Q3. A breakdown of the sickness absence costs by SBU can be found **in appendix 1, section 4.**

There are currently 93 short term sickness absence cases and 61 long term sickness absence cases being formally managed through the employee relations team as at the end of March 2018. The number of short term sickness absence cases that are being formally managed has increased by seven since the last quarter. The HR Business Partners continue to review how we support those areas with high sickness absence rates through either additional support from occupational health or the use of health and wellbeing initiatives. The Trust is also undertaking a study with NHSI to look at Health and Wellbeing initiatives and personalised sickness absence rates.

3.10 PDP Rates

The PDP rates have remained constant since Q3 at 87 %. The PDP rates for each SBU are as follows:

SBU	Q1%	Q2	Q3	Q4
LD&F	90%	94%	94 %	88 %
East and North	86%	92%	91 %	90 %
West	86%	89%	86 %	89 %
Corporate	79%	72%	65 %	72 %
Trust	**86%**	**89%**	**87 %**	**87 %**

At the end of March East and North SBU PDP rates were at 90% a slight decrease from the previous quarter. A concentrated effort was made with a target of 100 % and although this has not yet been met the focus at team performance meetings and core management meetings will continue.

The West SBU PDP rate increased at the end of Q4 to 89% which was positive although below the anticipated increase. Single Point of Access and the

Management team reached 100%. Managers continue to be reminded of the importance of the initial PDP and the '100 day' discussion.

The LD&F SBU PDP rate is disappointing at 88 % given the SBU's positive previous performance. Norfolk and North Essex are below 85% and therefore there is a particular focus on monitoring compliance in these two areas.

Corporate – the completion rate increased in Q4 however there continues to be an increased focus in the Corporate areas as the PDP rates are significantly lower than both the clinical SBUs and the Trust target.

3.11 Mandatory Training Rates

The Core Skills Statutory and Mandatory training rates in Quarter 4 has ended as follows:

Statutory and Mandatory Training = 86%
Essential Training = 89%

Whilst the compliance rates are below the Trust target of 92%, statutory and mandatory training compliance has seen an increase of 22% in the last Quarter.

Quarter 4 Compliance by SBU based on the new competencies:

	31-Jan-18		28-Feb-18		31-Mar-18	
Business Streams	**Mandatory**	**Essential**	**Mandatory**	**Essential**	**Mandatory**	**Essential**
Corporate Services	**73%**	**85%**	**78%**	**87%**	**83%**	**84%**
SBU Learning Disability & Forensic	**74%**	**91%**	**83%**	**92%**	**90%**	**93%**
SBU MH East & North Herts	**69%**	**84%**	**76%**	**92%**	**85%**	**86%**
SBU MH West Herts	**67%**	**85%**	**74%**	**85%**	**83%**	**87%**
Overall	**70%**	**87%**	**77%**	**87%**	**86%**	**89%**

The table below shows the statutory and mandatory training compliance rates for each training competency based on both the new competencies.

Competence Name	**End of Mar 18**	**Does not meet requirement**
367|LOCAL|Fire Safety - 2 Year|	85%	300
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	96%	121
NHS|CSTF|Health, Safety and Welfare - 3 Years|	94%	171
NHS|CSTF|Infection Prevention and Control - Level 1 - 2 Years|	82%	121
NHS|CSTF|Infection Prevention and Control - Level 2 - 2 Years|	81%	395
NHS|CSTF|Information Governance - 1 Year|	92%	236
NHS|CSTF|Moving and Handling - Level 1 - 3 Years|	87%	185
NHS|CSTF|Moving and Handling - Level 2 - 2 Years|	82%	251
NHS|CSTF|Preventing Radicalisation - Levels 3, 4 & 5 (Prevent Awareness) - No Specified Renewal|	78%	465
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	81%	316
NHS|CSTF|Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year|	88%	2
NHS|CSTF|Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year|	85%	70
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	76%	170
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	83%	362
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	76%	164
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	84%	263
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	85%	65
NHS|MAND|Fire Safety - 1 Year|	77%	171
Grand Total	**86%**	**3828**

A significant amount of work has been undertaken from November 2017 with regards to improving the statutory and mandatory training rates so that we are aligned to the core skills training framework. Recovery plans in safeguarding, WRAP, moving and handling, resuscitation, and infection prevention and control were closely monitored and trajectories to achieve compliance against the new competencies, by the end of March 2018, were in place. A review of statutory and mandatory training resulted in the following changes:

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

A weekly statutory and mandatory task and finish group was established with a target to reach 92% compliance in statutory and mandatory training by the end of March 2018. Progress against the targets and trajectories was closely monitored and where progress was not being achieved or behind trajectory the subject matter experts and the learning and development team took appropriate action. Every competence has seen a significant improvement and although the target of 92% was not achieved, the trust is now in a good position to achieve 92% in 2018.

Planning and commissioning for training for the financial year 2018 – 2019 is now complete with the exception of Safeguarding which has seen a transformation in its training approach. This will be monitored and reviewed through the financial year.

In a response to feedback from staff regarding the current learning management system a new Learning Management System has been purchased and is currently being implemented. The new system will automate a lot of the manual process that are currently in place and will be more user friendly for staff to use and access. Think Associates have been selected as the supplier and are currently working with a project group to build and implement the system. They are working to a 'go live' date of end of June 2018.

4.0 Organisational Development Activity

The OD team works closely with the Workforce Team to deliver the Workforce & OD Strategy. The next 12 month activity plan for OD and L&D is currently under review.

In addition to the activity plan there are a number of interventions the OD Team have been involved with this quarter

- Saberr Coachbot - a digital team coaching tool powered by artificial intelligence (AI) has been recognised for helping NHS teams improve how they work together. 4 teams have been identified and the launch meeting has taken place.

- Safe Care Project – Final OD Support session to teams
- Locality Boards Development Sessions – OD consultancy support and liaison between HCT & HPFT
- STP Systems Leadership Laboratory – lead liaison with STP organisations, provider and HEE Leadership Academy including circulation and collation of applications.
- Broadland – OD support to the Senior Team (see below) and the development and delivery of the wider team development sessions
- West SBU Band 8a Development Programme – OD consultancy scoping of programme and delivery of MBTI session.
- Coaching Network – ongoing support to the network including dealing with requests for coaching and allocation of coaches.

4.1 Delivering Effective Leadership Capacity and Capability

The Senior Leaders Forum this quarter focused on the CQC outcomes/results, annual plan, staff survey results, and a community update.

Leadership Development activity this quarter has included the following:

- Senior Leaders Forum
- An On boarding Programme is currently being considered aimed at managers new to the Trust, as an alternative to Managing Service Excellence, which would deliver bite-size just-in-time training on the essentials of line management and the expectations of HPFT in this regard. It is anticipated that this method of training could be more effective that traditional classroom workshops.
- Cohorts 1,2 and 3 (a total of 16 HPFT participants) of the Mary Seacole Local Programme have completed. This is a joint initiative with the NHS Leadership Academy and STP colleagues. Another 3 cohorts (cohorts 4, 5 and 6) are currently underway for 2018.
- Further role out of the 4 day Senior Leadership Programme for West SBU and Broadland Senior Team.
- Cohort 9 of the Leadership Academy is close to completion, (15 Emerging Leaders and 10 Leaders) and cohort 10 is in the planning stage - anticipated to commence in September/October 2018.
- As part of the collective leadership work a coaching for leader's development programme, which will support a change in culture around appreciative enquiry, empowerment, and supporting the workforce has been approved and a tender process will take place during Q4 to secure a provider who will design, develop and evaluate a coaching programme for our tier 2 and tier 3 leaders.

4.2 Maintaining and Growing Staff Engagement

Two Inspire Award presentations have taken place with 37 nominations received. The national annual staff survey results were released in Quarter 4. It was the first year we did a full census and out of 3020 eligible staff 1396 have responded, which

is 46.9%. The overall engagement score was above average compared to other mental health trusts but slightly lower than last year 3.87 (3.90). The results demonstrate a continuing positive position for the Trust. Just over 90% of our scores are in line with or above the national average (when compared to other mental health and learning disability Trusts).

The top five scores were as follows:

- Effective use of service user feedback
- Quality of non-mandatory training, learning and development
- Staff motivation at work
- Staff confidence and security in reporting unsafe clinical practice
- Staff recommendation of the organisation as a place to work

The bottom five scores were as follows:

- Percentage of staff working extra hours
- Percentage of staff experiencing physical violence from staff
- Percentage of staff experiencing harassment, bullying and abuse from staff
- Support from immediate line managers
- Percentage of staff experiencing discrimination at work

A new way of delivering the Pulse survey to staff was utilised this quarter. Individual emails with a survey link were sent to all staff directly from MES with weekly reminders only to individuals who had not completed the survey. The total number of respondents was 391 double the response rate compared to the same quarter last year and the highest response rate we have received in the past 3 years.

The results highlighted similar themes to the staff survey with 26% of staff unlikely to work additional unpaid hours, 78% believe the trust take positive action on their wellbeing and 76% staff reporting it is easy for them to make improvements at work. Additionally 85% of staff said that they did not experience bullying and harassment at work, a negative decrease of 3% on Quarter 3 and 88% did not experience violence a negative decrease of 4% on the previous Quarter.

In the qualitative responses of the staff who had experienced Bullying and Harassment felt either unable to report the incident for fear of reprisal or lack of support from the Trust or their manager if they did.

Staff continue to reflect that better use of technology, improved IT and data systems and more access to developmental training (not Stat/Man) and CPD would enable staff to progress and be more effective. Plans to focus on the areas of improvement are being drawn up with the SBUs.

4.3 Improving Staff Health and Wellbeing

Health and Wellbeing activities have continued throughout Q4. Details of the activities which have taken place is shown in the table below:

Health Hub Activity	Staff participation numbers
HPFT 5km Challenge	152 participants signed up
5 a day Challenge	Completed through Health Manager
Mini Health Checks	90 staff attended a health check in February
Schwartz Rounds	7 Rounds held, 81 attendees
8 week Mindfulness course	16 attendees over two 8 week courses.
Working together As One	This was printed and distributed in March
Flu	57.9% of our frontline workforce received the flu vaccination
Health Manager	413 registered users, 272 Active users before the platform was temporarily shut down due to a system upgrade
Quarterly Social - Quiz	Participation numbers unknown
Health Hub Booklet	Created and Printed the Health Hub booklet which details all the H&W activities throughout 2018

The Trust saw a 13% improvement in the response that 'the Trust takes an interest in health and wellbeing' in this year's staff survey which reflects the positive work that the Trust has undertaken.

