TRUST BOARD MEETING IN PUBLIC
AGENDA

05 October 2017 at 9.30am – 12.00noon

Terrace Executive Meeting Room, Spice of Life Restaurant, Watford Hospital

Apologies should be conveyed to the Trust Secretary, Jean Hickman on jean.hickman@whht.nhs.uk or call 01923 436 283

Item ref	Title	Objective	Previously presented	Lead	Paper or verbal
01/52	**Opening and welcome**	To note	N/A	Chair	Verbal
02/52	**Patient experience presentation**	To receive	N/A	Chief Nurse	Presentation
OPENING					
03/52	**Apologies for absence**	To note	N/A	Chair	Verbal
04/52	**Conflicts of interests**	To note	N/A	Chair	Paper
05/52	**Minutes of the meeting held on 07 September 2017**	For approval	N/A	Chair	Paper
06/52	**Board action log from 07 September 2017 and previous meetings and decision log**	To note	N/A	Chair	Paper
07/52	**Chair's report**	To note	N/A	Chair	Paper
08/52	**Chief Executive's report**	To note	N/A	Chief Executive	Paper
PERFORMANCE					
09/52	**Integrated performance report – month 5**	To note	Trust Executive Committee	Chief Operating Officer	Paper
SAFE EFFECTIVE CARE (BAF RISK 1)					
10/52	**Quality improvement plan update**	For information	Trust Executive Committee	Chief Nurse	Paper
11/52	**Annual report on complaints and PALs**	For information and noting	Safety and Compliance	Chief Nurse	Paper
DELIVER A LONG TERM STRATEGY (BAF RISK 9)					
12/52	**Strategy update – month 6**	To note	Trust Executive Committee	Deputy Chief Executive	Paper

COMMITTEE REPORTS					
13/52	**Assurance report from Finance and Investment Committee**	For information and assurance	Finance and Investment Committee	Committee Chair/ Chief Financial Officer	Paper
14/52	**Assurance report from Clinical Outcomes and Effectiveness Committee**	For information	Clinical Outcomes and Effectiveness	Chief Nurse	Paper
REPORTS TO CORPORATE TRUSTEES					
15/52	**Assurance report from Charitable Funds Committee**	For information and assurance	Charitable Funds Committee	Committee Chair/ Director of Communications	Paper
16/52	**Charity annual report and accounts**	For information and assurance	Charitable Funds Committee	Committee Chair/ Director of Communications	Paper
ANY OTHER BUSINESS					
17/52	**Any other business previously notified to the Chairman**	N/A	N/A	Chair	Verbal
QUESTION TIME					
18/52	**Questions from Hertfordshire Healthwatch**	To receive	N/A	Chair	Verbal
19/52	**Questions from our patients and members of the public**	To receive	N/A	Chair	Verbal
ADMINISTRATION					
20/52	**Draft agenda for next board meeting**	To approve	N/A	Chair	Paper
21/52	**Date of the next board meeting in public:** 02 November 2017, Terrace Executive Meeting Room, Watford Hospital	To note	N/A	Chair	Verbal

Background briefing for presentation on dementia awareness

Agenda item 02/52

SUMMARY REPORT: NATIONAL AUDIT OF DEMENTIA 2016-17: WATFORD RESULTS.

BACKGROUND:

This is the third round of the National Audit of Dementia (NAD), Watford has participated in every round previously reporting in 2011 and 2013. The NAD examines care of dementia in general hospitals and is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England as part of the National Clinical Audit programme.

METHODOLOGY:

NAD data was collected between April and November 2016 and was open to all hospital in England and Wales. 198 (98%) of eligible hospital took part. The NAD consisted of 4 elements:

I. Hospital level organisational checklist.
II. Retrospective case note audit (>19 required; WGH submitted 55 entries)
III. Carer survey of experience (>10 required; WGH submitted 61 completed questionnaires)
IV. Staff questionnaire (> 20 required; WGH submitted 100 staff questionnaires).

The NAD audit standards have been derived from national and clinical guidance including NICE, Royal Colleges, Alzheimer's society and Dementia Friendly Hospital Charter.

Each of the 4 components above is used to generate information and scoring related to 7 themes:

1. ***Assessment***- clinical comprehensive assessment based on case note audit.
2. **Information and communication**- all components used to triangulate evidence of communication systems in hospital.
3. **Staffing and training**- staffing numbers and training and delivery as described through the 4 domains
4. **Nutrition**: organisational and staff feedback reviews services meet needs of dementia patients.
5. **Discharge and hospital transfer**: organisational and checklist data used to score planning of discharge from hospital and whether family kept adequately informed.
6. **Governance**: involvement of hospital leads and the Executive board in monitoring dementia care provision.
7. **Carer** rating of patient care- carer survey results

Additional comments on methodology:

Caution advised on direct comparison of round 2 and 3 as differences in way questions asked and sample size may vary. Quality assurance visits to 5 hospitals did identify differences in data collection- but no adjustments were made. Inter rater reliability analysis was carried out and areas of variance highlighted in report.

SUMMARY RESULTS: WGH AS COMPARED TO NATIONAL AVERAGE:

SCORING:	WATFORD HOSPITAL %	WGH RANK (OUT OF TOTAL)	NATIONAL AVERAGE %
ASSESSMENT	96.1%	4th /195	83.7%
STAFF RATING OF INFORMATION AND COMMUNICATION	72.1%	16TH/ 182	64.8%
NUTRITION	100%	1st/199	83.8%
DISCHARGE	68.9%	129TH/ 195	72.7%
GOVERNANCE	71.9%	73/199	65.1%
CARER RATING COMMUNICATION	66.9%	62/148	64%
CARER RATING PATIENT CARE	74.2%	62/148	72%

KEY FINDINGS FROM NATIONAL REPORT AND WGH:

The report identifies key findings and makes the following national recommendations a local action plan has been drafted for discussion with the Dementia Implementation Group:

1) **Delirium recording requires improvement**.
    - Assessment of delirium had poor interrater reliability. WGH notes recorded screening 84% (vs 45% nationally). 100% clinical assessment but only 29% discharge summaries included symptoms of delirium.
2) **Personal information about care needs must be accessible**
    - Hospitals were asked to find the personal information document about eg food and drink preferences, factors that cause and alleviate distress and communication aids eg This Is Me do within the set of case notes. WGH 70% of notes had a document recording these preferencese(vs 49% nationally).
    - Carers were asked how well informed the staff were about needs of person with dementia (sample size 60). 93% responded 'yes definitely/ to some extent' that staff were well informed as compared 90% national average.
    - 98% staff (as compared 93% nationally) said they have accessible information relating to the person with dementia's preferences.
3) **Nutritional needs must be met**
    - Catering services should be able to offer finger foods and snacks to people who may not eat at regular times. This is already in place at WGH we scored 100% on this domains required responses.
4) **Supporting staff to manage needs of patients with dementia.**
    - Staff said they needed support out of hours with regard specialist advice. Staff questionnaire asked support available and training provided. Our staff reported: 60% 'much better prepared' (vs national average 42%) after the training received and 34% somewhat better prepared after training (overall 94% positively rated training)
    - 92% staff felt supported by specialist dementia services (vs 88% nationally) in hours but only 56% felt supported out of hours (nationally 51%).
    - Key recommendation is that a dementia champion is available 24 hours a day eg through training of site practitioner.

5) **Involve patient in decision making**
    - Poor recording of consent identified eg where a change in residence after discharge was planned from hospital. WGH returns were 0% - this relates however to adult care services recording of consent capacity and best interests decisions in their records and not ours.

Carer feedback:

WGH carer feedback revealed 90% of carers rated the care their relative got as good, very good or excellent (as compared with 85% nationally. Further 5% rated care as 'fair' and only 5% rated care as poor.

Carer comments included various themes eg: staffing levels , discharge, environment , patient care- all of these were in line with national average feedback. However there was an increase number of negative comments related to perception of staff 11% negative comments vs only 6% nationally, this needs to be explored further.

National Audit Dementia action plan: WGH.

DOMAIN	ISSUES	ACTIONS	BY WHOM	BY WHEN
Delirium	• Cognitive assessment on admission and prior to discharge • Results recorded on discharge summary	○ New cognitive care bundle in development ○ New admission summary- needs to include this domain	TA/ WB discuss with Anna wood	November
Personal information	70% of casenotes had This Is Me	○ Continue to audit TIM and provide ward feedback ○ New bundle to include 'reasonable adjustments' to use preferences to enhance care	TA/ WB/ DIG	October
Staff support	• 56% only felt supported out of hours	○ RAID to become 24 / 7 already planned ○ Training of site practitioners to become dementia champions – this is to be incorporated into planned restructuring of site manager role	DFo	sept
Negative perception of carers about staff	• 11% of carers had negative comments about our staff (not our care)	○ For further discussion at DIG and TEC- ? further 'customer care' communication training required		
Assessment	✓ Mobility, nutrition, weight, pressure ulcer, continence, function all significantly improved from last NAD • Standardised mental test score 61% • Delirium screening 84%	○ Maintain improved recording of these domains ○ As above re: delirium need to improve cognitive assessment and recording on admission and discharge. ○ Ongoing regular audits by junior doctors presented back to increase compliance		
Information and communication	✓ Systems in place to identify pts with dementia on ward and in other areas (forget me nots and blue clasps) • Carer kept informed and involved as much as wished (better than national average but still 1/8 negative feedback)	○ Improved communication and discharge planning are key themes and require separate strategy- whole hospital		
Staff training	✓ Staffing support on ward increases if dependency needs change: 91% said yes vs 81% nationally ✓ 94% of staff who received training positively reported it • Dementia care training- 25% staff reported no training received	○ Review our training strategy with feedback from attendees and also review uptake of elearning module after its formal launch		
Nutrition	✓ Protected mealtimes ✓ Carers can visit anytime	○ Maintain good practice		

	✓ Finger food available ✓ Other food eg cereal, bread, soup, yoghurt available 24/7 ✓ Snacks eg biscuits and cake available			
Discharge	• Cognitive assessment at time of discharge 2.9% vs national average 22% • Only 28% had symptoms of delirium summarised for discharge • Consent / best interests recorded by SW in their notes • Poor evidence that person planning discharge had discussed this with patient (only 32% vs 54% national average) or carer (67% vs 81% nationally): NB carer survey is NOT unhappy about discharge suggests that this is about recording actions • Care support needs are not summarised as a discharge plan 44% vs 60% nationally • No evidence of discharge planning initiated within 24 hours 0% vs 47% nationally • Recorded carer notice period for discharge 29% <24 hours (19% nationally) 35% 24-48 hours 24% not recorded	○ This will need to be communicated using the results of this audit across medicine. ○ Discharge planning is the single biggest area for improvement across the organisation and is recognised as such not just from this audit but complaints, incident and patient feedback. ○ Discharge taskforce set up to improve discharge planning- these results to be shared with this group		
governance	✓ Physical environment reviewed ✓ Dementia champions at ward and director level ✓ Access to IMC • Night bed moves not reported to the Board • Readmissions with dementia patients identified reviewed by Board (31% nationally) • DTOC identifies patients with dementia and reported to Board (31% nationally) • Dementia care pathway with stroke and NOF and delirium links- in development	○ Need to obtain data for Board review of night moves; readmissions and DTOC	TA to discuss with Seena Shah	

Declaration of Board members and attendees conflicts of interest
05 October 2017

Agenda item: 04/52

Name	Role	Description of interest	Relevant dates	
			From	To
Professor Steve Barnett	Trust Chair	• Chair and Client Partner of SSG Health Ltd • Non-Executive Chairman of Finegreen Associates • Trustee and Director of the Institute of Employment Studies • Wife is CEO of Rotherham NHS Foundation Trust • Visiting Professor University of West London Business School • Honorary Visiting Professor Cranfield University School of Management • Member of the East Midlands Regional Committee for Clinical Excellence Awards		Present Present Present Present Present Present Present
Tammy Angel	Divisional Director for Unscheduled Care	• None		
John Brougham	Non-Executive Director	• Non-Executive Director and Chair of the Audit Committee of Technetix Ltd	2010	Present

Helen Brown	Deputy Chief Executive	• None		
Professor Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	• None		
Paul Cartwright	Non-Executive Director	• Treasurer for St Peter's Church • Trustee and Chair of Finance and Audit Committee for The Church Lands, St Albans. • Charitable Funds for West Hertfordshire Hospitals NHS Trust	Nov 2015 Nov 2015 Nov 2015	Present Present Present
Virginia Edwards	Non-Executive Director	• Trustee Peace Hospice Care • Global Action Plan; providing support to their programme called Operation TLC • Director Edwards Consulting Ltd • Husband is CEO of Nuffield Trust • Husband is a non-remunerated member of the Strategy Committee of Guys and St. Thomas's Charitable Trust • Husband is Director of Edwards Consulting Ltd • Charitable Funds for West Hertfordshire Hospitals NHS Trust	2011 2016 2011 2011 2011 2011 2014	Present Present Present Present Present Present Present
Katie Fisher	Chief Executive	• None		
Jeremy Livingstone	Divisional Director of Surgery , Anaesthetics and Cancer	• Jeremy Livingstone Ltd		Present

Arla Ogilvie	Divisional Director for Medicine	• Private practice		Present
Jonathan Rennison	Non-Executive Director	• Kings College London • Rising Tides Ltd • The Yellow Chair Ltd • Edgecumbe Consulting • Association of NHS Charities • The Teatpot Trust • Swindon Museum and Art Gallery Trust • BNET (Britain-Nigeria Education Trust) • Centre for Sustainable Working Life, Birkbeck College • Evidence Aid	March 2017 May 2017 August 2012 April 2015 Sept 2015 June 2016 Dec 2016 Oct 2016 April 2017 January 2017	Present Present Present Present Present Present Present Present Present Present
Don Richards	Chief Financial Officer	• Director of 7M Ltd		April 2017
Phil Townsend	Non-Executive Director	• None		
Sally Tucker	Chief Operating Officer	• None		
Dr Mike van der Watt	Medical Director	• Owner and Director Heart Consultants Ltd • Private Practice • Wife is Director of Hearts Consultants Ltd		Present