5.0 Learning, Education and Development

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

5.1.1 Apprenticeship Levy

In May 2017 the Trust signed up to the Apprenticeship Levy and from this point the levy money is taken from the Trust which is drawn down through training our learners on an Apprenticeship Standard with an approved provider. We currently have 32 apprentices in the system and a new Apprenticeship Standard for Adult Care Worker has started during Q4. Procurement has been completed for the Medical Administration Apprenticeship and staff working in this area have been contacted and advised that they can complete this programme. To increase the number of apprenticeships moving forward we are proposing that the majority of Band 2 Health Care Assistants are employed on an apprenticeship as well as exploring which posts in the organisation would benefit from the offer of a higher degree apprenticeship programme.

To date these are the numbers and Training providers that are been used by the Trust for Apprenticeships.

Training provider	Apprenticeships
Unique : Adult & Lead Adult Care	23
Ixion: Business Administration	6
Dynamic: Medical Administration	3

The validation with the University of Hertfordshire to deliver the Nursing Associate Apprenticeship was completed on 13th March 2018 with the Trust. There is a plan for 15 apprentices for each cohort in May and September 2018.

The Nursing Degree Apprenticeship was validated for the University of Hertfordshire in February with the cohort commencing in September 2018. We are also exploring with training providers that could deliver the Associate Project Manager Level 4 Apprenticeship and also the HR Support Level 3 Apprenticeship.

Prior to the introduction of the Apprenticeship scheme the Trust supported the NVQ (National Vocational Qualification) run through C&G (City and Guilds) These were competency based modules which were then measured by assessment and observation from senior staff, allowing staff to expand their skills and knowledge in health and social care to gain a nationally recognised qualification. Mandatory and optional unit choices also helped staff to gain additional confidence and competence in their respected areas. We had 61 staff registered and their current position to date is shown in the table below.

Completed apprenticeships	25
Left the Trust	12
Working with Education facilitator towards completion	10 (Completion July)
Ongoing with work based assessors	11
Other : On hold, Maternity leave etc	3

The way forward 2018/19:

Future Apprenticeships:

- Both the Nursing Associate Apprenticeship and the Nursing Degree Apprenticeship were validated in Q4 with new cohorts starting in Q1 and Q2.

- As lead Trust for the Trainee Nursing Apprenticeship (TNA) we will be coordinating 55 staff from the STP in which 15 places will be placed with HPFT.

- The Nursing Degree Apprenticeship was validated in March 2018 and will commence in September 2018. This opportunity is for existing HCA's who have the relevant entry qualification to gain a qualification as a registered nurse or new starters that wish to gain a qualification as a registered nurse.

- We are exploring with training providers that could deliver the Customer Service Apprenticeships, at all levels for receptionist and staff working in SPA. The role of a customer service practitioner is to deliver high quality products and services to the customers of their organisation. Completion of this apprenticeship will lead to eligibility to join the Institute of Customer Service as an Individual member at Professional level.

- We are currently sourcing potential training providers for the Associate Project Manager Level 4 Apprenticeship programme and the HR Support Level 3 Apprenticeship.

- Work is currently being undertaken with training provider Steadfast who will deliver Adult Care - Level 2 and Lead Adult Care - Level 3 to Essex and Norfolk.

- The Social Worker Degree, apprenticeship programme is in development. use.

- The Social Worker Degree Apprenticeship and Occupational Therapist Degree Apprenticeships standards are in development but to date are not ready to use as they are only available for delivery once the standard and assessment plan is approved and a funding band has been assigned.

5.2.1 Access to learning

During Q4 there have been a total of 4269 attendances on a range of classroom based training sessions. A further 1745 e-learning packages have been completed by staff and a total of 508 classes were commissioned. In addition to this the Learning and Development Team have received and manually updated 892 WRAP certificates and 317 Information Governance certificates in an attempt to remedy OLM issues. Considerable effort has been made to ensure that delegates attend courses they are booked on by contacting staff directly. The total DNA figure for Q4 was 1347 which is 32% of reserved places on face to face courses.

5.2.2 Library and Knowledge Services

During Q4 the library generated 245 general article requests and 322 general book requests. We have continued to actively promote and encourage enrolment to library services at corporate induction to new staff. During Q4 our membership has risen to 120 from 83 in Q3.

We are working towards the renewal of Knowledgeshare, which is an invaluable resource that provides personalised, targeted, up to date evidence based information to staff as well as the latest publications on quality, safety, education and patient information. This resource is currently used by 50 libraries across 100 NHS Trusts and CCGs.

The library quality assurance framework (LQAF) was submitted to Health Education England during Q3. The Trust is awaiting the outcome of the assessment which will become available during Q1.

6.0 Recommendation

The Board is asked to note the Q4 position and the level of activity that is being undertaken to support delivery of the Workforce and Organisational Development metrics as well as the actions being identified to improve the position moving forward.

Mariejke Maciejewski
Deputy Director of Workforce and OD
April 2018

Mar 2018 - Based on Q4 2017/2018

HPFT Workforce Information Report Summary

WORKFORCE INFORMATION REPORT SUMMARY

Workforce Report Mar 2018 (Based on data for Q4 (2017/2018)

Section 1: KPI summary position

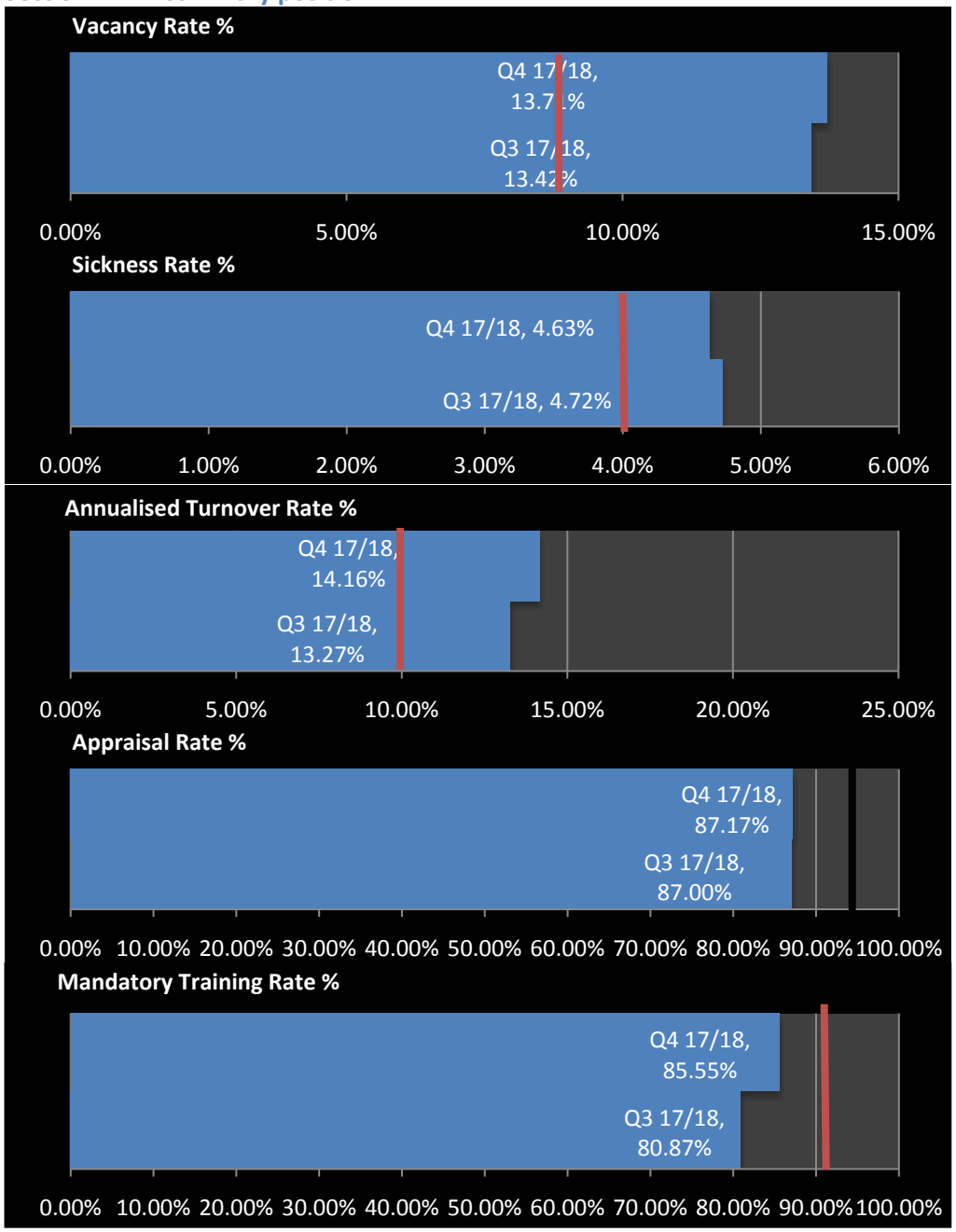
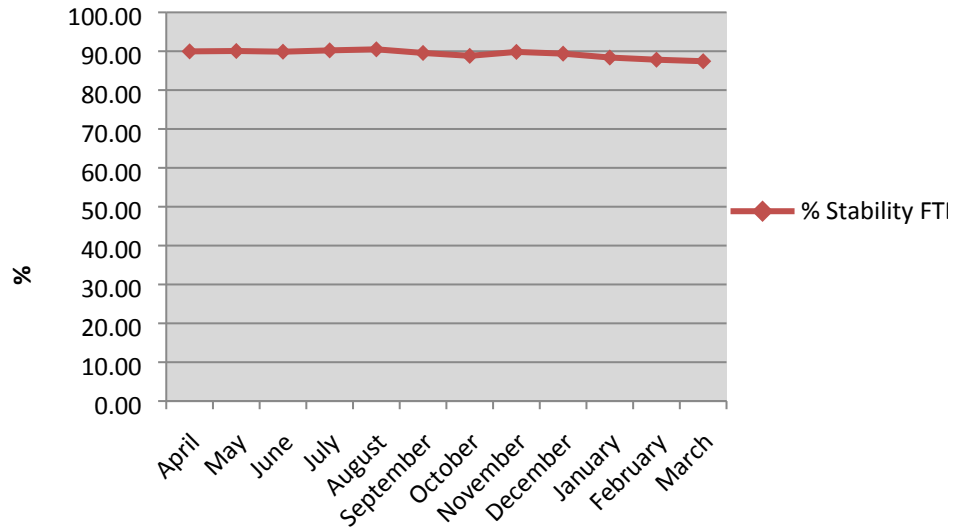


Table 1: Establishment Data

Funded Establishment =	3345.26
Staff in post =	2886.45
Vacant posts =	458.81
% Vacancy rate =	13.71
% Turnover rate =	14.16
% Stability rate =	87.43

Graph 1 : % Stability



Section 2: Recruitment

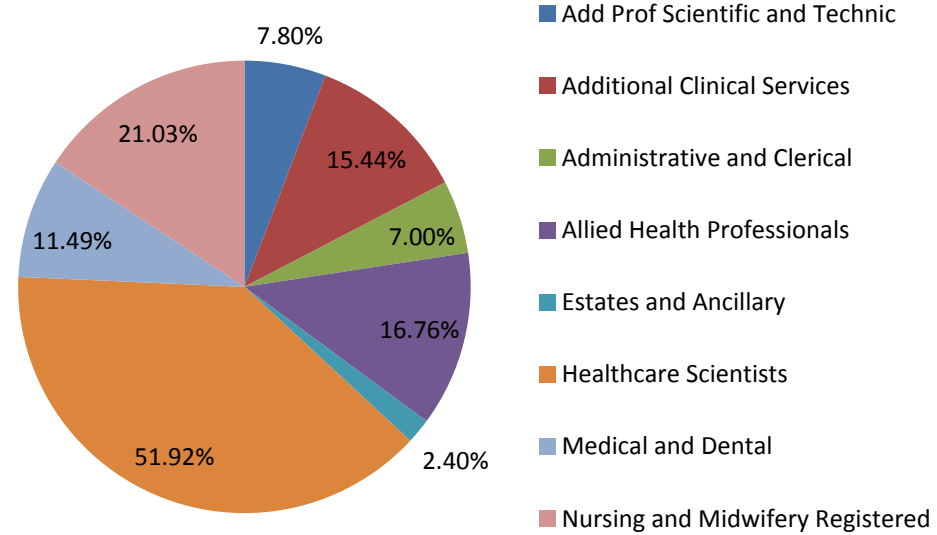
Table 2: Recruitment Summary by SBU

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Authorisation	7.4	14.6	7.8	18.48	48.28

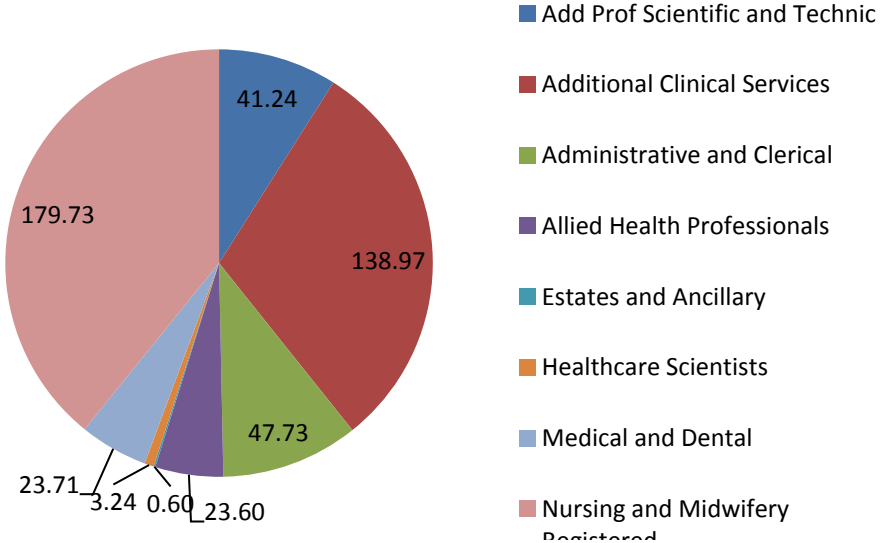
Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Longlisting	4	27.2	44.25	17.63	93.08
Shortlisting	5	3	11.6	13.7	33.3
Interview	1	8	16.9	21.5	47.4

Vacancy Stage	Corporate FTE	SBU LD&F FTE	SBU East & North FTE	SBU West FTE	Total FTE
Offer	7	36.1	42.13	65.8	151.03
Starting	1	4	13.03	5.8	23.83

Graph 2: Vacancies (%) by Staff Group



Graph 3: Vacancies (fte) by Staff Group



Section 3: Turnover

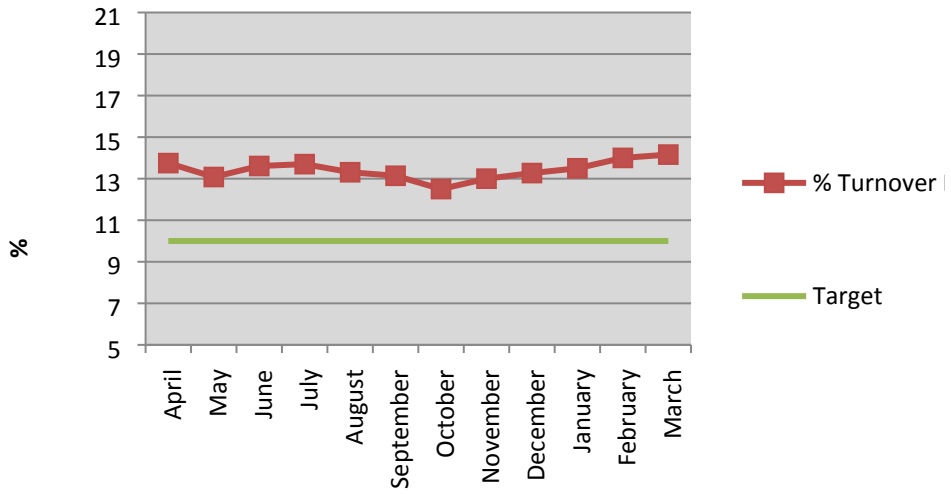
Table 3: Q4 2017-2018 Leavers by Leaving Reason

Leaving Reason	Total
Voluntary Resignation - Relocation	23
Voluntary Resignation - Promotion	23
Voluntary Resignation - Other/Not Known	19
Retirement Age	16
Voluntary Resignation - Work Life Balance	13
Voluntary Resignation - Better Reward Package	11
End of Fixed Term Contract	5
Voluntary Resignation - Health	4
Voluntary Resignation - Lack of Opportunities	3
Voluntary Early Retirement - no Actuarial Reduction	3
Voluntary Early Retirement - with Actuarial Reduction	3
Dismissal - Conduct	2
End of Fixed Term Contract - End of Work Requirement	1
End of Fixed Term Contract - Completion of Training Scheme	1
End of Fixed Term Contract - External Rotation	1
Voluntary Resignation - To undertake further education or training	1
Redundancy - Compulsory	1
Voluntary Resignation - Child Dependants	1
Dismissal - Some Other Substantial Reason	1
Grand Total	**132**

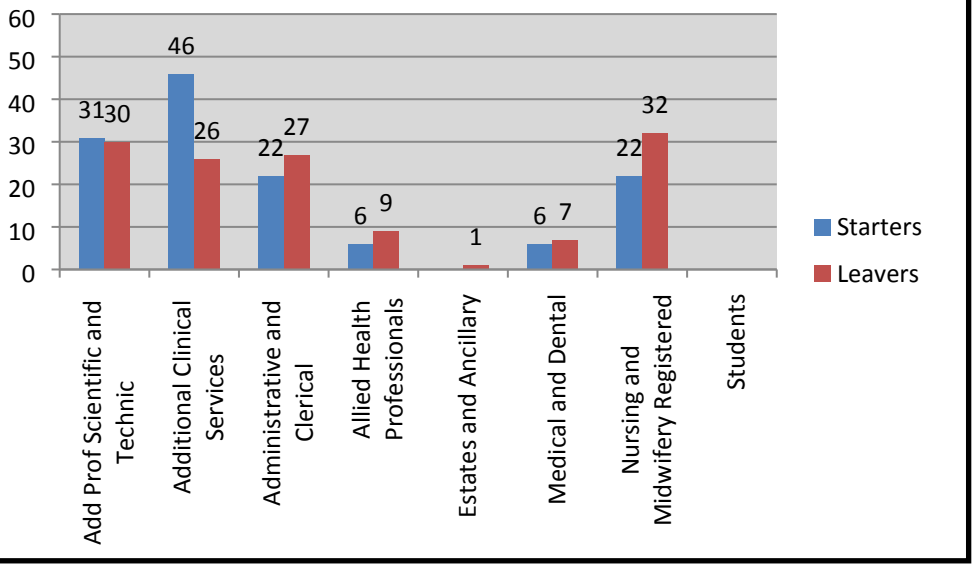
Table 4: Retirement Profile

	Age		
Retirement profile	**55-59**	**60-64**	**65+**
367 Corporate	43	22	16
367 SBU Learning Disability & Forensic	118	40	16
367 SBU MH East & North Herts	122	79	37
367 SBU MH West Herts	97	70	24
Grand Total	**380**	**211**	**93**