Minutes of Trust Board meeting
held on 07 September 2017
at 9.30am - 12.00noon

Postgraduate Centre, St Albans Hospital

Agenda item: 05/52

Chair	Title	Attendance
Professor Steve Barnett	Chair	Yes
Members		
John Brougham	Non-Executive Director	Yes
Helen Brown	Deputy Chief Executive	Yes
Professor Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	Yes
Paul Cartwright	Non-Executive Director	Yes
Ginny Edwards	Non-Executive Director	No
Katie Fisher	Chief Executive	Yes
Jonathan Rennison	Non-Executive Director	Yes
Don Richards	Chief Financial Officer	Yes
Phil Townsend	Non-Executive Director	Yes
Dr Mike van der Watt	Medical Director	Yes
In attendance		
Dr Tammy Angel	Divisional Director, Unscheduled Care	No
Paul da Gama	Director of Human Resources	Yes
Lisa Emery	Chief Information Officer	Yes
Jean Hickman	Trust Secretary	No
Mr Jeremy Livingstone	Divisional Director, Surgery, Anaesthetics and Cancer	
Dr Arla Ogilvie	Divisional Director, Medicine	No
Sally Tucker	Chief Operating Officer	Yes
Leigh Franklin	Assistant Trust Secretary (notes)	Yes

MEETING NOTES

Agenda item	Discussion	Lead	Dead-line
01/51	**Opening and welcome**		
01.01	The chairman opened the meeting and welcomed the board and members of the public.		
02/51	**Patient experience presentation**		
02.01	The Board received a presentation from a member of the public on her experience encountered at Watford Hospital and her subsequent complaint.		
02.02	The Chair thanked the member of the public for their frank and in-depth presentation of their experience and apologised for the difficulties experienced and any distress the Trust may have caused.		
02.03	The Medical Director advised that learning since the incident has ensured that there are now systems in place to ensure that a screen for suspected sepsis takes place within 15 minutes of arrival in A&E.		
02.04	The Chief Nurse also wanted to assure the member of the public and the Board that learning from this incident has helped to change the complaints procedures, including sign-off of letters by the Chief Executive.		
OPENING			
03/51	**Apologies for absence**		
03.01	Apologies were received from the divisional director for unscheduled care, Ginny Edwards, non-executive director and the divisional director for medicine.		
04/51	**Conflicts of interests**		
04.01	There were no changes to the register of interests which had been circulated prior to the meeting.		
05/51	**Minutes of the meeting held on 06 July 2017**		
05.01	Item 09.05 should read JB noted that the indicator summary in the IPR did not demonstrate how close the trust was to achieving its *bank staff* spend target.		
05.02	The minutes were recorded as a true record with the above amendment.		
06/51	**Board action log from 06 July 2017 and previous meetings and decision log**		
06.01	All actions were either completed or confirmed to be on track.		
07/51	**Chair's report**		
07.01	The chair presented his report to the Board and highlighted a number of key areas.		
07.02	Parliament had published a number of bills relating to arrangements for Brexit, including the Immigration Bill. The figures obtained by the Health Foundation show a sharp decline in the number of nurses from the EU registering to practice in the UK since July 2016, the Immigration Bill will allow the UK to end EU rules on free movement. The Director of HR advised that he and the Chief Nurse had met with the EU nurses currently working in the Trust to update them and provide assurances regarding employment.		
07.03	Professor Ted Baker had been appointed the new Chief Inspector of Hospitals. Professor Baker was previously the Deputy Chief Inspector of Hospitals and took over from Dr Mike Richards when he retired at the end of July 2017.		

Agenda item	Discussion	Lead	Dead-line
07.04	NHSI had recently provided an update to all Freedom to Speak Up guardians on how it is continuing to work with organisations to create an open and honest reporting culture in the NHS. NHSI is developing a whistleblowers support scheme for providers and has appointed Wendy Webster to the post of Employment Support Manager, responsible for the development and implementation of the scheme.		
07.05	The Trust welcomed the Care Quality Commission (CQC) for a planned re-inspection of its hospitals on 30 August to 01 September 2017. The Chair thanked all of the staff across the whole organisation for their huge efforts in getting ready for the inspection.		
07.06	Resolution: The board noted the report.		
08/51	**Chief Executive's report**		
08.01	The board received a report from the chief executive.		
08.02	A series of 'Getting it right first time' visits are taking place this year. Following a recent GIRFT trauma and orthopaedic review visit the trust has implemented the following:- • Ring fenced beds on Beckett ward, St Albans for orthopaedic surgery patients • Created a 13 bed elective orthopaedic unit on Flaunden Ward at Watford, to be completed mid September. • Suspended or moved to other providers, operations on joints that require metal work insertion, until the new unit on Flaunden is open.		
08.03	The CQC completed their on-site inspection; it is however likely they will return to do some unannounced inspections over the next 10 days. The Trust will receive a draft report in mid November and will have 10 days in which to respond. The final report will be published on the 15 December 2017.		
08.04	As of the 01 October 2017, the Trust will be smoke free in order to offer a more pleasant environment to patients, staff, volunteers and visitors. Steps will be taken to encourage no smoking on site, including the removal of smoking shelters, improving signage and raising staff awareness.		
08.05	John Brougham, Non-executive director asked what action was being taken to improve the unacceptable delays in non – emergency transport. The Chief Operating officer advised that the Trust has been working closely with the Commissioner; Hertfordshire Valleys Clinical Commissioning group holding regular meetings and receiving daily escalations and update. It has today been agreed that there will be a further 5 vehicles available and recruitment of 12 extra staff to facilitate. There will be a further update by the Chief Operating Officer at the next board meeting in October.	ST	10/17
08.06	Resolution: The board noted the report.		
PERFORMANCE			
09/51	**Integrated performance report- month 4**		
09.01	The chief operating officer presented an integrated performance report and highlighted areas of good performance and areas which required improvement. She assured the board that all areas of performance are monitored by assurance committees and the trust executive committee.		

Agenda item	Discussion	Lead	Dead-line
09.02	Paul Cartwright, Non-executive director queried the Delayed Transfers of care rise from 5.1% to 6.7% in July. The chief operating officer advised that the Trust continues to monitor DTOC performance on a weekly basis with a once a month full disclosure deep dive and analysis. Closure of beds in the community has further added to the problems.		
09.03	Referral to Treatment times (RTT) figures were discussed. The RTT incomplete indicator was below national average. The divisional director for surgery reported that there have been some ongoing issues with theatre ventilation, although over schedule for completion these should be resolved shortly.		
09.04	The chief operating officer updated the board on the four hour wait A&E position. Performance has not been sustained and remains challenging to meet the national target. Further work is being undertaken to ensure the national target of 90% is met by the end of September.		
09.05	Staff turnover and the loss of band 5 nurses have been ongoing issues. The Director of Human resources reported that a working group specifically looking at retention of the band 5 nursing staff has been set up; they are looking at job role enrichment, training and environment. The Chief Nurse advised that the Trust is working with local partnerships on rotation of nurses to ensure we are offering the right level development opportunities.		
09.06	Don Richards, Chief Finance officer updated the board on the current control total of £15.0m deficit. Deficit year to date at July is £15.4m, £1.6m adverse to the plan. There were a number of reasons for this deviation; historical challenge with the Clinical commissioning group, new rules on CQUIN payments and Sustainability and transformation fund adjustments. The financial risks remain high but underlying controls are strong with recovery action identified and actions monitored through the Finance and Investment committee.		
09.07	Resolution: The board noted the report.		
10/51	**NHS England's emergency preparedness, resilience and response annual assurance**		
10.01	The chief operating officer presented a report on the outcome of a self assessment process regarding the trust's emergency preparedness, resilience and response arrangements. She assured the board that the assessment had demonstrated that the trust had maintained a fully compliant status pending a 'confirm and challenge session' by the local health resilience partnership. The committee was advised that the safety and compliance committee had reviewed the self-assessment and had been fully assured.		
10.02	Resolution: The board approved the report.		
SAFE EFFECTIVE CARE (BAF RISK 1)			
11/51	**Quality improvement plan - month 3 & 4**		
11.01	The board received a report on the delivery of the quality improvement plan for June and July 2017. It was noted that the overall status of the plan at the end of July was green and the board was assured that the forecast for August remained green. One project on patient flow had been completed and closed in July 2017, and of the 15 active plans 13 were rated as green and 2 IT related projects were reported as red due to the impact of cyber threats, resource conflicts and issues with supplier performance. Open actions had reduced from 58 in the		

Agenda item	Discussion	Lead	Dead-line
	previous reporting period to 43. The board was assured that progress against the plan was monitored regularly by the trust executive committee, and in particular all red rated milestones were reviewed as part of a deep dive process.		
11.02	Resolution: The board noted the report.		
12/51	**End of life care annual report 2016/17**		
12.01	The chief nurse presented an annual report on the activity regarding end of life (EoLC) care during 2016/17 and setting out the priorities for 2017/18. It was noted that a care quality commission inspection in September 2016 had rated the EoLC service as 'good'. She advised that the clinical outcomes and effectiveness committee had reviewed and been assured by the report.		
12.02	Resolution: The board noted the report.		
13/51	**Infection prevention and control annual report 2016/17**		
13.01	The board received an annual report which summarised the work undertaken on the management of infection prevention and control in 2016/17. The chief nurse provided an overview of performance and highlighted that there had been a sustained reduction in Clostridium difficile infections which had led to the trust meeting its performance target and one case of MRSA bacteraemia had resulted in breaching the target. It was noted that a high outlier notice had been received from Public Health England during the reporting period as surgical site infection rate was above the 90th percentile for total knee and hip replacements. The board was assured that the trust's performance in this area benchmarked better when compared to other trusts.		
13.02	Resolution: The board noted performance and approved the report for publication on the Trust's website.		
14/51	**Biannual establishment review – adult inpatient wards**		
14.01	The chief nurse presented the outcome of an establishment review of adult inpatient wards completed in February 2017. She advised that the safety and compliance committee had monitored the results of the review and had been assured that the process had demonstrated that inpatient wards are appropriately established for the activity, dependency and occupancy. It was noted that a further review would be undertaken in September 2017.		
14.02	Phil Townsend asked what other methodology was used in the review. The chief nurse advised that the safer nursing health tool was used; going forward the Trust could also use the Model Hospital data to underpin results.		
14.03	Resolution: The board noted the report for information and assurance.		
15/51	**Safeguarding annual report 2016/17**		
15.01	The board reviewed a report which gave a detailed account of safeguarding activity during 2016/17. It was noted that the safety and compliance committee had reviewed the report and been assured that the trust was appropriately protecting children, young people and vulnerable adults. The board was informed that an audit undertaken by herts valleys clinical commissioning group had highlighted good practice.		
15.02	In the past year there has been one safeguarding adult review and one domestic homicide review involving the Trust and no serious incidents or involvement in serious cases reviews for safeguarding children.		
15.03	The training rates continue to meet the Trust's target and in August adult		

Agenda item	Discussion	Lead	Dead-line
	level 2 was at 96% and children level 3-97%, children level 2-95%.		
15.04	All relevant policies are in date and updated in regard to national learning from safeguarding cases or recommendations.		
15.05	The chief nurse advised the Board that the Quality improvement plan in the Trust had focused on mental capacity assessments with improvements in both the training rates and understanding in the Trust. The audit strategy consisted of regular dip dives on practice and to demonstrate that practice and processes of safeguarding are in place.		
15.06	Phil Townsend asked for assurance that FGM cased are being reported. The chief nurse advised that these are reported mostly through the women's service and some from outpatients, although further work is required in other areas. The establishment of the FGM clinic now forms part of the maternity monthly mandatory training.		
15.07	Resolution: The board noted the report for information and assurance.		
RETAIN AND ENGAGE WORFORCE (BAF RISK 2)			
16/51	**Report on medical revalidation 2016/17**		
16.01	The medical director presented a report on the outcome of an annual audit into medical revalidation performance in 2016/17. He advised that the trust was required to conduct and submit the results of an annual organisation audit to NHS England as part of the framework for quality assurance for responsible officers and revalidation. The medical director advised that overall compliance at 31 March 2017 was 96.6% and 100% of the framework standards had been evidenced. He advised that the patient and staff experience committee had reviewed the results of the audit and had been assured that it had demonstrated an effective embedded appraisal and revalidation system was in place.		
16.02	Resolution: The board noted the report for information and assurance and		
17/51	**Annual public sector equality duty report 2016/17**		
17.01	The director of workforce outlined the key findings of a public sector equality duty report 2016/17, along with priority areas for 2017/18. He advised that the report was required to be published in order to comply with the Equality Act 2010. The board was advised that the patient and staff experience committee had reviewed the findings of the report and was assured that in 2016/17 the trust had complied with its equality and diversity legal duties and regulatory expectations and plans were in place to further strengthen the approach in 2017/18.		
17.02	The director of human resources reported that 41 staff declaring a disability seemed very low. In the 2016 national staff survey, 239 of staff declared a disability.		
17.03	The aim is to ensure equality and diversity is integral to all decision making and as representative as possible of the communities the Trust serves. Together with the Workforce Equality Forum and Let Me See/Hear You Panel, a number of key priority areas for 2017/19 have been identified to maximize impact and achieve the priority outcomes.		
17.04	Resolution: The board noted the assurance report.		
DELIVER A LONG TERM STRATEGY (BAF RISK 9)			
18/51	**Strategy update – month 5**		
18.01	The deputy chief executive presented a progress update on strategic		