Graph 4 : % Turnover



Graph 5: Starters & Leavers by Staff Group Q4



Section 4: Sickness Absence

Table 5: Q4 2017-2018 Top 10 Reasons for Sickness Absence

Sickness Absence Reason	No Of Episodes
S13 Cold, Cough, Flu - Influenza	443
S98 Other known causes - not elsewhere classified	179
S99 Unknown causes / Not specified	178
S25 Gastrointestinal problems	173
S10 Anxiety/stress/depression/other psychiatric illnesses	95
S12 Other musculoskeletal problems	63
S15 Chest & respiratory problems	54
S21 Ear, nose, throat (ENT)	52
S28 Injury, fracture	50
S16 Headache / migraine	49

Graph 6: % Sickness Absence by Month

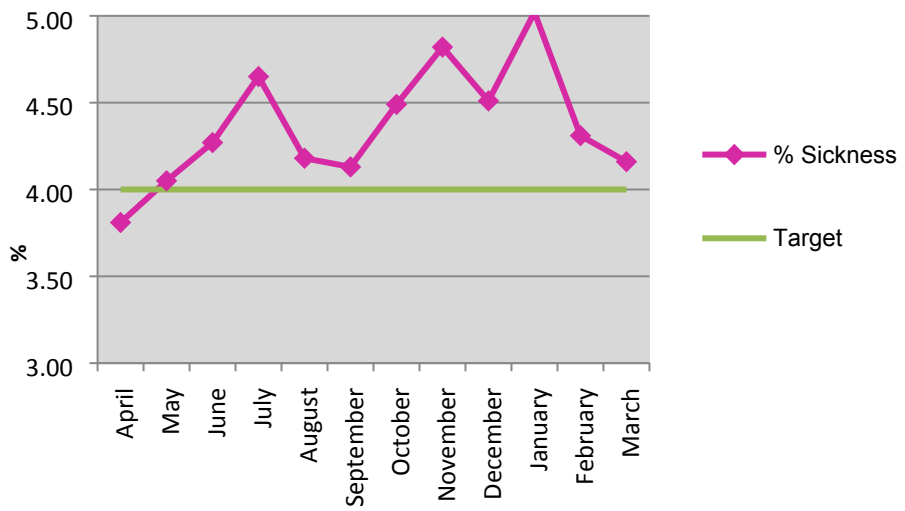
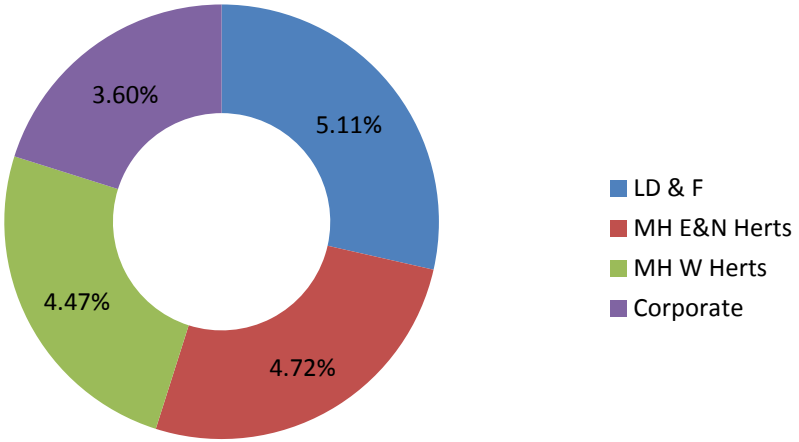


Table 6: Sickness Cost

SBU	Estimated Cost of sickness Q4
Corporate	£109,898
LD & F	£331,601
MH E&N Herts	£284,209
MH W Herts	£297,433
Trust	**£1,023,142**

Graph 7: Q4 % Sickness Absence by SBU



Section 5: Temporary Staffing

Table 7: Q4 2017-2018 Bank, Agency & Substantive Spend

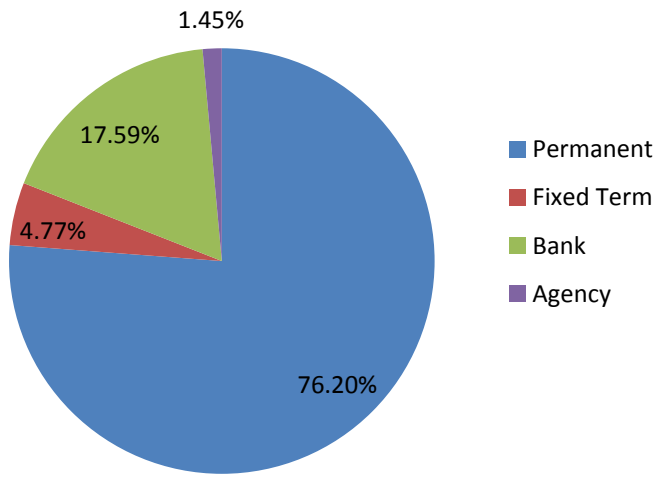
2017- 2018				
Total spend	**Q4**		**YTD**	
	£	**%**	**£**	**%**
Agency				
Bank				
Substantive				
Total				

Not available from finance yet

Table 8: Q4 2017-2018 Bank and Agency Usage

Staff	Number of Shifts requested minus the cancellations	Number of Bank Shifts Filled	Bank Fill Rate	Number of Agency Shifts Filled	Agency Fill Rate	Total Fill Rate
Nursing Qualified and Unqualified	25,338	19,124	75.48%	4,513	17.81%	**93.29%**
Admin	4,789	4,143	86.51%	451	9.42%	**95.93%**
Social Workers	1,015	452	44.53%	336	33.10%	**77.64%**
OT/AHP	1,021	822	80.51%	105	10.28%	**90.79%**
Total	**32,163**	**24,541**	**76.30%**	**5,405**	**16.81%**	**93.11%**

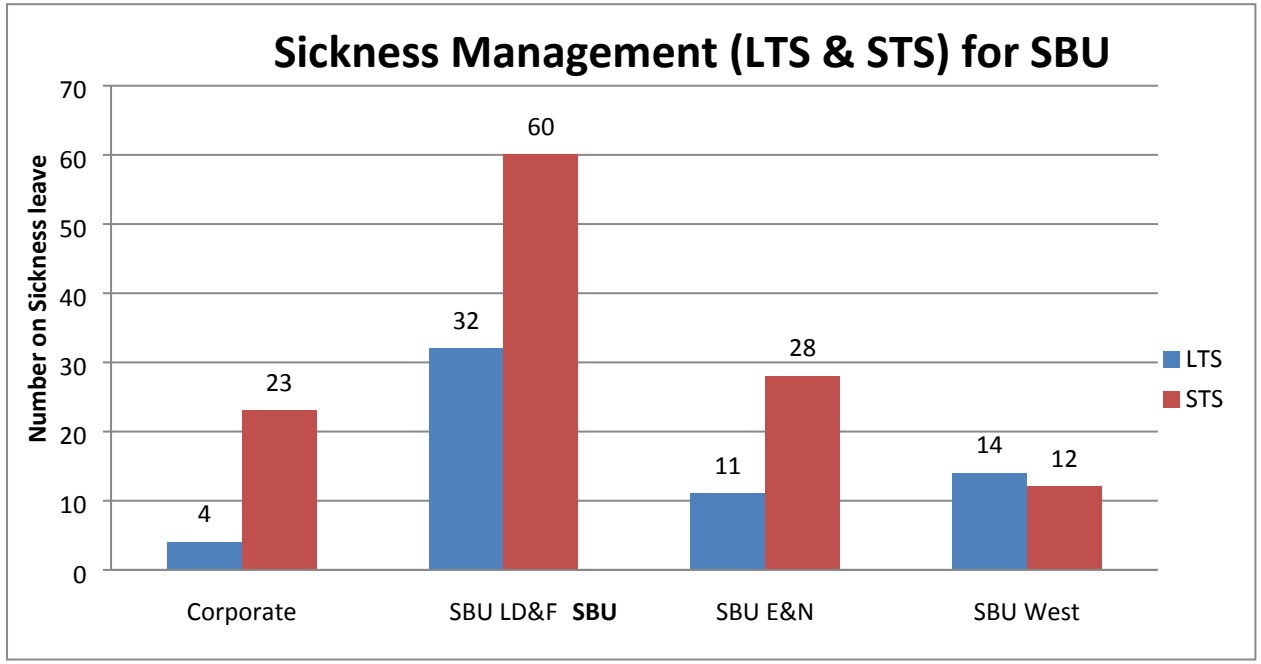
Graph 9: % FTE of Workforce by Assignment Category



Section 6: Employee Relations & Sickness Management

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

Live ER Cases	Add Prof Scientific and Technic	Additional Clinical Services	Admin and Clerical	Allied Health Professionals	Medical and Dental	Nursing and Midwifery Registered	Total
Number of Disciplinary Cases	2	9	7			6	**24**
Number of Grievances		2		1			**3**
Number of Capability cases							**0**
Number of Bullying & Harassment cases			2			2	**4**
Number of Whistleblowing cases							**0**
Total number of cases in progress	**2**	**11**	**9**	**1**	**0**	**8**	**31**
Number of Mediation sessions	1	2				1	**4**
Number of suspensions/restricted duties	1	5	4			4	**14**
Number of appeals			1			3	**4**



Section 7: Staff Development

Table 10: Appraisal Compliance

SBU	Number of completed appraisals	Number of Staff	PDP Rate %
367 Corporate	225	311	**72%**
367 SBU Learning Disability & Forensic	676	765	**88%**
367 SBU MH East & North Herts	659	731	**90%**
367 SBU MH West Herts	729	819	**89%**
Grand Total	**2289**	**2626**	**87%**

Graph 10: % PDP Compliance

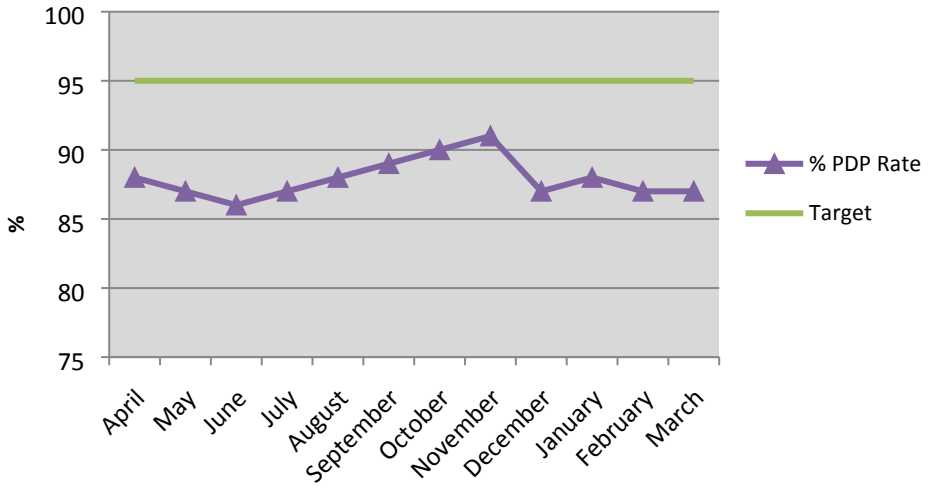
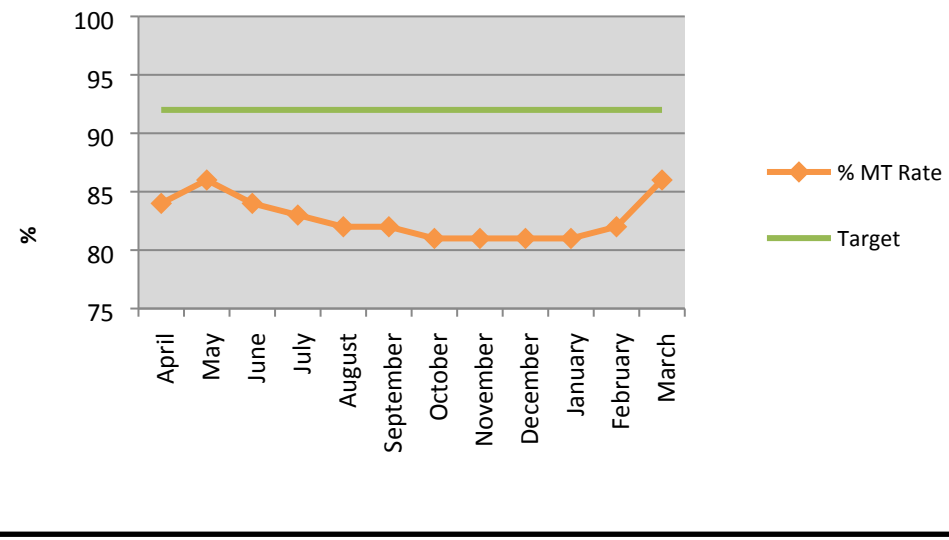


Table 11: Mandatory Training Compliance

SBU	Does not meet requirement	Meets Requirement	Grand Total	% Compliance
367 Corporate	434	2095	2529	**83%**
367 SBU Learning Disability & Forensic	788	7011	7799	**90%**
367 SBU MH East & North Herts	1175	6466	7641	**85%**
367 SBU MH West Herts	1431	7085	8516	**83%**
Grand Total	**3828**	**22657**	**26485**	**86%**

Graph 11: % Mandatory Training Compliance



Board of Directors

Meeting Date:	**28th June, 2018**	**Agenda Item: 11**
Subject:	**OD Stocktake and next phase of OD**	**For Publication: yes**
Author:	**Jinjer Kandola**	**Approved by: Jinjer Kandola**
Presented by:	**Jinjer Kandola (Deputy CEO/Director of Workforce & OD)**	

Purpose of the report:

To apprise the Board on the stocktake on the year one organisational development action plan, the gaps identified and a recommendation on the next phase of OD activity within the Trust.

Action required:

To receive update and endorse the way forward.

Summary and recommendations:

The OD strategy was approved by the Board in March 2017, and will be delivered through annual OD plans which will be reviewed by the Executive team and the Board to ensure that they are fit for purpose and support the Trust aspirations as outlined in the Good to Great Strategy.

Summarised in this paper is the progress to date and the identified areas of gap or requires improvement. A full summary is attached at Appendix 1.

Given organisations are dynamic, constantly evolving and reacting to planned and unplanned events and interventions both internal and external it is important that we review other sources of feedback and evidence. In order to ensure we have a holistic view of current state of the organisation and plan OD interventions appropriately.

During the first year of the OD strategy we have had the CQC inspection of our Core Services and the Well Led Review of Services. Workforce challenges remain an issue both within the Trust and throughout the NHS as whole, demand for services is probably the highest it has ever been and we continue to see higher levels of acuity amongst our service users.

Many of the issues that staff are reporting via the NHS Staff Survey or Pulse survey or that the CQC highlighted remain static and have been of no major surprises, many of the initiatives in the OD action plan have been designed and planned to address these. However, it is evident that in some areas there has been slow progress. Detailed below is a summary of the emerging issues:-

It is recommended that priority is given to the following areas in order to make a step change to the Trust and support the delivery of Good to Great.

- **Collective Leadership** – clarity around what this means and how this is embedded at a local level
- **Quality (Continuous) Improvement & Innovation** – moving this from theory into practice and providing teams with the skills to utilise these in every day practice
- **Culture of Safety** – what we mean and how it is embedded
- **Productivity and efficiency** – what do we mean by this and how are we addressing this at a local level
- **Accountability** – clarity around what this means and then embedding this through the

Trust values and behaviours (Professional value).

It is recommended that the next phase of the OD focuses on the teams, their function, development and methodology of working. The way forward is not to introduce another new initiative, our workforce has told us on numerous occasions this does not assist them in undertaking their roles, it causes confusion and duplication. However, we need to provide a framework/approach to guide the development of sustainable high performance teams (embedding collective leadership, continuous improvement methodology and mind set, which supports translating OD at team level) should be the way forward.

Detailed in the paper and the presentation is the recommended way forward in relation to adopting a team based framework.

OD Activity Plan Year 2117-2019

The activity plan lists the priorities for year one of the strategy. The implementation of each of these activities will impact on several Elements of the Strategy. The activities are not individual solutions (several activities will be delivered simultaneously by developing tailored programmes or work).

Activity	Timeline	Lead Owner	Culture	Customer Experience	Staff Capability & Experience	Leadership	Organisational Effectiveness and Design	RAG
1. Commission, design and deliver a program for all staff on embedding a culture of innovation and continuous improvement across the Trust. (Living our values phase 2 focus on professional – *creativity, improving and effective*)	2017/19	ED Workforce & OD & Director of Innovation & Transformation	√	√	√	√	√	
2. Develop a team of change agents (approx. 5%) of the workforce who will support, develop and embed the cultural change – innovation and continuous improvement based on the collective leadership model.	2017/19	ED Workforce & OD & Director of Innovation & Transformation	√	√	√	√	√	
3. Develop a series of master class for targeted leadership groups (Board, Exec, MD, CD, Medical Leads, Service Line Leads) on • Population based approach to health care	2017/18	ED of Strategy & Partnerships & ED Workforce & OD			√	√	√	

Activity	Timeline	Lead Owner	Culture	Customer Experience	Staff Capability & Experience	Leadership	Organisational Effectiveness and Design	RAG
• System leadership and system thinking • Collaboration in complex health care systems.								
4. Provide masterclass for the Board & Executive Team on the new organisational forms and arrangements for provision healthcare	By end of Q4	Deputy CEO, and ED Strategy & Partnerships				√	√	
5. Engagement – systematic approach to deliver the agreed engagement model. • Two “road shows” across within Trust (connection & scope) • Two Big Listen (voice) • Local Listen (voice) • 4 CEO Breakfasts throughout the year(voice)	Ongoing	ED Workforce & OD	√	√	√	√	√	
6. Delivery of the agreed Health & Well-being strategy • Focusing on resilience and mindfulness. • Monitoring and reducing work stressors. *	Ongoing	Deputy Director of Workforce, Head of OD	√	√	√	√		
7. Deliver on the outputs of the collective leadership • Supporting managers in delegation and accountability.	Starting 2017	ED Workforce & OD	√	√	√	√	√	

Activity	Timeline	Lead Owner	Culture	Customer Experience	Staff Capability & Experience	Leadership	Organisational Effectiveness and Design	RAG
• Manageable workload • Empowerment and involvement in decision making. • Good governance								
8. Continue to roll out unconscious bias training to all staff	Q1-Q4	Head of OD, Head of L&D	√	√	√	√		
9. Leadership – review the current leadership competencies within the Trust taking on board the national leadership framework, skills and competencies required for Good to Great and collective leadership.	Q1	ED Workforce & OD, Deputy Director of Workforce, Head of OD	√	√	√	√	√	
10. Undertake a review of the management and leadership programs currently delivered to reflect the new requirements.	Q2-Q3	ED Workforce & OD, Deputy Director of Workforce, Head of OD	√	√	√	√	√	
11. Develop a clinical leaders program for medical and nursing leadership • Prioritising team leaders program • Medical leads, modern matrons	Q3-Q4	ED Quality & Medical Leadership, ED Quality & Safety, supported by OD.	√	√	√	√	√	
12. Development of the senior leaders program for 2017-18, supporting engagement and development of the top 70 leaders in the Trust	2017/18	ED Workforce & OD	√	√	√	√	√	
13. Review and refresh the talent	Q3-Q4	ED Workforce &	√		√	√		

Activity	Timeline	Lead Owner	Culture	Customer Experience	Staff Capability & Experience	Leadership	Organisational Effectiveness and Design	RAG
management & succession planning		OD, Deputy Director of Workforce, Head of OD						
14. Undertake and review the governance processes and levels of delegated authority to support the desired intentions for a culture of innovation.	Q2-Q3	Deputy CEO, ED Finance & Director of Innovation	√		√	√	√	
15. Delivery leadership, staff capability aspects of Quality & Service Delivery – prevention and wellbeing	TBC	TBC	√	√	√	√	√	
16. Delivery of the key year one organisational priorities as highlighted in the Physical Health Strategy	2017/18	ED Strategy and Partnerships	√	√	√		√	
17. Identify the key OD priorities that emerge from the HCT alliance and then develop appropriate actions to deliver.	Q1 – identify actions Q2 develop Q3 deliver	Deputy CEO, and ED Strategy & Partnerships			√		√	
18. Design and deliver a development program for effective communication and feedback for service user facing staff including aspects to support the prevention.	Q2-Q4	Director of service Delivery & SU Experience, Head of OD		√	√		√	