Agenda item	Discussion	Lead	Dead-line
	developments, including integrated care and pathway re-design and stroke, vascular and pathology services. She also advised that formal review by NHS Improvement (NHSI) of the strategic outline case (SOC) for the redevelopment of acute hospital services had commenced and the trust had submitted the SOC to NHS England (NHSE) for review via the sustainability and transformation capital process. The report also included an update on the development of SOCs for the redevelop of Hemel Hempstead hospital and car parking. The board was advised that a business case for theatres had been submitted to NHSI for formal review to establish whether the case would require approval via NHSI's resource committee.		
18.02	The deputy chief executive also updated on partnership working with the royal free hospital trust. She informed the board that a work programme was being developed and advised that this would be discussed in the private session of the board.		
18.03	Resolution: The board noted the progress update.		
19/51	**Bi-monthly corporate risk register update**		
19.01	The board received a summary report on the status of the corporate risk register and corporate risk profile. The board was advised that the safety and compliance committee had reviewed the overall risk register and had been assured that risks were being appropriately identified and managed. It was reported that as at 24 August 2017 the register recorded 24 risks with a score of 15 or above and between April and August 2017 there had been an overall decrease of risks on the register. The board was assured that work continued to improve the quality of information on the register and the e-learning induction training system had been reviewed and improved.		
19.02	The board noted the number of IT high category risks, the chief information officer reported that splitting out the ICT risks enabled a better level of information on each specific area.		
19.03	Resolution: The board noted the report.		
COMMITTEE REPORTS			
20/51	**Assurance reports from the Finance and Investment Committee**		
20.01	The board received an assurance report from John Brougham on the work of the finance and investment committee. In the reports from meetings held on the 27 July and 31 August he updated the board on:- • Financial performance, I&E deficit, back office savings, capital expenditure and funding and revenue funding • ICT infrastructure programme update • Corporate risk register • Review of policies • Internal audit reports • BAF action tracker		
20.02	Resolution: The board noted the report.		
21/51	**Assurance report from the Audit Committee**		
21.01	Paul Cartwright presented a report on the work of the audit committee. He advised that an anti-bribery policy is to be approved by the Chair outside of the meeting schedule and that the Audit annual self assessment check list had been completed.		
21.02	He also presented an annual report for 2016/17, which concluded that the committee had taken appropriate steps to perform its duties and		

Agenda item	Discussion	Lead	Dead-line
	raised no issues of concern.		
21.03	Resolution: The board noted the report.		
22/51	**Assurance report from the Clinical Outcomes and Effectiveness Committee**		
22.01	Jonathan Rennison presented a report on the work of the clinical outcomes and effectiveness committee. He advised that the Committee had reviewed an annual report relating to end of life care. The Committee was encouraged to note that there had been a significant amount of clearly targeted work in this area to improve performance. The report highlighted key achievements which were resulting in increased referrals of patients to this service, including increased referrals of non-cancer patients. Additionally, the report highlighted that there had been a significant improvement in the numbers of patients being supported, where appropriate, with an advanced care plan, identifying patient's preferred place of death, and provision of appropriate support.		
22.02	The Committee reviewed and interrogated an annual report on infection prevention and control and was assured that appropriate measures were in place across the Trust and where there were risks, that these were clearly identified, recorded on the risk register and were proactively managed.		
22.03	Resolution: The board noted the report.		
23/51	**Assurance report from the Safety and Compliance Committee**		
23.01	The board received a report on the work of the safety and compliance committee from Phil Townsend. He advised that members had received and approved the EPRR self-assessment for submission to NHS England.		
23.02	The Risk register is a live document. Two items were flagged to the committee's attention. Both have mitigation underway by the respective exec leads (Medical Director & Estates Director). The first is in Orthopaedics (concerning changes to ward access) and the second concerns an audit on medical devices to assure their status. Both will be presented to the Risk Group		
23.03	Resolution: The board noted the report		
24/51	**Assurance report from the Patient and Staff Experience Committee**		
24.01	In the absence of Ginny Edwards, the director of human resources presented a report on the work of the patient and staff experience committee. He advised that the Committee recommended the 2016-17 Medical Revalidation Annual Organisational Audit to the board for its approval.		
24.02	Resolution: The board noted the report		
ANY OTHER BUSINESS			
25/51	**Any other business previously notified to the chairman**		
25.01	No further business was reported.		
26/51	**Questions from Hertfordshire Healthwatch**		
26.01	The Healthwatch representative advised the Trust that the Patient Led Assessment of the Care Environment (PLACE) Annual report by NHSE had highlighted that West Herts Trust had results below average in a number of areas. It was agreed that a meeting would be arranged for the Vice Chair of Healthwatch to discuss the results further with the Trust.		

Agenda item	Discussion	Lead	Dead-line
	The Healthwatch representative also highlighted the results of the Access Audit produced this year, there are a number of areas within that report that need to be addressed at West Herts. It was agreed that the Deputy chief executive would arrange a meeting with the vice-chair of Healthwatch to discuss these issues further.		
27/51	**Questions from patients and members of the public**		
27.01	Q1. Why is the proportion of emergency admissions to A&E attendances above 40% whilst other nearby Trusts report figures below 25%? A1. Our ambulatory activity is recorded as an emergency admission, and therefore this will result in a higher admission rate compared to trusts without the same level of ambulatory care. The national average for proportion of admissions to ED attendances is 27%. If you remove ambulatory care, frailty and gynae ambulatory care from the WHHT figures, the Trust sits at the national average of 27%.		
27.02	Q2. What is the proportion of new outpatient appointments compared to follow-up appointments? Is the trust satisfied with this proportion, in view of the 10% reduction in average income per appointment since a year ago? A2. The Chief finance officer reported that overall the Trust had seen an improvement generally in this year; he was not unduly concerned and will continue to monitor.		
27.03	Q3. Why has the number of elective admissions increased when income from those admissions decreased compared to the same period last year? Will this trend continue? A3. The Trust over time increases the proportion of its elective work as a day case and day cases attract a lower tariff than longer stay admissions.		
ADMINISTRATION			
28/51	**Draft agenda for next board meeting**		
28.01	The draft agenda was approved.		
29/51	**Date of the next board meeting**		
28.01	The next board meeting will be held from 9.30am on 05 October 2017 in the terrace executive meeting room at Watford hospital.		

Agenda item 06a/52

Action log Part 1 – 05 October 2017
(from meeting held on 07 September 2017 and earlier Boards if outstanding)

Ref No.	Action from agenda item	Action	Lead for completing the action	Date to be completed	Update
1	09.04/49	Consider mapping indicators in the integrated performance report to a specific committee to allow a clear focus on key areas of work.	Chief Information Officer	10/2017	Work is underway to consider this action and will be completed in October 2017. Action deferred to October 2017
2	08.05/51	The Chief Operating Officer to give a further update on the unacceptable delays in non-emergency transport at the October board meeting.	Chief Operating Officer	10/2017	
3	11.02/48	Follow up report when the guidance on learning from deaths has been confirmed. Version 1 of the Trust's policy to be agreed and ratified week commencing 28/08/17. The Board will receive a quarterly report from December 2017 of a variety of metrics, including numbers of deaths.	Medical Director	12/2017	

BOARD AND CORPORATE TRUSTEE
DECISION LOG PART 1

Board meeting/decision date	Decision reference (from minutes)	Item presented to Board for action	Comments/outcome
07/04/2016	16/36	The Board received corporate aims and objectives for 2016/17	Approved, subject to inclusion of comments from Board
07/04/2016	17/36	The Board received a refreshed Board Assurance Framework for 2016/17	Approved
05/05/2016	17/37	The Board received the updated terms of reference and work plans for 2016/17 for the Audit, Remuneration, Workforce, Finance and Performance, Charitable Funds and Integrated Risk and Governance Committees	Approved
07/07/2016	.09/39	The quality account 2015/16	Approved
07/07/2016	16/39	Funding for external advisory support to develop a strategy outline case (SOC) for the configuration of acute hospital service	Approved
07/07/2016	17/39	Infection prevention and control annual report 2015/16	Approved for publication
07/07/2016	18/39	The end of life care strategy	Approved
07/07/2016	19/39	The Board received the updated terms of reference and work plans for the Safety and Quality Committee and the Trust Board	Approved
07/07/2016	21/39	Updated Board Assurance Framework	Approved
01/09/2016	21/40	Charitable Funds annual report and annual accounts 2015/16 , £12,000 of funds of funds to support a holistic service for patients and their carers	Approved
01/09/2016	23/40	Terms of reference for the Trust Executive Committee	Approved
07/10/2016	07/41	Recommendation to increase the number of scheduled Board meetings to eleven per annum.	Approved
07/10/2016	14/41	Recommended changes to the BAF 2016/17.	Approved
03/11/2016	12/42	Patient experience and carer strategy	Approved
03/11/2016	13/42	Statutory annual public sector equality duty report 2015	Approved
03/11/2016	18/42	The gifts, hospitality and sponsorship policy	Approved
03/11/2016	19/42a	Recommendation to reduce the frequency of Integrated Risk and Governance Committee meetings	Approved
03/11/2016	19/42c	Update to terms of reference for the Board	Approved
03/11/2016	19/42b	Draft Board and Committee meeting schedule 2017/18	Approved
01/12/2016	10/43	Nursing, midwifery and allied health professions strategy	Approved

12/01/2017	15.2/44	counter fraud policy	Approved
02/02/2017	02.13/45	Recommendation that the Watford site continue to be the location for emergency and specialised care and the St Albans site continue to be the location for planned care as recommeded in the SOC	Approved
02/02/2017	12.01/45	An interim revenue support loan of £2.3m to cover February 2017 revenue cash requirements	Approved
02/02/2017	12.01/45	The transfer of 0.29 hectares (0.72 of an acre), to Watford Borough Council in line with the Trust's obligations under the Health Campus agreement	Approved
06/03/2017	13.07/46	A graded approach to workforce metrics for future reporting.	Approved
06/03/2017	15.02/46	An interim loan of £4m to cover cash flow requirements in February and March 2017 Approved	Approved
06/03/2017	15.02/46	The conversion of an IRWCF loan of £26.8m to an ISLF loan.	Approved
06/03/2017	17.02/46	Recommendation to delegate responsibility to the Audit Committee to sign off the Annual Accounts, Annual Report and Annual Governance Statement.	Approved
06/03/2017	18.02/46	The 2017/18 Board and Committee structure and meeting schedule	Approved
06/04/2017	11.04/47	Hospital Pharmacy Transformation Plan	Approved as direction of travel for pharmacy service.
06/04/2017	14.02/47	Aims, objectives and principle risks.	Approved
06/04/2017	16.02/47	Interim capital support facility agreement £7.5m	Rattified
06/04/2017	16.02/47	Deficit control totals for 2017/18 of £15.4m	Approved
04/05/2017	15.02/48	An interim revenue support loan of £1.964k	Approved
04/05/2017	20a.03/48	West Herts charity strategy	Approved
04/05/2017	20b.02/48	Discretionary resources policy	Approved
01/06/2017	14.04/49	Outline business case for theatre reconfiguration	Approved option E
01/06/2017	15.03/49	Proposed monitoring arrangements for aims and objectives	Approved the approach
01/06/2017	17.01/49	NHS self-certification 2017/18	Approved condition G6 (3)
01/06/2017	18.02/49	Assurance report from Finance and Investment Committee	Ratified the terms and conditions of a £42m interim revenue support loan
06/07/2017	16.04/50	The terms of reference and work plans for the board and committees	Approved
06/07/2017	18.02/50	The board approved the annual accounts, annual report, governance statement and quality account 2016/17.	Approved
06/07/2017	22.05/50	The corporate trustee approved the recommended way forward to the future management of the charity	Approved
07/09/2017	10.02/51	The board aproved the NHS England emergency preparedness, resilience and response annual assurance.	Approved
07/09/2017	13.02/51	The board approved the infection prevention and control annual report 2016/17 for publication on the Trust website	Approved

Trust Board Meeting
05 October 2017

Title of the paper	**Chair's report**
Agenda item	**07/52**
Lead Executive	**Professor Steve Barnett, Chair**
Author	**Leigh Franklin, Assistant Trust Sectretary**
Executive summary **(including resource implications)**	The aim of this paper is to provide an update on items of national and local interest/relevance to the Board.
Where the report has been previously discussed, i.e. Committee/Group	N/A

Action required:

- The Board is asked to note the report for information.

Link to Board Assurance Framework (BAF)

[Please indicate which Principal Risk this paper relates to by double clicking on the corresponding box]

- ☐ **PR1** Failure to provide safe, effective, high quality care
- ☐ **PR2** Failure to recruit to full establishments, retain and engage workforce
- ☐ **PR3** Current estate and infrastructure compromises the ability to deliver safe, responsive and efficient patient care
- ☐ **PR4a** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – IM&T
- ☐ **PR4b** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – Information and information governance
- ☐ **PR5a** Inability to deliver and maintain performance standards for Emergency Care
- ☐ **PR5b** Inability to delivery and maintain performance standards for Planned Care(including RTT, diagnostics and cancer)
- ☐ **PR7a** Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency programmes
- ☐ **PR7b** Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure

	☐ **PR8** Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation. ☐ **PR9** Failure to deliver a long term strategy for the delivery of high quality, sustainable care ☐ **PR10** System pressures adversely impact on the delivery of the Trust's aims and objectives PR6 – business continuity has been closed (incorporated into PR1)
Trust objectives	*[Double click on the box to mark as appropriate]* ☐ To deliver the best quality care for our patients ☐ To be a great place to work and learn ☐ To improve our finances ☐ To develop a strategy for the future
Benefits to patients/staff from this project/initiatives	
Risks attached to this project/initiatives and how these will be managed	

Agenda Item: 07/52

Trust Board Meeting – 05 October 2017

Chair's report

Presented by: Professor Steve Barnett, Chair

1. Purpose

1.1. The aim of this paper is to provide an update on items of national and local interest/relevance to the Board.

2. NATIONAL NEWS AND DEVELOPMENTS

2.1 New NHS Providers programme: Supporting providers: STPs and accountable care

A major programme of work has been launched this week by NHS Providers to put support and a strong advocate in place for trusts moving to accountable care structures.

The programme of support has been created to help leaders of trusts, sustainability and transformation partnerships (STPs) and other integrated care systems adapt to the new challenges created by this new way of working.

Called 'Supporting Providers: 'STPs and accountable care', the programme will be developed with trusts over the next six weeks.