Activity	Timeline	Lead Owner	Culture	Customer Experience	Staff Capability & Experience	Leadership	Organisational Effectiveness and Design	RAG
19. Review and develop program of learning to improve technological competence in the workforce	Q2-Q4	Director of Innovation, Head of IMT, Head of L&D		√	√		√	
20. Review of organisational structure leadership capacity and support to ensure that it remains fit for purpose and nimble to respond to changing landscape in health	ongoing	CEO				√	√	

Organisational Development Stock Take

1. Introduction

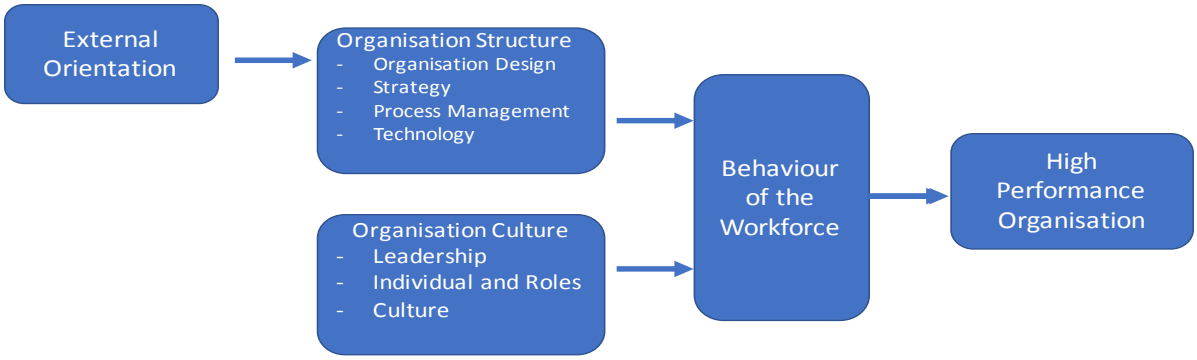
Our current OD strategy was written in the context of delivering the Trust "Good to Great Strategy", which has been co-developed with the key stakeholders. Set against the backdrop of NHS Five Year Forward View – the implementation of which is outlined at a footprint level by the sustainability and transformation plan (STP). Our services fall within Hertfordshire & West Essex, footprint. The local STP plan's will help the organisations prepare and adapt to the changes this initiates and build the capabilities to continuously improve population health, care for our service users and ensure value for money. The Good to Great Strategy high level objectives are illustrated below.

The OD strategy was approved by the Board in March 2017, and will be delivered through annual OD plans which will be reviewed by the Executive team and the Board to ensure that they are fit for purpose and support the Trust aspirations as outlined in the Good to Great Strategy.

Summarised in this paper is the progress to date and the identified areas of gap or requires improvement. A full summary is attached at Appendix 1.

2. Background and approach

Since 2012, HPFT has adopted DeWaal (2007) model which focuses on factors that contribute to a high performing organisation, this model is still fit for purpose and it is recommended that it be retained.



Our OD strategy has five key themes which are listed below:-

- **Culture** – establishing the workforce culture fit to deliver all our expectations
- **Customer Experience** – customers (those who use the services of HPFT) being the heart of everything we do and the reason for these actions.
- **Leadership** – building the leadership capacity and capability to ensure we can deliver these actions
- **Organisational Effectiveness and Design** – making sure we have the right structures, systems, processes and functions to enable the workforce to deliver these actions.
- **Staff Experience & Capability–** recognising that there are core skills required of all staff to be successful and to get the most from our people we must continue to invest in their experience at work and their health and wellbeing.

The OD activities that were agreed to support the first two years of delivery is attached at Appendix 2, to deliver the OD strategy and nurture the culture within the Trust, there is an agreed model of engagement. Which is the integrated model of employee engagement from Holbeche, & Mathews this model connects four areas between individuals and the organisation.

- **Connection** – (which is about identification with the organisation, its value and its core purpose 'the why). To what extent is there a strong feeling of a sense of belonging with the organisation, both in terms of sharing the same beliefs or values and in an individual's readiness to follow the direction of the organisation
- **Support** – (which is about the vital role of line managers). The practical help, guidance and others resources provided to help people do a great job. Ensuring that managers support both in good times and in bad times.
- **Voice** – (which is about the opportunity to be involved and contribute). The extent to which people are informed, involved and able to contribute to shaping their work environments.
- **Scope – (**which is about creating the environment to thrive and flourish). Giving the opportunity employees have to meet their own needs grow and develop, to have control over their work. This is reliant on mutual trust which is under pinned by meaning and purpose.

The OD interventions will support the agreed engagement approach and ensure that these encourage the workforce within the Trust to release potential to ensure we maximise performance.

3. Gap Analysis

The areas identified as gaps under the key areas are outlined below the full details can be found in Appendix 1:-

Culture

We work embracing the principles of Collective Leadership	• Whilst the term "collective leadership" is used throughout the Trust there remains an inconsistent approach to how this is translated at team level.
We are continuously looking to improve the way we deliver healthcare and the way we do our jobs – improving efficiency	• The workforce development programme has been delayed and not yet procured. • Our model(s) are not fully embedded and the systems and process are not aligned. • There is inconsistent use of the approach, however, where it is used it is beginning to take hold and make a difference. • Aligning the CI improvements to demonstrate efficiency – clarity around the outcome measures from the outset is required. • The "change agents" for CI have not been recruited or progressed.
There is a culture of safety at every level. Embedding human factors.	• There has been some progress with this, but there is limited approach to embedding human factors.
There is accountability at every level within the Trust. Everyone is accountable for the decisions/actions and indecision or lack of action. We have a can do attitudes	• There are still delays in delivering agreed plans; escalation of the right issues is inconsistent. There remains a view that decision making is held at the top. • As pathways and models of care change, there is a necessity to be clear around decision making levels and autonomy.
We learn from mistakes and events and we use these to improve the way we work.	• There is an inconsistent approach to how learning is shared widely within the Trust. There are some really good examples but not widespread.
We respect and celebrate differences.	• Whilst there are still is significant activity in relation to networks and partnerships. The WRES results are not improving and disabled staff experience needs to improve.

Customer Experience

At the heart of the way we will work with our Service Users, carers and partners will be the ethos of co-creation embedding the principles of recovery.	• Whilst there is good progress in relation to awareness of "service users at the heart of everything we do" – more can be done in relation to co-creation particularly in relation to change and new models of care.
The way we deliver services will value and respect the time constraints of those using services.	• There has been some good approaches to embedding new methods of working to support this such as "Skype clinics" to support the work on productivity and efficiency. However, this is not widely embraced and it is difficult to quantify the tangible outcomes – needs more quantifying.
We will focus on supporting the staff experience to provide them with the resources required to deliver their work	• Staff are still reporting that they do not have the resources to do the job, citing mobile phones, laptops and environmental issues.

Staff Experience & Satisfaction

Development of management skills and capability to deliver e.g. ○ Team working ○ System leadership ○ Giving feedback ○ Coaching ○ Creating clarity & purpose ○ Manageable workloads ○ Improvement skills ○ Driving change ○ Unconscious bias ○ Resilience ○ Negotiating and Influencing ○ Project Management	• Some aspects being delivered through management / leadership programmes and local SBU activity listed below are the areas that haven't been delivered. ○ Giving feedback – **limited delivery through OD classes** ○ Coaching – **securing for tier 2 &3** ○ Creating clarity & purpose – **not delivered** ○ Manageable workloads – **limited via management programs** ○ Improvement skills – **not delivered** ○ Driving change – **not delivered** ○ Project Management - **not delivered**
Developing workforce on principles of continuous improvement & innovation	• As per section under culture.
New ways of working and new skills to deliver integrated approach to healthcare as per quality and service delivery strategy	• QSDS late in development, new skills not delivered, work in early stages re integrated approaches.
Recruitment, retention and reward aligned to delivering good to great and cultural change	• Slow progress – needs more work in relation to alignment in order to reward for delivery of key aspects of Good to Great.

Leadership

Leadership strategy which address, capacity, capability and leadership style as per output of collective leadership work outlined for all levels of leaders	• Review part completed, programmes continue to be developed.
Leadership skills – learning from events.	• See earlier note under culture.
Encouraging Team working and cross boundary working	• Limited success needs more prioritisation.
Workload management	• Limited if no success staff still reporting this as an issue.
Support from line managers	• Still low levels of satisfaction being reported from staff.
Talent & Succession management	• Inconsistent practices, most SBUs have stagnated with their approach. Needs energising and a systematic approach
Matrix working	• Slow progress, still appears too much silo working and not cross department working.

Organisational Effectiveness and Design

There is clarity around people's scope of decision-making, control and accountability. o Scheme of delegation	• Remains a continued source of concern, regular brought up at Good to Great road shows.
Earned autonomy clarity on what this means in new changing external regulation.	• No real clarity or freedoms developed
Effective two way communications channels are in place across services, linking board to floor. Streamline communications and initiatives	• Some progress, cascade team brief not up, interim website improved, still not effective board to ward communications.
Organisational effectiveness – process are reviewed to ensure they are streamlined. Including the implementation of the "Carter Review".	• Some progress, part of the Carter review, Safecare has assisted in the development of this. • See also the note in relation to culture
Modernised and innovative corporate/support functions to support the frontline services.	• Support has been commissioned

4. Analysis of themes emerging from other sources of feedback

Given organisations are dynamic, constantly evolving and reacting to planned and unplanned events and interventions both internal and external it is important that we review other sources of feedback and evidence. In order to ensure we have a holistic view of current state of the organisation and plan OD interventions appropriately.

During the first year of the OD strategy we have had the CQC inspection of our Core Services and the Well Led Review of Services. Workforce challenges remain an issue both within the Trust and throughout the NHS as whole, demand for services is probably the highest it has ever been and we continue to see higher levels of acuity amongst our service users.