Ideas that are being developed include creating new and effective relationships with local authorities, primary care and commissioners as well as responding to specific challenges such as moving care closer to home and prioritising mental health and workforce strategies.

This is particularly important after a CIPFA survey last week found that joint working between organisations and local government was not being delivered in the vast majority of England's 44 STP areas.

The programme will also explore new ways to support change, identify "enablers" including new approaches to contracting, different financial flows, adopting risk stratification and whole-population health management approaches, and developing STP-level governance arrangements.

2.2 New quality of life measure for recovering cancer patients

NHS England are leading a move to improve the quality of life for cancer patients, to radically improve care and support for people once treatment ends.

The ground-breaking new approach is set to drive improvements in after care which includes personalised plans for people with cancer outlining not only their physical needs, but also other support they may need, such as help at home or financial advice.

The first five pilot areas where patients will benefit from this new approach were announced at Health and Care Innovation Expo 2017 in Manchester, the pilot will run between September 2017 and early 2019.

3. LOCAL NEWS AND UPDATE

Chairs Networking event: Wednesday 1 November

3.1 There will be a Chairs networking event in November for Chairs to discuss issues and challenges and to network. Dale Bywater, Midlands and East Executive Regional Managing Director, will provide a regional update followed by a Q&A session.

Watford Riverwell

3.2 The Board received a presentation on the Watford Riverwell, formerly Watford Health Campus, at its private meeting in September 2017.

Annual General Meeting

3.3 The Trust held its Annual General Meeting on 21 September 2017 in the Terrace Executive Meeting Room, Spice of Life Restaurant at Watford Hospital.

Members of the public and staff attended; this year's AGM was well attended, with a number of in depth questions. The annual report and annual review were published at the meeting.

Macmillan cancer support event

3.4 The Macmillan team is hosting an event, 'Living Well With and Beyond Cancer' on Tuesday 3 October from 11am to 2pm at the Holywell Community Centre, Tolpits Lane, Watford.

The event aims to provide an opportunity for people to talk about their experiences, find out more about available support services and meet our cancer nursing team.

CQC Inspection

3.5 It will be some months before we have formal feedback from the Care Quality Commission following their inspection. However, we do have a letter from the CQC outlining a number of key observations ahead of a more detailed report which we should receive later this year.

The message coming through loud and clear is that the inspectors feel strongly that we have made considerable further progress with our quality improvement plan. Improvements were observed across the board.

On balance, the initial feedback is very good. The areas where we need to sharpen up our practice can soon be sorted.

Celebrating our staff

Well done to the following staff and teams for their outstanding work since the last Board meeting:

- On 8 September two more of our colleagues were awarded their MSc in Leadership and Healthcare Management from the University of Hertfordshire, having studied through our Leadership Academy:-
  Florence Muzanechita, assistant divisional manager for elderly care and stroke services and Alison McGirr both succeeded in gaining this prestigious award – studying on top of extremely busy day jobs.

Alison, who was the divisional manager in women's and children's services has now left the trust and works at Moorfields Hospital.

- Well done to the estates team!
  The estates team carried out the soft transfer generator testing of the HV generators at Watford General and this went really well as there was no disruption to the service.

- Congratulations to Maternity!
  Maternity has been shortlisted for the workforce category in the HSJ awards. A huge congratulations to the team.

- Huge congratulations to recent winners of the staff member of the month: Rebecca Jeggo (May), Polly Anna Smith (June) and Antonio de Martino (July).

3 KEY MEETINGS

- Attended the Michael Green Charity Day
- Attended the Orthopaedics Hip and Knee Consultant appointment panel
- Chaired the Annual General Meeting
- Chaired a Board Business Workshop
- Met with Dorothy Thornhill, Mayor of Watford
- Presented staff awards at St Albans and Watford
- Presented volunteer awards
- Toured the Acute Admissions Unit at Watford Hospital with Wendy Wilson of the Patients' Panel

4 RECOMMENDATION

The Board is asked to note the report.

Professor Steve Barnett
Chair

September 2017

Trust Board Meeting

05 October 2017

Title of the paper	**Chief Executive's report**
Agenda item	**08/52**
Lead Executive	**Katie Fisher, Chief Executive Officer**
Author	**Leigh Franklin, Assistant Trust Secretary**
Executive summary **(including resource implications)**	The aim of this paper is to provide an update on items of national and local interest/relevance to the Board.
Where the report has been previously discussed, i.e. Committee/Group	N/A

Action required:

The Board is asked to note the report for information.

Risk to Board Assurance Framework (BAF)	*[Please indicate which Principal Risk this paper relates to by double clicking on the corresponding box]* ☐ **PR1** Failure to provide safe, effective, high quality care ☐ **PR2** Failure to recruit to full establishments, retain and engage workforce ☐ **PR3** Current estate and infrastructure compromises the ability to deliver safe, responsive and efficient patient care ☐ **PR4a** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – IM&T ☐ **PR4b** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – Information and information governance ☐ **PR5a** Inability to deliver and maintain performance standards for Emergency Care ☐ **PR5b** Inability to delivery and maintain performance standards for Planned Care(including RTT, diagnostics and cancer) ☐ **PR7a** Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency programmes ☐ **PR7b** Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure ☐ **PR8** Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation. ☐ **PR9** Failure to deliver a long term strategy for the delivery of high quality, sustainable care ☐ **PR10** System pressures adversely impact on the delivery of the Trust's aims and objectives PR6 – business continuity has been closed (incorporated into PR1)
Trust objectives	*[Double click on the box to mark as appropriate]* ☐ To deliver the best quality care for our patients ☐ To be a great place to work and learn ☐ To improve our finances ☐ To develop a strategy for the future
Benefits to patients/staff from this project/initiatives	
Risks attached to this project/initiatives and how these will be managed	

Agenda Item: 08/52

Trust Board Meeting – 05 October 2017

Chief Executive's report

Presented by: Katie Fisher, Chief Executive

1. PURPOSE

1.1. The aim of this paper is to provide an update on items of national and local interest/relevance to the Board.

2. LOCAL NEWS AND DEVELOPMENTS

Emergency Care Improvement

2.1. Absolute priority is currently being given by the Trust leadership team to driving improvements to our emergency care pathway and galvanising clinical support across the whole organisation. A new weekly clinical leads meeting has been convened to ensure that senior clinicians are fully engaged in developing and delivering solutions and supporting the emergency care department.

The Trust continues to work closely with system partners to address external factors, with a particular focus on ensuring that discharge pathways are effective and delayed transfers of care kept to a minimum.

Issues with non emergency patient transport

2.2. Over the past few months, there have been some unacceptable delays in the transportation of non emergency patients to and from hospitals in the Trust. This has resulted in a poor experience for patients and is being taken very seriously by the Trust. After continued discussions with Herts Valley Clinical Commissioning Group as the Commissioner of the service a number of improvements have been put in place, including the option to commission additional ad hoc capacity as required. The Trust continues to monitor the issue on a daily basis.

Smoke free Trust

2.2 The Trust will be going smoke free from the beginning of October, to coincide with the national 'Stoptober' campaign. The smoking shelter and stub bins are being removed the week beginning 02 October and new signage will be in place on all three sites from Sunday 1 October.

A key element in becoming a smoke free trust is providing support and advice to patients, visitors and staff who do smoke and want to quit. We're running a stop smoking clinic on Level 4, PMOK at Watford Hospital every Monday from 1.30 – 4.30pm. This is

open to all patients, visitors and staff. Hertfordshire Health Improvement Service offers professional specialist advice and support to smokers wishing to quit. They also provide weekly one-to-one support across the county for up to 12 weeks or telephone support if required or groups support at workplaces.

In patients who are smokers will be offered nicotine replacement therapies, and there will be a ward smoking folder which will contain lots of useful information for patients and staff who smoke or want to quit smoking.

Quality Strategy & Engagement Approach

2.3 The Trust Executive committee and Board were joined by representatives from Gate One at the Board Development Session earlier this month. Gate One are providing advisory support and facilitation in the development of the quality strategy. Extensive engagement is currently underway to get the views and input of our staff in the development of the long term vision and priorities for quality improvement.

Flu vaccination programme

2.4 The flu vaccination programme will be starting 02 October 2017 and will be available to everyone, information and details have been communicated regularly to staff.

The programme aims to immunise as many staff as possible within a six week period by offering flexible flu clinics and multiple drop-in immunisation sessions in clinical areas and open spaces including staff restaurants.

Model Hospital

2.5 TEC received a presentation from NHS Improvement on the Model Hospital digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities.

NHS trusts are able to explore their comparative productivity, quality and responsiveness, to provide a clearer view of improvement opportunities. Whilst some variation in trust activity is expected and warranted, the Model Hospital supports trusts to identify and tackle unwarranted variation. Access is currently provided to NHS provider trusts only.

The NHSI team presented an overview of the areas where the Trust has the potential to make savings based on the comparative data contained within the model hospital database.

The committee suggested that a presentation at a future Board development session should be arranged to show the level of data and analysis now available.

Staff Survey

2.6 The 2017 staff survey has now gone live. All staff with an active trust email address should receive an email with a link to the staff survey. Those that don't have an email account will be given paper copies. This year, to encourage participation there will be a prize draw with winners picked at random by Quality Health (who administer the survey).

3. COMMUNICATIONS REPORT

Our communications report aims to give the board an update on our progress during the month of August 2017 covering our regularly used key communication channels

including press and media, website and social media, internal communications and responses to Freedom of Information requests (FoI).

Media

We received coverage on a variety of topics during August. A number of letters were published in The Watford Observer and The Hemel Gazette and Express about the plans for the new hospital site. The local media also reported that members of the New Hospital Campaign group, along with Hemel Hempstead MP Mike Penning, attended a meeting with Jim Mackey, chief executive of NHS Improvement, to put forward their proposal for a brand new hospital to be built on a greenfield site.
Katie Fisher chief executive of West Hertfordshire Hospitals NHS Trust commented: "NHS Improvement and NHS England are the two national bodies who are looking at our proposals in detail. We expect a high level of scrutiny, which is understandable given the sum of money involved. The bottom line is that we are committed to providing patient care from the best buildings and facilities possible. The communities we serve have waited a long time for much-needed improvements to our estate. We are keen to move on with this work and so await an update on the approvals process with bated breath."

Other articles in the media during August included:

- BBC Three Counties Radio featured an interview with Rachael Coffey – a new mother who gave birth at Watford Hospital – talking about the iSeeU initiative (02.21 minutes into the radio broadcast). The initiative gives mothers who are separated from their baby for medical reasons the opportunity to watch a live video of their newborn, like Facetime but for mothers. Rachael talked about how the initiative benefited her as a mother who was unable to spend physical time with her baby during the first few hours of him being born.
- The Evening Standard reported that MasterChef winner Saliha Mahmood-Ahmed will cook dishes based on her Pakistani heritage at one of London's most popular Indian restaurants to mark 70 years of independence for India and Pakistan. She will team up with Sameer Taneja, the Indian-raised executive chef at Covent Garden's Talli Joe, to create a one-off feast of 10 dishes from across India and Pakistan to celebrate the strong cultural ties between the nations.
- The Hemel Gazette and Express printed a letter from a reader from Tring who praised and thanked West Herts Hospitals for the outstanding care their grandmother received in A&E and on the wards.

August 2017	Positive coverage	Neutral coverage	Negative coverage	Rebuttals/not run
National coverage	3	0	0	0
Coverage (Watford)	5	1	1	0
Coverage (Dacorum)	2	0	2	0
Coverage (St Albans)	0	1	0	0
Other local	2	2	1	0
Letters coverage	2	1	1	1

Website

	Month's Figures 17/18	Month's Figures 16/17	Total Quarter 1 (April –June)	Total Quarter 2 (July – Sept)	Total Quarter 3 (Oct – Dec)	Total Quarter 4 (Jan – Mar)	Running total 17/18	Total 16/17
	August	August						
Total Page Views	428,472	372,993	1,364,707				1,793,179	4,901,513
Number of unique visitors	39,402	35,290	106,195				145,597	370,658

Top five pages visited on internet site (apart from home page and vacancy pages):

1. Watford wards and departments
2. Travel information - parking
3. Pathology
4. Our services home
5. Contact the Trust

Internal Communications

	August 17/18	Total Quarter 1 (April - June)	Total Quarter 2 (July – Sept)	Total Quarter 3 (Oct – Dec)	Total Quarter 4 (Jan – Mar)	Running total 17/18
Number of news stories shared with staff on intranet	5	10	6			20
Number of e-newsletters (e-update)	9	15				33
Number of CEO briefings	7	12				25
Number of Herts & Minds newsletters	0	1				2

Freedom of Information

	August 17/18	Total Quarter 1 (April – June)	Total Quarter 2 (July – Sept)	Total Quarter 3 (Oct – Dec)	Total Quarter 4 (Jan – March)	Running total 17/18	Total 16/17
Number of FoIs received	66	153				370	662
Compliance within 20 day deadline	83%	95%				93%	94.3%
No of FoIs received from media outlets	9	24				40	100

Social Media

Twitter	Followers	Posts	Likes	Retweets
August 2017	41	177	119	41

We were more active on Twitter than we were on Facebook during the month of August. We posted 41 times and our engagement from our followers was good as our posts received 77 likes and 119 retweets.

Our most popular Tweet was *"We are the proud owners of new state of the art scanners. The scanners allow us to offer both CT coronary angiography and Cardiac MRI scans,"* with 24 likes and four retweets.

Facebook	Followers	Posts	Likes	Reach	Shares	Comments
August 2017	10	411	62	28,309	13	10

We posted 10 times on Facebook during the month of August.

Our most popular post was *"We are beyond proud of our stroke team which has maintained its AA rating for the third time in a year! Not only have they maintained the highest level but the service is in the top 16% across England, Wales & Northern Ireland in the Sentinel Stroke National Audit Programme. Well done to the team!"* as it received 133 likes, was shared 30 times and reached 5,709 people.

4. RECOMMENDATION

4.1. The Board is asked to note the report.

Katie Fisher
Chief Executive

September 2017

Trust Board Meeting
05 October 2017

Title of the paper	**Integrated Performance Report**
Agenda item	**09/52**
Lead Executive	**Sally Tucker, Chief Operating Officer**
Author	**Mark Currie, Associate Director Information and Performance**
Executive summary **(including resource implications)**	The Integrated Performance Report covers the September reporting period (August data). For this reporting period, the Board is asked to particularly note the following performance changes *since the last reporting period*: Safe, Effective, Caring: • There were no cases of MRSA bacteraemia (1 case recorded in July) • The maternity FFT indicator measuring the % of positive responses was better than the performance target (96.5% against the 95% target. Performance was 92.8% in July) • There were 12 mixed sex accommodation breaches (10 recorded in July) • Harm free care decreased to 88.4% (89.6% in July). Responsive: • Breast symptomatic performance increased to 97.4%*, ahead of the performance standard (88.3% recorded in July) • Cancer 62 GP performance is provisionally worse than the 85% standard (83.6%* compared to 87.7% recorded in July) • RTT (incomplete) performance dropped to 88.8% (90.0% recorded in July) • ED 4 hour performance dropped slightly to 82.5% (82.9% recorded in July) • Ambulance turnaround times between 30 and 60 increased (deteriorated) in August compared to July (466 vs 395), while turnaround times over 60 minutes deceased (improved) compared to July (169 vs 174) • Formal delayed transfers of care decreased to 3.7%, though remain above (worse than) the performance standard (6.7% recorded in July). Well Led: • Agency pay improved to 7.4%, below (better than) the 8.0% target (9.0% recorded in July) • Appraisal rates improved further, maintaining a compliant position of 91.2% (90.0% recorded in July) • Staff turnover (rolling 3 months) was above (worse than) target, increasing to 16.0% (13.7% recorded in July) • Vacancy rate was above (worse than) target, increasing to 12.7% (12.3% recorded in July). Further detail is provided in the executive summary and relevant exception reports, including performance trends. *please note data is provisional at the time of this report

Where the report has been previously discussed, i.e. Committee/Group	Trust Executive Committee (Performance)

Action required:

- The report is provided for information and discussion.

Link to Board Assurance Framework (BAF)

☒	**PR1**	Failure to provide safe, effective, high quality care
☒	**PR2**	Failure to recruit to full establishments, retain and engage workforce
☐	**PR3**	Current estate and infrastructure compromises the ability to deliver safe, responsive and efficient patient care
☐	**PR4a**	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – IM&T
☐	**PR4b**	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – Information and information governance
☒	**PR5a**	Inability to deliver and maintain performance standards for Emergency Care
☒	**PR5b**	Inability to delivery and maintain performance standards for Planned Care(including RTT, diagnostics and cancer)
☒	**PR7a**	Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency programmes
☒	**PR7b**	Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure
☒	**PR8**	Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation.
☐	**PR9**	Failure to deliver a long term strategy for the delivery of high quality, sustainable care
☒	**PR10**	System pressures adversely impact on the delivery of the Trust's aims and objectives

PR6 – business continuity has been closed (incorporated into PR1)

Trust objectives

☒ To deliver the best quality care for our patients

☒ To be a great place to work and learn

☒ To improve our finances

☐ To develop a strategy for the future

Benefits to patients/staff from this project/initiatives

The Integrated Performance Report provides a view of performance across all key metrics in the areas of Safe, Effective, Caring, Responsive and Well Led

Risks attached to this project/initiatives and how these will be managed

The Integrated Performance Report is reviewed monthly at the Trust Executive Committee prior to submission to the Board.
Individual performance indicators are also reviewed at divisional level at monthly Performance meetings, where associated risks and issues are discussed and documented, and relevant actions tracked.
Data quality is regularly reviewed both internally and by the Trust's auditors.

West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

September 2017

(August data)

West Hertfordshire Hospitals NHS Trust

Executive Summary

West Hertfordshire Hospitals NHS Trust

Safe Effective Caring

Reporting sub committees – COE and S&C

Areas of good performance

- Mortality indicators show sustained excellent performance *(pages 3 & 13)*
- No medication errors causing serious harm *(pages 4 & 18)*
- There were no never events *(pages 4 & 17)*
- Patients spending 90% of their time on the stroke unit was better than the performance standard *(pages 4 & 14)*
- The percentage of patients receiving a caesarean section was better than the performance threshold (pages 4 & 22)
- Clostridium difficile was better than the monthly threshold (zero cases recorded) and better than the year to date threshold (6 vs 14) *(pages 3 & 17)*

New to category this month:

- There were no cases of MRSA bacteraemia *(pages 3 & 17)*
- The maternity FFT % positive indicator was better than the performance standard *(pages 3 & 34)*

Achieving	
Aug-17	13
Jul-17	10
Jun-17	11

Better than national average	
Aug-17	11
Jul-17	11
Jun-17	12

Areas requiring performance improvement

- VTE risk assessment was below threshold *(pages 4 & 19)*
- Admissions to stroke ward within 4 hours was below the performance standard but better than the national average *(pages 4 & 14)*
- There were 12 mixed sex accommodation breaches *(pages 3 & 22)*
- Harm free care was worse than the performance standard and the national average *(pages 4 & 20)*
- New harms, as measured through the Safety Thermometer, were worse than the national average *(pages 4 & 20)*
- Complaints responded to within agreed timescales was worse than the 85% external performance threshold and behind the internal improvement trajectory *(pages 3 & 15)*

New to category this month:
None

Not achieving	
Aug-17	8
Jul-17	11
Jun-17	10

Worse than national average	
Aug-17	6
Jul-17	8
Jun-17	7

**NB the c-section indicator was reported as compliant last month but has since changed to non compliant in July due to late data entry.*

Responsive

Reporting sub committee – TEC

Areas of good performance

- Diagnostic wait times delivered to the performance standard *(pages 5 & 24)*
- The 2WW cancer indicator achieved the performance standard (provisional) *(pages 5 & 25)*
- Cancer 31 day first , 31 subsequent drug and surgery, and 62 day screening indicators are delivering to the performance standard (provisional) *(pages 5 & 26 - 27)*
- Hospital initiated outpatient cancellations under 6 weeks performed better than the performance standard *(pages 6 & 24)*
- The Trust did not report any patients waiting 52 weeks on an incomplete pathway *(page 5)*

New to category this month:

- The breast symptomatic indicator was better than the performance standard (provisional) *(pages 5 & 25)*

Achieving	
Aug-17	11
Jul-17	11
Jun-17	10

Better than national average	
Aug-17	9
Jul-17	9
Jun-17	9

Areas requiring performance improvement

- A&E 4 hour wait performance was below standard *(pages 5 & 28)*
- Formal DToCs were below standard *(pages 6 & 29)*
- Ambulance turnaround times' performance was worse than standard *(pages 5 & 28)*
- The RTT incomplete indicator was worse than the standard *(pages 5 & 23)*
- Patients not treated within 28 days of their last minute cancellation was below standard *(pages 6 & 24)*

New to category this month:

- The 62 day GP indicator was provisionally worse than the standard (*pages 5 & 27*)

Not achieving	
Aug-17	10
Jul-17	10
Jun-17	11

Worse than national average	
Aug-17	5
Jul-17	5
Jun-17	5

Well led

Reporting sub committee – PSE

Areas of good performance

- Temporary costs and overtime as % of total pay bill was better than target *(pages 7 & 30), including and excluding unfunded beds (two indicators)*
- The sickness rate was better than target *(pages 7 & 30)*
- Maternity Friends and Family response rate was better than target *(pages 7 & 33)*
- Mandatory training was better than target *(pages 7 & 31)*
- Bank pay was within the new target range of 8 %– 12% *(pages 7 & 30)*
- Appraisals was better than target *(pages 7 & 31)*

New to category this month:

- Agency pay was better than target *(pages 7 & 30)*

Achieving	
Aug-17	8
Jul-17	7
Jun-17	7

Better than national average	
Aug-17	6
Jul-17	5
Jun-17	5

Areas requiring performance improvement

- The staff turnover rate (rolling 12 months) was below the performance standard *(pages 7 & 30)*
- Staff turnover (rolling 3 months) was worse than target *(pages 7 & 30)*
- The vacancy rate was worse than the performance standard *(pages 7 & 30)*
- Friends and Family response rate for A&E was below threshold *(pages 7 & 33)*
- Inpatient FFT response rate was worse than the target *(pages 7 & 33)*

New to category this month:
None

Not achieving	
Aug-17	8
Jul-17	8
Jun-17	6

Worse than national average	
Aug-17	4
Jul-17	5
Jun-17	5

NB. The sum of indicators achieving and not achieving may not be equal between months due to some indicators being reported with a lower frequency than monthly

NB. Indicators achieving relate only to where targets have been set - as seen on the indicator summary. Ratings showing the number of indicators better or worse than the national average relate to only those indicators where the national average was available. Indicators which are identified in the main pack as provisional may lead to changes to achieving/not achieving counts previous months in Executive Summary.

West Hertfordshire Hospitals NHS Trust

Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Indicator	Target	Jun-17	Jul-17	Aug-17	YTD Actual	YTD Target	Executive Lead	Month	Included in Detailed Reports	National / Local	National avg.	National avg. Period	Trend	Data Quality RAG	Financial impact
Safe, Effective, Caring		SHMI (Rolling 12 months)	100	✓ 88.9	✓ 89.6	✓ 89.5			MD	Feb-17	Y	National	100	Feb-17		G	
		HSMR - Total (Rolling three months)	100	✓ 83.7	✓ 80.6	✓ 77.7			MD	May-17	Y	National	100	May-17		G	
		Crude Mortality Rate (Non elective ordinary)**	3.5%	✓ 2.3%	✓ 2.2%	✓ 2.9%	✓ 2.6%	3.5%	MD	Aug-17	Y	National	2.75% (East of Eng.)	May-17		G	
	•	30 Day Emergency Readmissions - Combined *	4.0%	✗ 7.1%	✗ 7.6%	✗ 7.8%	✗ 7.4%	4.0%	MD	Aug-17	Y	National	11.4%	2011-12		G	£ Marginal tariff reimbursement, possible penalties
		30 Day Emergency Readmissions - Elective *	n/a	2.8%	3.8%	3.3%	3.2%	n/a	MD	Aug-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties
		30 Day Emergency Readmissions - Emerg *	n/a	11.0%	10.7%	11.8%	11.1%	n/a	MD	Aug-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties^
		Number of patients with a length of stay > 14 days *	tbc	320	333	318	1691	tbc	MD	Aug-17		Local	n/a			G	£ Reduction in reimbursement vs largely fixed costs. No penalty levied.
		Staff FFT % recommended care	tbd NHSI^	N/A	61.5%	51.1%	51.1%	tbd NHSI^	DoW	Jun-17	Y	National	n/a			G	
		Inpatient Scores FFT % positive	95%	✗ 93.7%	✗ 90.6%	✗ 91.0%	✗ 92.7%	95%	CN	Aug-17	Y	National	95.9%	Jul-17		G	
		A&E FFT % positive	95%	✗ 90.2%	✗ 90.5%	✗ 93.3%	✗ 91.3%	95%	CN	Aug-17	Y	National	85.9%	Jul-17		G	
		Daycase FFT % positive	95%	✓ 98.6%	✓ 98.8%	✓ 98.2%	✓ 98.5%	95%	CN	Aug-17	Y	National	n/a			G	
		Maternity FFT % positive	95%	✗ 94.8%	✗ 92.8%	✓ 96.5%	✗ 94.7%	95%	CN	Aug-17	N	National	96.5%	Jul-17		G	
	•	% Complaints responded to within one month or agreed timescales with complainant	85%	✗ 50.8%	✗ 50.9%	✗ 45.9%	✗ 53.0%	85%	CN	Aug-17	N	Local	n/a			R	
		Complaints - rate per 10,000 bed days	tbd NHSI^	41.3	31.3	48.2	36.3	tbd NHSI^	CN	Aug-17	N	National	n/a			R	
		Reactivated complaints		5	6	9	37	n/a	CN	Aug-17	N	Local	n/a			R	
		Proportion of complaints with verbal communication at the beginning of the		N/A	N/A	58.5%	58.5%		CN	Aug-17	N	Local				R	
	•	Mixed sex accommodation breaches	0	✗ 4	✗ 10	✗ 12	✗ 41	0	CN	Aug-17	N	National	44 Trusts breaching	Jul-17		G	£ Penalties from CCG. £250 per day per service user.
		Clostridium Difficile	2	✗ 4	✓ 0	✓ 0	✓ 6	14	CN	Aug-17	Y	National	3.0 average	Jul-17		G	£ Penalties from CCG, fines from other statutory authorities. £10,000 per case above threshold.
		MRSA bacteraemias	0	✓ 0	✗ 1	✓ 0	✗ 1	0	CN	Aug-17	Y	National	n/a			G	£ Penalties from CCG, fines from other statutory authorities. £10,000 in respect of each incidence in the relevant month.
		E. Coli Bacteraemia	tbc	3	8	3	16	tbc	CN	Aug-17	Y	National	n/a			G	

* Performance may change for the current month due to data entered after the production of this report
** Crude mortality threshold UCL upper control limit (2 standard deviations from mean)
tbd NHSI^ - threshold/target to be determined by Trust Development Agency guidance when available
NB. Where national avg. blank - information not currently available

^Calculation of emergency re-admissions penalty – Re-admission rate is applied to the value of all admitted activity. 25% of this is then applied on the basis that this proportion is avoidable.