Many of the issues that staff are reporting via the NHS Staff Survey or Pulse survey or that the CQC highlighted remain static and have been of no major surprises, many of the initiatives in the OD action plan have been designed and planned to address these. However, it is evident that in some areas there has been slow progress. Detailed below is a summary of the emerging issues:-

5. Areas of Priority moving forward

It is recommended that priority is given to the following areas in order to make a step change to the Trust and support the delivery of Good to Great.

- **Collective Leadership** – clarity around what this means and how this is embedded at a local level
- **Quality (Continuous) Improvement & Innovation** – moving this from theory into practice and providing teams with the skills to utilise these in every day practice
- **Culture of Safety** – what we mean and how it is embedded
- **Productivity and efficiency** – what do we mean by this and how are we addressing this at a local level
- **Accountability** – clarity around these embedding Trust values and behaviours

6. Recommendations

Whilst the results of the National Staff Survey within the Trust were very positive and remained in a good place, closer analysis demonstrated that team effectiveness and experience of line managers could be improved to enable the Trust to achieve its objectives.

It is recommended that the next phase of the OD focuses on the teams, their function, development and methodology of working. The way forward is not to introduce another new initiative, our workforce has told us on numerous occasions this does not assist them in undertaking their roles, it causes confusion and duplication. However, we need to provide a framework/approach to guide the development of sustainable high performance teams (embedding collective leadership, continuous improvement methodology and mind set, which supports translating OD at team level) should be the way forward.

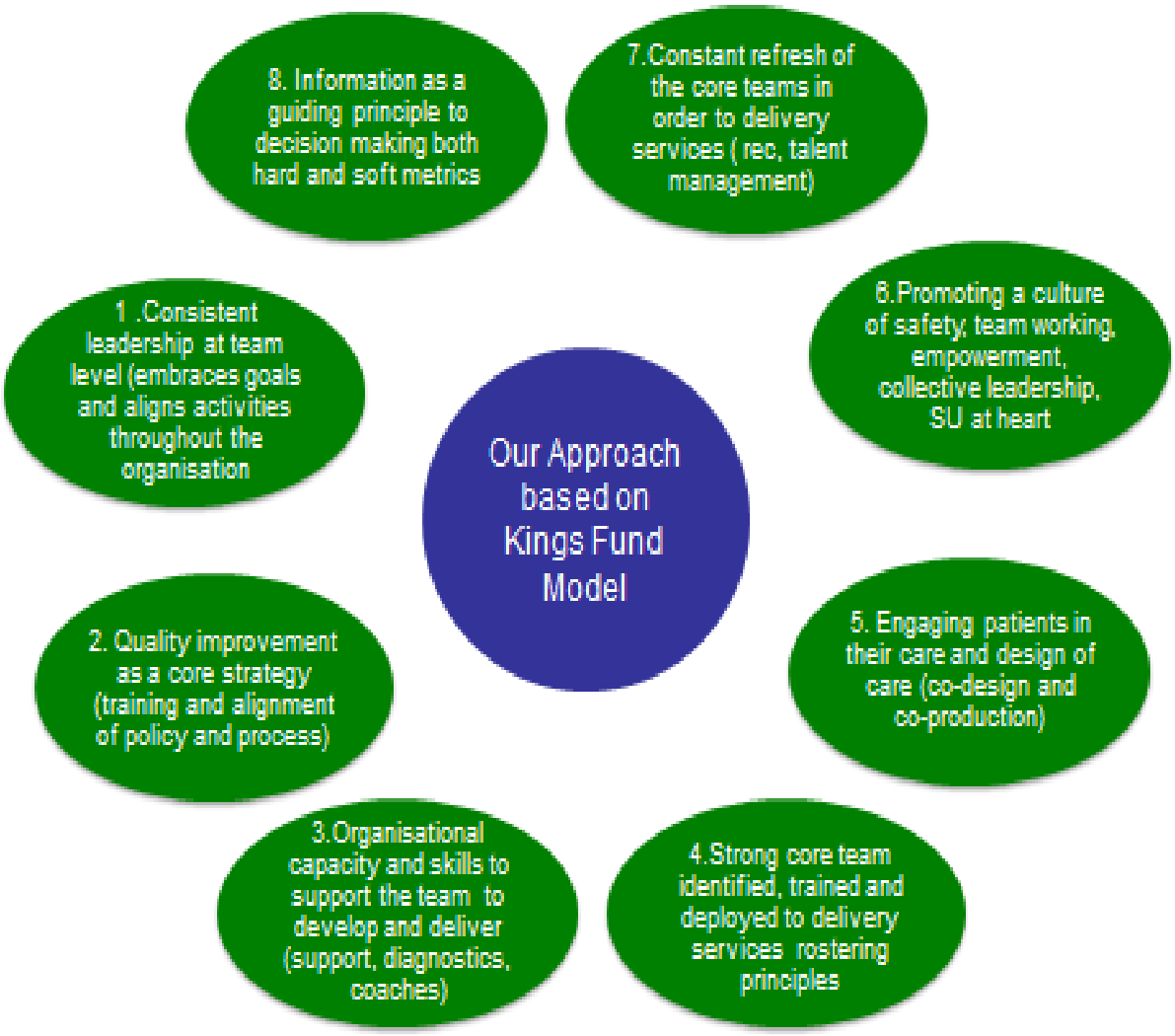
It is recommended that the model below is piloted within the Trust in a couple of areas to establish if it can make a sustainable change. It is recommended that this is undertaken in both clinical and non-clinical areas, both in teams who are performing well as well as those that are not.

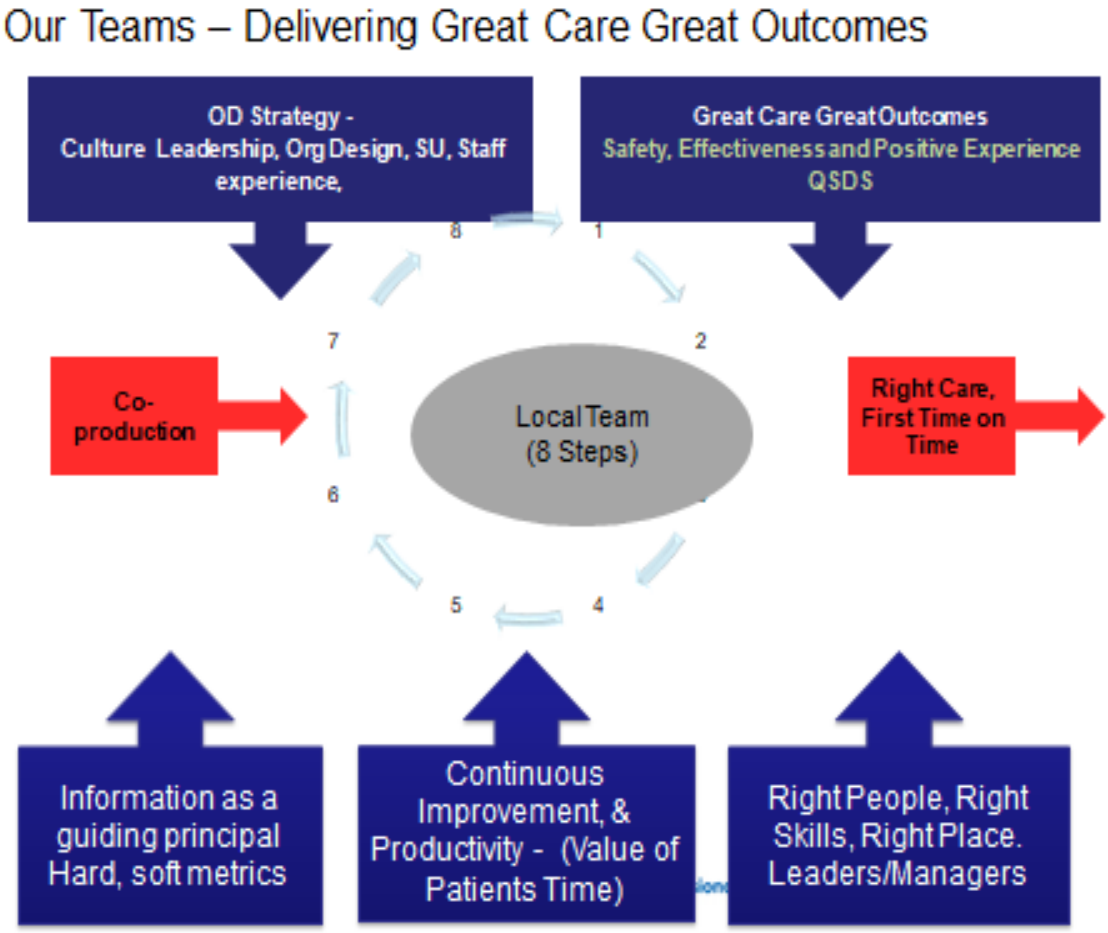
The support functions and senior leadership teams will need to understand the principles and how this relates to their work. It provides a structured approach to review, develop and structure teams (people, process and structure) against the eight steps to deliver a consistent operating model for teams across the Trust and therefore support the aspirations of the Trust to achieve the Good to Great Strategy.

Kings Fund approach to High performing teams.