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- ◆ Red for the latest data point

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West Hertfordshire Hospitals NHS Trust

Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Indicator	Target	Jun-17	Jul-17	Aug-17	YTD Actual	YTD Target	Executive Lead	Month	Included in Detailed Reports	National / Local	National avg.	National avg. Period	Trend	Data Quality RAG	Financial impact
Safe, Effective, Caring		Never events	0	✓ 0	✓ 0	✓ 0	✗ 1	0	MD	Aug-17	Y	National	n/a			G	£ Penalties from CCG, fines from other statutory authorities, prosecution^
		Serious incidents - number*	tbd NHSI^	1	3	3	14	tbd NHSI^	MD	Aug-17	Y	National	n/a			G	
		% of patients safety incidents which are harmful*	n/a	10.8%	9.7%	9.9%	10.8%	n/a	MD	Aug-17	Y	National	n/a			G	
		Medication errors causing serious harm *	0	✓ 0	✓ 0	✓ 0	✓ 0	0	MD	Aug-17	Y	National	n/a			G	
	●	CAS Alerts: Number issued each month	n/a	16	5	16	16	n/a	CN	Aug-17	Y	National	n/a			G	
		CAS alerts not acknowledged within 48 hours	0	✓ 0	✓ 0	✓ 0	✓ 0	0	CN	Aug-17		National	n/a			G	
		Number of falls*		85	100	114	507		CN	Aug-17	Y	Local				G	
		Number of falls with harm*		16	24	20	105		CN	Aug-17	Y	Local				G	
	●	Harm Free Care*/**	95.0%	✗ 93.2%	✗ 89.6%	✗ 88.4%	✗ 91.3%	95.0%	CN	Aug-17	Y	National	94.1%	Aug-17		G	
		% New Harms (Safety Thermo - New/All Harms)*/**	tbd NHSI^	19.4%	21.0%	21.7%	18.8%	tbd NHSI^	CN	Aug-17	Y	National	36.3%	Aug-17		G	
		Pressure Ulcers New Harms*/**	tbd NHSI^	3	4	5	16	tbd NHSI^	CN	Aug-17	Y	National	WHHT 0.84 vs 0.89	Aug-17		G	
		Falls New Harms*/**	tbd NHSI^	1	1	3	6	tbd NHSI^	CN	Aug-17	Y	National	WHHT 0.51 vs 0.51	Aug-17		G	
		Catheter & UTI New Harms*/**	tbd NHSI^	1	5	4	12	tbd NHSI^	CN	Aug-17	Y	National	WHHT 0.67 vs 0.32	Aug-17		G	
		VTE New Harms*/**	tbd NHSI^	2	3	3	14	tbd NHSI^	CN	Aug-17	Y	National	WHHT 0.51 vs 0.43	Aug-17		G	
	●	VTE risk assessment*	95.0%	✗ 93.0%	✗ 91.7%	✗ 91.2%	✗ 91.5%	95.0%	MD	Aug-17	Y	National	95.2%	Q1 2017		A	
		Caesarean Section rate - Combined*	26.5%	✓ 24.7%	✗ 26.8%	✓ 22.5%	✗ 26.7%	26.5%	MD	Aug-17	Y	Local	26.7%	Apr15-Aug15		A	
		Caesarean Section rate - Emergency*	n/a	13.4%	16.9%	12.0%	15.5%	n/a	MD	Aug-17	Y	Local	15.3%	Apr15-Aug15		A	
		Caesarean Section rate - Elective*	n/a	11.3%	9.9%	10.5%	11.2%	n/a	MD	Aug-17	Y	Local	11.4%	Apr15-Aug15		A	
		Maternal deaths	0	✓ 0	✓ 0	✓ 0	✓ 0	0	MD	Aug-17	N	National	n/a			G	
	●	Patients admitted directly to stroke unit within 4 hours of hospital arrival *	90.0%	✗ 71.4%	✗ 61.1%	✗ 73.0%	✗ 66.7%	90.0%	COO	Aug-17	Y	National	54.8%	Mar-17		G	
		Stroke patients spending 90% of their time on stroke unit *	80.0%	✓ 81.0%	✓ 83.3%	✓ 89.2%	✓ 82.0%	80.0%	COO	Aug-17	Y	National	82.7%	Mar-17		A	

* Performance may change for the current month due to data entered after the production of this report
tbd NHSI^ - threshold/target to be determined by Trust Development Agency guidance when available
** Indicators reported from NHS Safety Thermometer
NB Exception reports not provided for FFT scores
NB. Where national avg. blank - information not currently available

^Recovery of cost of procedure or episode plus any additional charge incurred for corrective procedure or care in consequence to the event.

Exception indicators key
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West Hertfordshire Hospitals NHS Trust

Indicator Summary

Domain	Indicator	Target	Jun-17	Jul-17	Aug-17	YTD Actual	YTD Target	Executive Lead	Month	Included in Detailed Reports	National / Local	National avg.	National avg. Period	Trend	Data Quality RAG	Financial impact
Responsive	● Referral to Treatment - Admitted*	90.0%	✗ 72.3%	✗ 80.0%	✗ 72.8%	✗ 73.7%	90.0%	COO	Aug-17	Y	Local	76.1%	Jul-17		G	
	● Referral to Treatment - Non Admitted*	95.0%	✗ 89.8%	✗ 90.1%	✗ 89.4%	✗ 89.8%	95.0%	COO	Aug-17	Y	Local	90.2%	Jul-17		G	
	● Referral to Treatment - Incomplete*	92.0%	✗ 90.7%	✗ 90.0%	✗ 88.8%	✗ 90.1%	92.0%	COO	Aug-17	Y	National	89.9%	Jul-17		G	£ CCG penalty of £100 in respect of each excess breach above the threshold
	Referral to Treatment - 52 week waits - Incompletes	0	✓ 0	✓ 0	✓ 0	✓ 0	0	COO	Aug-17		National	1630 (all Trusts)	Jul-17		G	
	Diagnostic wait times	99.0%	✓ 99.6%	✓ 99.2%	✓ 99.0%	✓ 99.3%	99.0%	COO	Aug-17	Y	National	98.2%	Jul-17		G	£ CCG penalty of £200 in respect of each excess breach above the threshold
	● ED 4hr waits (Type 1, 2 & 3)	95.0%	✗ 89.0%	✗ 82.9%	✗ 82.5%	✗ 83.0%	95.0%	COO	Aug-17	Y	National	90.3%	Aug-17		G	£ CCG penalty of £120 in respect of each excess breach above the threshold (cap off 8% of attendances)
	ED 12hr trolley waits	0	✓ 0	✓ 0	✓ 0	✓ 0	0	COO	Aug-17	Y	National	61 (all Trusts)	Aug-17		G	£ CCG penalty £1,000 per incidence
	● Ambulance turnaround time between 30 and 60 mins	0	✗ 323	✗ 395	✗ 466	✗ 1,898	0	COO	Aug-17	Y	Local	n/a			R	£ CCG penalty £200 per service user waiting over 30 mins
	● Ambulance turnaround time > 60 mins	0	✗ 85	✗ 174	✗ 169	✗ 896	0	COO	Aug-17	Y	Local	n/a			R	£ CCG penalty £1,000 per service user waiting over 60 mins
	Cancer - Two week wait *	93.0%	✓ 94.4%	✓ 94.7%	✓ 95.3%	✓ 94.8%	93.0%	COO	Aug-17	Y	National	93.7%	Q1 17/18		G	£ CCG penalty breaches per qtr in excess of tolerance is £200 for each breach.
	Cancer - Breast Symptomatic two week wait *	93.0%	✗ 92.3%	✗ 88.3%	✓ 97.4%	✗ 91.4%	93.0%	COO	Aug-17	Y	National	90.7%	Q1 17/18		G	£ CCG penalty breaches per qtr in excess of tolerance is £200 for each breach.
	Cancer - 31 day *	96.0%	✓ 99.4%	✓ 97.9%	✓ 98.5%	✓ 98.8%	96.0%	COO	Aug-17	Y	National	97.5%	Q1 17/18		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
	Cancer - 31 day subsequent drug *	98.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	98.0%	COO	Aug-17	Y	National	99.3%	Q1 17/18		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
	Cancer - 31 day subsequent surgery *	94.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 98.4%	94.0%	COO	Aug-17	Y	National	96.0%	Q1 17/18		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
	◆ Cancer - 62 day *	85.0%	✗ 84.9%	✓ 87.7%	✗ 83.6%	✓ 88.4%	85.0%	COO	Aug-17	Y	National	81.6%	Q1 17/18		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
	Cancer - 62 day screening *	90.0%	✓ 100.0%	✓ 100.0%	✓ 94.4%	✓ 98.4%	90.0%	COO	Aug-17	Y	National	92.3%	Q1 17/18		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.

*RTT and cancer performance for latest month is provisional and subject to validation
NB. Where national avg. blank - information not currently available

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Indicator Summary

Domain		Indicator	Target	Jun-17	Jul-17	Aug-17	YTD Actual	YTD Target	Executive Lead	Month	Included in Detailed Reports	National / Local	National avg.	National avg. Period	Trend	Data Quality RAG	Financial impact
Responsive		Urgent operations cancelled for a second time	0	✓ 0	✓ 0	✓ 0	✓ 0	0	COO	Aug-17	Y	National	n/a			G	
	●	Number of patients not treated within 28 days of last minute cancellation	0	✗ 9	✗ 7	✗ 12	✗ 34	0	COO	Aug-17	Y	National	8 (avg. all Trusts)	Q1 17/18		G	
	●	Delayed Transfers of Care (DToC)*	3.5%	✗ 5.1%	✗ 6.7%	✗ 3.7%	✗ 5.9%	3.5%	COO	Aug-17	Y	National	6.0%	Feb-16		G	£ Marginal tariff reimbursement, possible penalties
		Delayed Tranfers of Care (DToC) beddays used in month		1,429	1,364	1,163	6,990		COO	Aug-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties
	●	Outpatient cancellation rate	8.0%	✗ 11.1%	✗ 11.4%	✗ 11.7%	✗ 11.5%	8.0%	COO	Aug-17	Y	Local	n/a			G	
		Outpatient cancellation rate within 6 weeks^	5.0%	✓ 3.8%	✓ 3.8%	✓ 4.1%	✓ 4.0%	5.0%	COO	Aug-17	Y	Local	n/a			G	
	●	Patient initiated cancellations (all)		13.1%	13.4%	13.5%	13.0%		COO	Aug-17	Y	Local				G	
		Hospital + Patient initiated cancellations (all)		24.2%	24.7%	25.2%	24.5%		COO	Aug-17	Y	Local	n/a			G	

^ Excluding valid cancellations (cancellations to provide earlier appointments, cancellations due to where patients have died, cancellations to appointments made in error and cancellations where there was a change to a clinic template without a change to a patient's appointment date, time or site)

NB. Where national avg. blank - information not currently available

**DToC benchmark estimated by total delayed patients nationaly as percentage of occupied general and accute beds*

Exception indicators key

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Indicator Summary

Domain		Indicator	Target	Jun-17	Jul-17	Aug-17	YTD Actual	YTD Target	Executive Lead	Month	Included in Detailed Reports	National / Local	National avg.	National avg. Period	Trend	Data Quality RAG	Financial impact
Well Led	●	Staff turnover rate (rolling 12 months)	12.0%	✗ 16.1%	✗ 16.1%	✗ 16.2%	✗ 16.2%	12.0%	DoW	Aug-17	Y	National	13.5% (Beds and Herts orgs)	Dec-15		G	
		Staff turnover rate (rolling 3 months)	12.0%	! 12.0%	✗ 13.7%	✗ 16.0%	✗ 14.0%	12.0%	DoW	Aug-17	Y	National	13.5% (Beds and Herts orgs)	Dec-15		G	
		Nurse Band 5 Turnover Rate			✗ 26.7%	✗ 25.8%	✗ 26.2%		DoW	Aug-17	Y	Local	n/a			G	
		% staffleaving within first year (excluding medics and fixed term contracts)		19.3%	18.6%	18.6%	19.1%		DoW	Aug-17	Y	National	n/a			G	
		Sickness rate	3.5%	✓ 2.9%	✓ 3.0%	✓ 3.0%	✓ 3.1%	3.5%	DoW	Aug-17	Y	National	3.8% (EoE orgs)	Dec-15		A	£ Payments made to staff for nil productivity
	●	Vacancy rate	9.0%	✗ 13.0%	✗ 12.3%	✗ 12.7%	✗ 12.7%	9.0%	DoW	Aug-17	Y	National	11% (local survey)	Dec-15		G	£ Costs saved in short term for nil productivity
		Appraisal rate (non-medical staff only)	90.0%	✗ 90.0%	✓ 90.0%	✓ 91.23%	✓ 91.2%	90.0%	DoW	Aug-17	Y	National	85% (local survey)	Dec-15		G	
		Mandatory Training	90.0%	✓ 92.1%	✓ 91.7%	✓ 90.1%	✓ 90.2%	90.0%	DoW	Aug-17	Y	Local	86% (local survey)	Dec-15		G	
		% Bank Pay**	8% - 12%	✓ 10.3%	✓ 9.1%	✓ 9.3%	✓ 9.6%	8% - 12%	DoW	Aug-17	Y	Local	n/a			G	£ Costs at established rates rather than premium
		% Agency Pay**	8.0%	✗ 8.0%	✗ 9.0%	✓ 7.4%	✗ 8.5%	8.0%	DoW	Aug-17	Y	Local	11.4% (local survey)	Dec-15		G	£ Costs at premium rates rather than established
		Temporary costs and overtime as % of total paybill** (Inc. unfunded beds)	22.6%	✓ 18.9%	✓ 18.6%	✓ 17.3%	✓ 18.5%	22.6%	DoW	Aug-17	Y	National	n/a			G	£ Premium payments of various types vs established rates
		*Temporary costs and overtime as % of total paybill** (Excl. unfunded beds)*		✓ 7.5%	✓ 8.5%	✓ 6.9%	✓ 7.7%		DoW	Aug-17	Y	National	n/a			G	£ Premium payments of various types vs established rates
	●	Inpatient FFT response rate	50.0%	✗ 22.2%	✗ 21.9%	✗ 30.9%	✗ 23.1%	50.0%	CN	Aug-17	Y	National	26.2%	Jul-17		G	
	●	A&E FFT response rate	15%	✗ 4.7%	✗ 5.7%	✗ 6.3%	✗ 4.7%	15.0%	CN	Aug-17	Y	National	12.8%	Jul-17		G	
		Daycases FFT response rate	tbd NHSI^	26.9%	39.2%	25.4%	30.8%	tbd NHSI^	CN	Aug-17	Y	National	n/a			G	
	◆	Staff FFT response rate	50%	N/A	✗ 15.7%	✗ 11.8%	✗ 11.8%	50%	DoW	Jun-17	Y	National	n/a			G	
		Staff FFT % recommended work	66%	N/A	✗ 58.5%	✗ 59.0%	✗ 59.0%	66%	DoW	Jun-17	Y	National	n/a			G	
		Maternity FFT response rate	35%	✓ 44.8%	✓ 52.5%	✓ 42.8%	! 39.6%	35%	CN	Aug-17	N	National	23.6%	Jul-17		G	

*Perfomance for current month may change due to data entry post production of this report

*Medication errors causing serious harm data for latest month is provisional and subject to validation. Temporary costs and overtime performance is provisional for the current month

tbd NHSI^ - threshold/target to be determined by Trust Development Agency guidance when available

NB. Exception reports not provided for FFT scores ** Trajectory set as target

NB. Where national avg. blank - information not currently available

Exception indicators key

● Red for a minimum of two data points and amber for one, out of the latest three data points

◆ Red for the latest data point

Data Quality RAG key

Red – Data accuracy is not known, it is incomplete and inconsistent with relevant standards

Amber – Data is assumed to be complete and accurate, although there may be limitations or unresolved queries

Green – Data is complete, accurate and consistent with the standards set for the specific indicator

West Hertfordshire Hospitals NHS Trust

Finance (Overview)

West Hertfordshire Hospitals NHS Trust

Financial Overview as at 31 August 2017

Month 5 Income & Expenditure

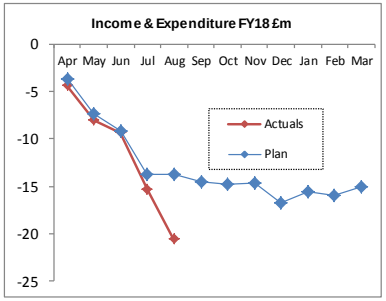
£m	Plan	Actual	Var
Surplus / (Deficit)	(0.0)	(5.2)	(5.1)

£m	Year to Date		
Surplus / (Deficit)	(13.8)	(20.5)	(6.7)

Statutory / Regulatory Duties

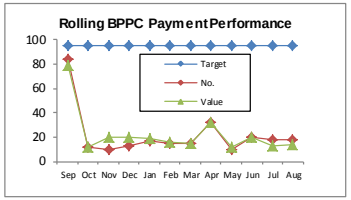
Breakeven	The Trust has a deficit plan of £15m for FY18.	R
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 31/08/17 equated to 3 days' spend	R
BPPC	Month 5 performance - 18% by number and 14% by value (95% target)	R

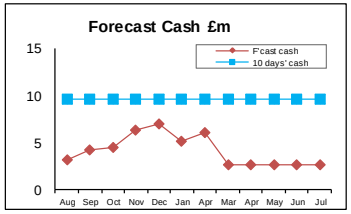
Financial Risk Rating FY18: 3

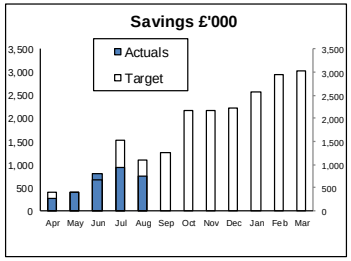


FY18 YTD Variance by Division

	£m	% Budget
Medicine	0.1	13
Unscheduled Care	(1.6)	(26)
Surgery	(2.8)	(60)
Women's	(0.3)	(4)
Clinical Support	0.4	15
Estates & Facilities	0.0	0
Corporate	0.4	2
Other	(2.9)	
Total	**(6.7)**	







Operational performance

Control total of £15.0m deficit accepted by the Trust. Deficit of £20.5m YTD M5 (£15.4m M4) includes CQUIN & STF adjustments relating to missing the prior year control total and represents a risk to achieving the £15.0m target. Also, the year will become progressively more challenging financially and the detailed finance report explains what this means financially alongside the intended recovery plans.

Savings and outlook for FY18

Savings achieved at £3.20m up to M5, slightly behind plan by £0.18m, i.e. projects costed vs actual delivery). 2017/18 Trust savings target is £21.9m, of which £13.7m has so far been assigned to divisions and £9.5m identified, i.e. £4.2m gap + unassigned total of £8.2m = £12.8m to find.

Formal forecast for the year is still to achieve the control total, with a number of risk areas identified and under review overall.

Statutory duties

Reliant on cash support from DH/NHSI, but within borrowing and capex limits.

Financial risks remain high but underlying controls are strong. Recovery actions are identified and actioned throughout the year, monitored primarily through the Finance & Investment Committee.

Finance (I&E)

West Hertfordshire Hospitals NHS Trust

Statement of Comprehensive Income (I&E)

Month 5 (Aug) Budget	Month 5 (Aug) Actual	Month 5 (Aug) Var		FY18 Budget	YTD Budget	YTD Actual	YTD Var	Prior Year Actual
			Volumes					
3,836	3,385	(451)	Elective	42,806	17,912	17,841	(71)	17,673
4,393	4,062	(331)	Non elective	49,525	20,496	20,872	376	20,511
41,458	35,812	(5,646)	Outpatient	433,803	190,504	183,244	(7,260)	178,440
10,448	9,280	(1,168)	A&E	117,791	48,749	49,211	462	49,173
£000's	**£000's**	**£000's**	**NHS REVENUE**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
4,887	3,650	(1,237)	Elective	55,461	22,780	21,083	(1,698)	22,568
8,956	8,306	(650)	Non elective	100,978	41,791	43,079	1,288	39,973
6,245	5,704	(541)	Outpatient	70,191	28,870	27,961	(909)	29,420
1,422	1,267	(155)	A&E	16,032	6,635	6,698	63	6,166
1,222	999	(223)	Critical care	13,781	5,703	5,492	(211)	5,834
3,812	3,379	(433)	Other NHS revenue	42,978	17,787	16,716	(1,071)	16,848
26,544	**23,306**	**(3,239)**	**TOTAL NHS REVENUES**	**299,421**	**123,566**	**121,028**	**(2,538)**	**120,809**
22	20	(2)	Private Patients	259	108	91	(16)	102
781	134	(647)	Other non-NHS clinical income	11,306	3,175	1,928	(1,247)	5,864
802	**154**	**(649)**	**TOTAL Non NHS Clinical**	**11,565**	**3,283**	**2,020**	**(1,263)**	**5,966**
716	729	13	Education & Training	8,590	3,579	3,667	88	3,500
1,391	1,524	133	Other Revenue	15,409	6,520	6,867	348	6,765
-	-	-	Income savings	-	-	-	-	
2,107	**2,253**	**146**	**TOTAL OTHER REVENUE**	**23,999**	**10,099**	**10,534**	**436**	**10,265**
29,453	**25,712**	**(3,742)**	**NET HOSPITAL REVENUE**	**334,984**	**136,948**	**133,582**	**(3,366)**	**137,040**

Outlook for FY18

The income profile was set at a level which may have been too challenging in the first quarter of the year, and is now largely addressed at M5.

Re-assessment of income still allows for achievement of annual plan, and apart from CQUIN adjustments and performance-related STF issues, income is recovering well.

Engagement with Commissioners

- Contractual HVCCG activity continues to form the bulk of all income (small areas of block contract).
- CQUIN management involves formal monitoring and regular operational controls, assuming 90% achievement at this stage less PY adjustment.
- Final FY17 income remains under discussion.

Operational performance

NHS income was £2.5m below plan YTD (£3.2m below in month), with a favourable variance in Non-Elective (£1.3m) offset by Elective (£1.7m), Outpatients (£0.9m) and Other (£1.1m).
Other income was £0.8m adverse YTD (£0.5m in month) primarily due to STF income assumptions offset by favourable car parking income.

Finance (I&E)

Statement of Comprehensive Income (I&E)

Month 5 (Aug) Budget	Month 5 (Aug) Actual	Month 5 (Aug) Var		FY18 Budget	YTD Budget	YTD Actual	YTD Var	Prior Year Actual
18,583	17,719	864	Permanent / Bank Staff	223,018	93,279	88,297	4,982	80,955
510	1,422	(913)	Agency	6,314	2,595	8,163	(5,567)	11,966
(645)		(645)	Unidentified pay savings	(9,177)	(1,325)		(1,325)	
18,447	**19,141**	**(694)**	**TOTAL PAY**	**220,155**	**94,550**	**96,459**	**(1,910)**	**92,921**
1,902	2,001	(99)	Drugs	21,336	8,665	9,296	(630)	9,035
2,871	2,610	261	Clinical services	32,618	13,469	12,745	724	13,113
5,695	6,270	(575)	Non-clinical services	70,462	30,091	31,447	(1,356)	29,628
(337)		(337)	Unidentified non-pay savings	(5,464)	(583)		(583)	
10,131	**10,881**	**(750)**	**TOTAL NON-PAY**	**118,952**	**51,642**	**53,488**	**(1,845)**	**51,776**
876	**(4,310)**	**(5,186)**	**EBITDA**	**(4,123)**	**(9,244)**	**(16,365)**	**(7,121)**	**(7,658)**
709	602	107	Depreciation & Amortisation	8,500	3,545	3,049	496	3,158
129	172	(43)	Interest	1,545	647	755	(108)	649
73	73	0	Dividends Payable	872	365	363	2	1,050
(35)	**(5,156)**	**(5,121)**	**Surplus / (Deficit)**	**(15,040)**	**(13,801)**	**(20,532)**	**(6,731)**	**(12,515)**

Outlook for FY18

The FY forecast is increasingly at risk as operational and CIP pressures increase. Mitigating actions, including use of the Model Hospital and close work with NHSI and the internal SDO are at various stages of progress.

Operational performance

Pay costs were £1.9m adverse YTD (Medical £1.0m adv, Other Clinical £0.5m adv, Sci / Tech / Prof £0.3m adv & Unidentified CIP £1.3m, offset by Non-Clinical £1.3m fav). Focus on agency management continues agency cost trend established in FY17, £0.3m behind plan YTD.

Non-pay costs were £1.46m adverse YTD – Increased outsourcing and drugs overspends were offset by favourable depreciation and clinical services.

[Further detail is given in the main Finance Report.]

CIP schemes

CIP schemes are a combination of expenditure, income, and transformational schemes.
All cross-cutting CIP themes are closely monitored through formal meetings and operational actions. Targets must be met, alongside other important schemes, in order to avoid greater financial difficulties for the Trust, the success of which will depend on Trust-wide efficiency schemes alongside consistently implemented ideas from all.

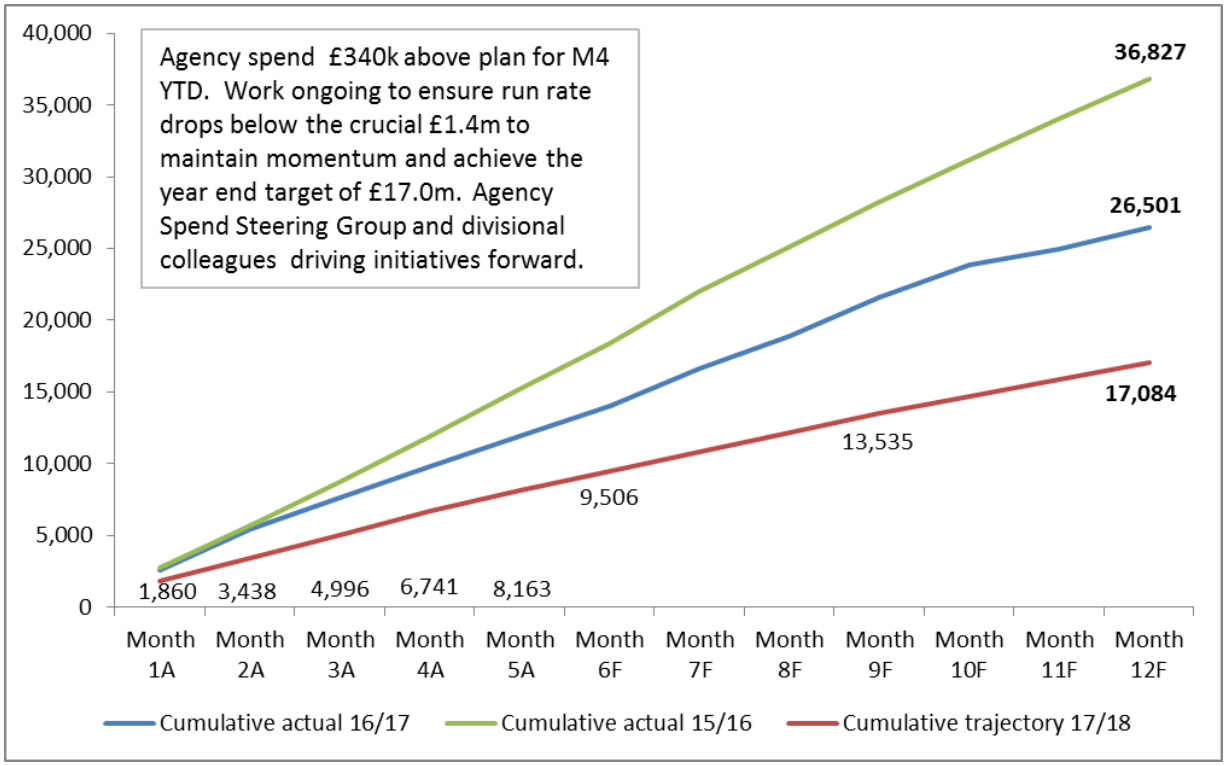
Finance (Agency)

West Hertfordshire Hospitals NHS Trust

Agency spend trajectory

	Month 1A	Month 2A	Month 3A	Month 4A	Month 5A	Month 6F	Month 7F	Month 8F	Month 9F	Month 10F	Month 11F	Month 12F
Cumulative trajectory 17/18	1,860	3,438	4,996	6,741	8,163	9,506	10,849	12,192	13,535	14,718	15,901	17,084
Cumulative plan 17/18	1,701	3,571	5,102	6,462	7,823	9,183	10,713	12,074	13,434	14,625	15,815	17,006
Cumulative actual 16/17	2,605	5,416	7,655	9,846	11,932	14,004	16,635	18,938	21,560	23,847	24,973	26,501
Cumulative actual 15/16	2,772	5,712	8,744	11,930	15,236	18,418	21,978	25,157	28,255	31,149	34,046	36,827

Months trajectory 17/18	1,860	1,578	1,558	1,745	1,422	1,343	1,343	1,343	1,343	1,183	1,183	1,183
Months plan 17/18	1,701	1,871	1,530	1,360	1,360	1,360	1,530	1,360	1,360	1,190	1,190	1,190
Months actual 16/17	2,605	2,811	2,239	2,191	2,086	2,072	2,631	2,303	2,621	2,288	1,126	1,528
Months actual 15/16	2,772	2,940	3,032	3,186	3,306	3,182	3,561	3,179	3,098	2,894	2,898	2,780



Green – 2015/16 £36.8m, large proportion of pay costs n agency spend; agency caps and other measures implemented in-year

Blue – 2016/17 £26.5m, a >£10m decrease on 2015/16 but still a high proportion of pay spend compared to peers.