Diagram 1= Kings Fund Model

Diagram 2 = Modified Model





Jinjer Kandola

Deputy CEO/Director of Workforce & OD

Our Culture	Progress review	Sources of feedback
➢ Our Service Users are at the heart of everything we do –always getting the fundamentals right We will work with our service users, carers and other partners to ensure the way we work supports the individuals recovery journey,	➢ Good progress in relation to awareness of "service user at the heart of everything we do". Always getting the fundamentals right – not consistently achieved	➢ CQC feedback, SU feedback, SI, internal reporting, quality visits, Staff survey, feedback from staff.
➢ We work embracing the principles of collective leadership.	➢ Inconsistent approach to collective leadership.	➢ Big Listen, Staff Survey – involvement
➢ There is a culture of safety at every level. – embedding human factors	➢ Culture of safety – some progress, limited approach embedding human factors.	➢ CQC, visits, staff feedback- Big Listen.
➢ A values led organisation	➢ Good progress on values – area need to focus on professional.	➢ Staff survey, CQC, pulse survey, Big Listen
➢ We are continuously looking to improve the way we deliver healthcare and the way we do our jobs. – Improving efficiency	➢ Continuous improvement – training programme not rolled out, model not fully embedded, systems and process not aligned. Inconsistent use, but where used shown to be effective.	➢ Staff survey, management discussions, staff feedback.
➢ We use every opportunity to look at innovation and creativity in the way deliver healthcare. We use research to support us with this.	➢ £1m Innovation fund set up, some good progress with generation of ideas and schemes. Limited use of research – spread of practice limited.	➢ No significant change in way of working.
➢ Our staff will be empowered to make decisions and changes to improve our services	➢ Slow progress, staff continue to report they are not involved in decision making, or trusted to do their jobs.	➢ Staff survey, pulse survey, and Big Listens.
➢ There is accountability at every level within the Trust. Everyone is accountable for the decisions/actions and indecision or lack of action. We have a can do attitudes	➢ Delivery of agreed plans – still not always on time, escalation of issues not consistently done. Still remains a view that decision making is held at the top.	➢ Feedback, lack of consistent behaviour change within the workforce.
	➢ Slow progress although the Annual Plan is getting greater traction and ownership.	

Our Culture	Progress review	Sources of feedback
➢ We work as one team to deliver our goals and objectives. Both within the Trust and externally with our partners and the system ➢ We learn from mistakes and events and we use these to improve the way we work. ➢ Everyone is involved and engaged in ensuring we deliver great care and great outcomes. ➢ We respect and celebrate differences.	➢ Inconsistent approach to how learning is shared widely within the Trust. Some really good examples but not widespread. ➢ Overall good levels of engagement, remain pockets where it is poor, but no significant improvement in results. ➢ Networks active and meeting, all holding sessions. Unconscious bias rolled out. However, WRES results still not improving, disabled staff experience could be better.	➢ Lack of ownership of AP, Staff Survey ➢ CQC feedback ➢ Staff survey, pulse, Big listen ➢ Staff survey, Big listen, WRES

Customer Experience	Progress review	Source of feedback
➢ At the heart of the way we will work with our Service Users, carers and partners will be the ethos of co-creation embedding the principles of recovery.	➢ Good progress in relation to awareness of "service user at the heart of everything we do. Some good examples of SU involvement. Co-creation can be stronger.	➢ Staff feedback, manager discussions
➢ The way we deliver services will value and respect the time constraints of those using services.	➢ Valuing the patient time - limited progress with Skype clinics. Working on productivity and efficiency approach. Ability to quantify the tangible outcomes.	➢ Staff feedback.
➢ We will ensure service user/carer involvement. (Gold triangle)	➢ Continued progress – may need reinvigorating. Not necessarily getting the publicity it used to.	➢ Carers network.
➢ Key outcomes of clinical strategy delivered	➢ Quality and Service Delivery Strategy agreed, programs of work starting.	➢ Annual plan updates.
➢ We will focus on supporting the staff experience to provide them with the resources required to deliver their work	➢ Staff still reporting they do not have the resources to do the job, citing mobile phones, laptops and environmental issues.	➢ Staff survey, good to great road shows.
➢ Health & Wellbeing strategy delivered	➢ Strategy completed year one activity plan in place. Achieving aspects of the CQUIN and improvements in the staff survey.	➢ Staff survey, positive feedback big listen, achievement of the cquin.
➢ Further develop our partnerships (University, Herts Community, others)	➢ No new projects developed with Uni of Herts, Hemel Hub being delivered community Trust. Partnership in Essex developed to deliver services.	➢ Our commercial activity.
➢ Respect for equality and diversity	➢ Unconscious bias training being rolled out, network events held, but staff survey WRES data no really signs of improvement. Some adverse comments during CQC well-led visit.	➢ CQC, staff survey.
➢ Work with commissioners to develop and deliver the service requirements	➢ Good relationships with Commissioners	➢ Manager feedback
	➢ Lead ambassadors – no longer visible within the Trust.	➢ Manager feedback

Customer Experience	Progress review	Source of feedback
➢ The Trust lead ambassadors will monitor customer experience and cultural change ➢ Developing the strategic alliance with HCT	➢ No longer – active	

Staff Experience & Satisfaction	Progress review	Source of feedback
➢ Development of management skills and capability to deliver e.g. ➢ o Team working o System leadership o Giving feedback o Coaching o Creating clarity & purpose o Manageable workloads o Improvement skills o Driving change o Unconscious bias o Resilience o Negotiating and Influencing o Project Management ➢ Developing workforce on principles of continuous improvement & innovation. ➢ Recruitment, retention & reward aligned to delivering good to great and cultural change ➢ Valued learning and development offering and CPD ➢ New ways of working and new skills to deliver	➢ Some aspects being delivered through management / leadership programmes and local SBU activity o Team working – Delivered in hot spot areas and on request o System leadership - delivered sessions o Giving feedback – limited delivery through OD classes o Coaching – securing for tier 2 &3 o Creating clarity & purpose – not delivered o Manageable workloads – limited via management programs o Improvement skills – not delivered o Driving change – not delivered o Unconscious bias – rolled out o Resilience – delivered via Health and Wellbeing o Negotiating and Influencing – delivered via HR training. o Project Management - not delivered ➢ Some progress via – leadership academy programmes and managing service excellence. No roll out to the wider workforce. ➢ Slow progress – needs more work in relation to alignment to Good to Great.	➢ Staff survey still an issue re team working and management fundamentals ➢ Staff survey. ➢ Staff survey, CQC.

integrated approach to healthcare as per clinical strategy. ➢ Use of technology and data ➢ Customer Experience ➢ Effective apprenticeship programme ➢ Managing Service Excellence Programme revised	➢ Continued good feedback on CPD and L&D programmes, funding secured internally to support opportunities for development ➢ QSDS late in development, new skills not delivered, work in early stage re integrated approach. ➢ Some good progress with technology and data, Spike, Safecare, LMS comissioned – still too many staff state they do not have the tools to do the job. ➢ Some good progress, but could do more in relation to SU involvement and the wider Customer Experience between functions. ➢ Some success – but limited. ➢ In progress.	➢ Good to Great road shows, staff survey. ➢ Community survey

Leadership	Progress review	Source of feedback
➢ Leadership strategy which address, capacity, capability and leadership style as per output of collective leadership work outlined for all levels of leaders	➢ Review part completed, programmes continue to be delivered.	➢ OD activity plan.
➢ Coaching skills for all leaders	➢ Programme in process of being procured.	➢ OD activity plan ➢ CQC
➢ Learning from events	➢ Some good progress, however, CQC said we could do more.	➢ Staff survey, pulse survey.
➢ Engaging the workforce to deliver great care great outcome	➢ Good levels of engagement and have remained above average in staff survey, but no longer top in this category. No improvement needs a step change.	
➢ Equality & Diversity	➢ WRES data still not improving, staff survey data shows no improvement.	➢ Staff survey. High level feedback network, CQC.
➢ Encouraging Team working and cross boundary working	➢ Limited success, although CQC did observe some areas of good practice.	➢ Staff survey.
➢ Inspirational leadership	➢ Some good progress.	
➢ Creating fellowship	➢ Good progression	
➢ Talent & Succession management	➢ Not consistent, T&S management being done at exec level.	➢ OD activity update.
➢ Customer experience	➢ Some good progress, but could do more in relation to SU involvement and the wider Customer Experience between functions.	➢ Surveys, CQC
➢ Collaborative working		➢ General observation.

Leadership	Progress review	Source of feedback
➢ Workload management ➢ ➢ Matrix working ➢ Maximise involvement and opportunity from the national leadership programmes, alliance and STP ➢ Delivering the outputs of collective leadership work	➢ Limited success, although CQC did observe some areas of good practice. ➢ Limited success, staff are still stating via they staff survey workloads are unmanageable. ➢ Slow progress, not the chosen method of working, still silo via SBUS. ➢ Good progress, strong recognition in the field also acknowledged by CQC. HPFT Facilitators are delivering Mary Seacole regional programme ➢ ➢ Limited success and some of the ambassadors have now left the organisation. CQC did observe some areas of good practice.	➢ Staff survey results. ➢ General observation. ➢ ➢ Feedback from staff, still not clear what it means on the ground.

Organisational Effectiveness and Design	Progress review	Sources of feedback
➢ Engagement of staff and stakeholders	➢ Some progress in SLT being engaged, in this agenda. 5 areas of focus out in the organisation, engagement strong progress limited.	➢ Feedback from leadership team, SLT.
➢ There is clarity around people's scope of decision-making, control and accountability. o Scheme of delegation	➢ Remains a continued source of concern, regular brought up at Good to Great road shows.	➢ Feedback from Good to Great Roadshows.
➢ Further develop service line management within Trust.	➢ No significant progress in this other than locality base movement.	➢ Observation.
➢ Earned autonomy clarity on what this means in new changing external regulation.	➢ No real clarity or freedoms developed.	➢ Observation.
➢ Effective two way communications channels are in place across services, linking board to floor. Streamline communications and initiatives	➢ Some progress, cascade team brief not up, interim website improved, still not effective board to ward communications.	➢ Staff survey feedback, Good to Great Roadshows.
➢ Organisational effectiveness – process are reviewed to ensure they are streamlined. Including the implementation of the "Carter Review".	➢ Some progress, part of the Carter review, Safecare has assisted in the development of this.	➢ Observations.
➢ Modernised and innovative corporate/support functions to support the frontline services.	➢ Work has commenced.	➢ Observations, ➢ Staff feedback Good to Great Roadshows, staff survey.
➢ Structured and developed approach to innovation and continuous improvement	➢ Slow progress, around a structured approach	➢ Staff feedback Good to Great Roadshows, staff survey.
➢ Accessible processes for innovation and infrastructure of support	➢ Limited progress.	

Organisational Effectiveness and Design	Progress review	Sources of feedback
➢ Staffing reviews for safety sustainability and productivity	➢ No progress.	