Red - This year, where we needed to be in order to achieve target expenditure of £17.0m. YTD results M5 were £0.3m behind plan, with M5 itself being the lowest recorded month in almost two years. Plans being implemented to maximise the chances of achieving FY18 targets.

Detailed reports

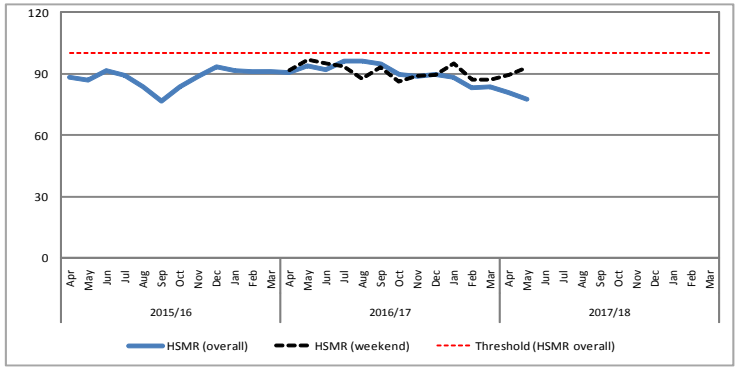
Safe, effective, caring

Reporting sub committee - S&C & COEC

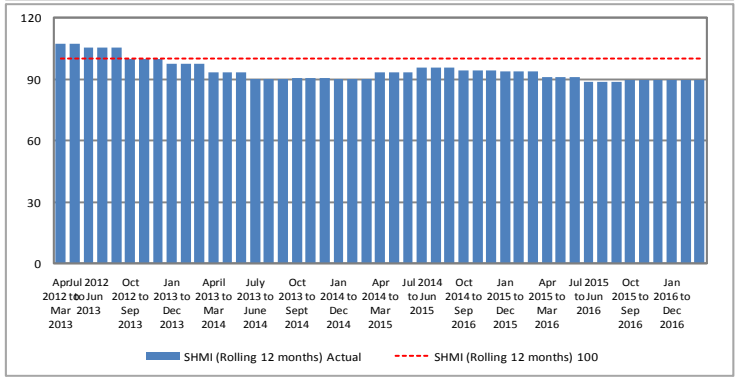
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

Performance relative to targets/ thresholds	Achieving	Not achieving
Aug-17	4	4
Jul-17	3	5
Jun-17	4	4

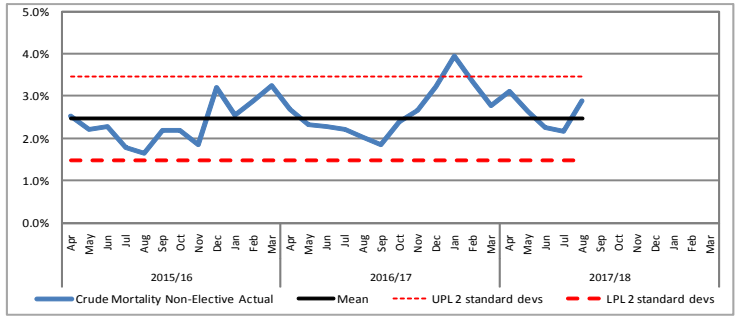
Hospital Standardised Mortality Ratio (HSMR)*



Summary Hospital Mortality Indicator*



Crude mortality rate (non-elective)*



Hospital mortality indices continue to demonstrate sustained improvement. Recent intelligence from Dr Foster benchmarks the Trust against the Shelford group, and places WHHT as one of six trusts in that peer group that sit within the 'lower than expected' range.

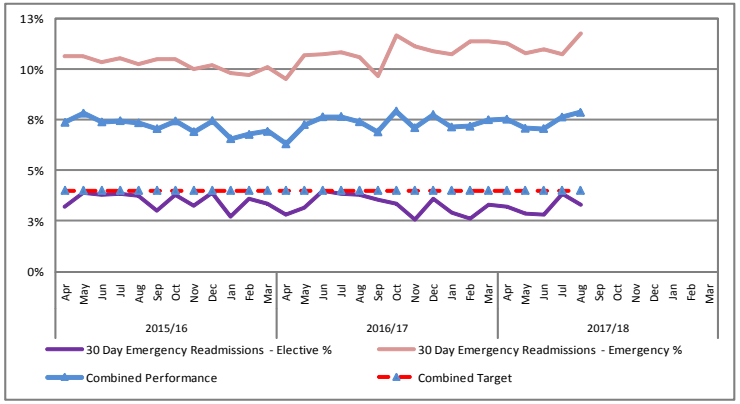
For the most recent 12 month period (July 2016 to June 2017), the Trust's HSMR of 90.86 was in the 'lower than expected' range. Nationally, WHHT had the 24th lowest HSMR out of 136 non specialist trusts, placing the Trust in the top 18% when compared across England. The Trust has the third lowest HSMR within the East of England region.

There was a peak in crude mortality over the winter period which was mirrored nationally.

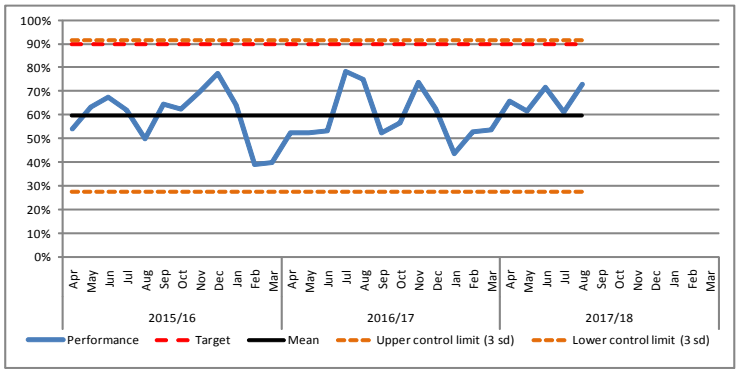
The Summary Hospital Mortality Indicator's (SHMI) latest performance (for January 2016 to December 2016) was 89.52 and 'as expected' (band 2), placing the Trust 15th nationally.

The Trust continues to hold monthly specialty/departmental Mortality Review meetings, cases from which are then discussed at a bi-monthly Trust wide Mortality Review, chaired by the Medical Director. The case note review process is currently being reviewed in order to align with the recent publication, 'National Guidance on Learning from Deaths'.

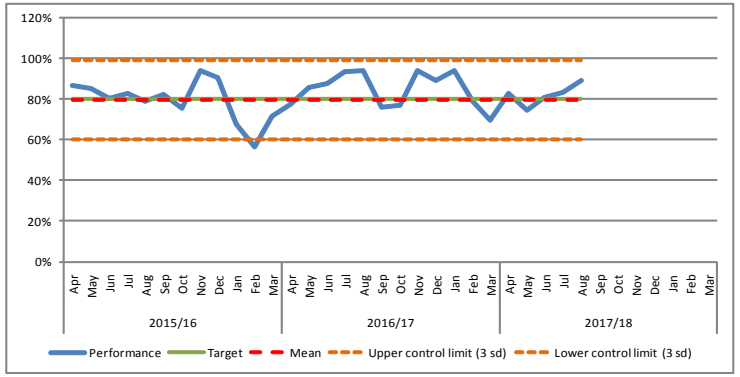
% Emergency re-admissions within 30 days following an elective or emergency spell*



Patients admitted directly to stroke unit within 4 hours of hospital arrival*



Stroke patients spending 90% of their time on stroke unit*



Stroke 60 mins, stroke care and STeMI 150 mins* (to follow)

Emergency Readmissions

Combined emergency readmission rates, including both emergency and elective admissions includes all patients with more than one admission to the hospital within a period of 30 days, regardless of whether the second admission was related.

Within the Trust's Unscheduled Care Transformation Programme there is a work stream directly related to reducing readmissions. This is being led by the divisional director.

Stroke

Performance improved during August to 73.0% for 4 hour admission to the Stroke Unit , with 89.2% patients spending 90% of their stay on the stroke unit, against a target of 80%.

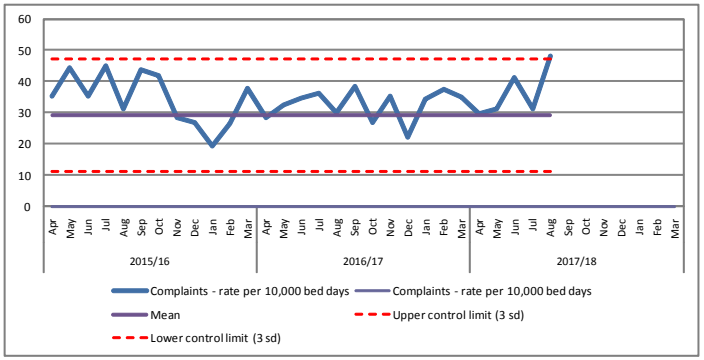
Patients that arrive via a pre-alert ambulance are seen immediately on arrival by the stroke team. However, other potential stroke patients who, during times of increased pressure, experience longer waits in A&E are not always admitted to the stroke unit within 4 hours. When waiting times to be assessed in A&E are long there is a resultant delay in timely referral to the stroke team for specialist assessment.

Maintaining ring fenced capacity for stroke patients remains a focus operationally.

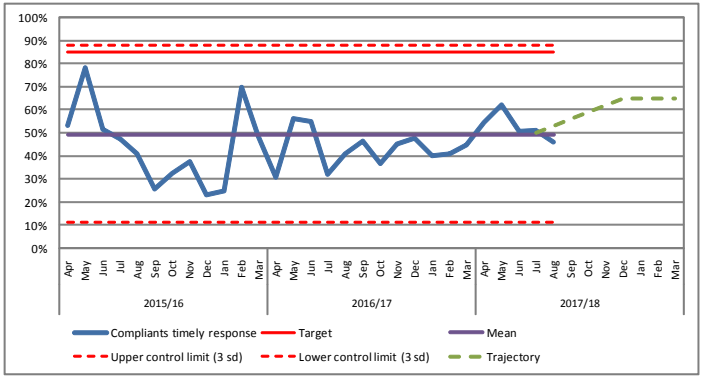
The latest SSNAP results for the reporting quarter December – March 2017, shows that Watford Stroke services maintained an "A" rating. Of the 220 stroke services included, Watford was one of 36 rated "A" putting us in the top 16%.

Annual National Average for 4 hours to the stroke unit for April 2016 – March 2017 is reported as 57.4%, Watford General Hospital achieved higher than the annual national average at 58.4%

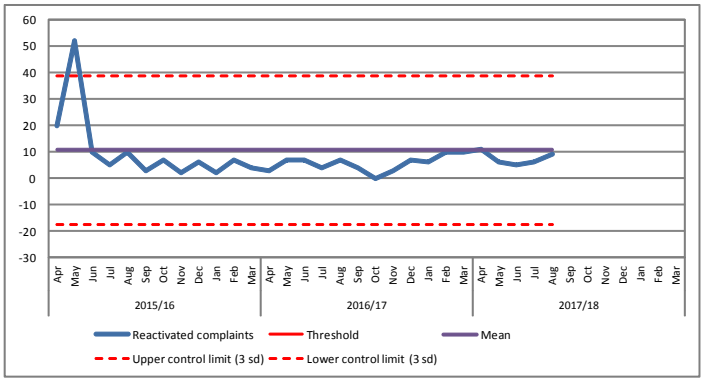
Complaints - rate per 10,000 bed days



% Complaints responded to within one month or agreed timescales with complainant



Number of reactivated complaints



Complaints rate per 10,000 bed days

94 new complaints were received in August, of which 32% (30) relate to Surgery, Anaesthetics and Cancer (SAC), 31% (29) relate to Unscheduled Care (USC), 16% (15) relate to Medicine, 11% (10) relate to Women's and Children's (WACS), 6% (6) relate to environment, 3 relate to corporate and 1 relates to Clinical Support. August saw a 36% increase in complaints, which reflects the usual seasonal peak in complaints as seen in previous years. The divisions seeing the biggest increases were USC and SAC, whose complaints doubled. Medicine saw an increase from 1 to15. For these divisions SAC and Medicine saw the biggest increase in complaints relating to appointments, admissions and surgery delays. For USC division the biggest increase was in communication and clinical care. Environment saw a reduction of 20 complaints directly attributed to the reduction in complaints relating to transport reflecting the new procedure in place escalating complaints directly to Private Ambulance Service. Trust wide the most common themes were clinical care (24 - 25%), communication (12 - 14%), admissions, appointments and waiting times (18 – 19%), staff attitude (9 - 10%),.

% Complaints responded to within one month or agreed timescales with complainant

The Trust has set an internal trajectory to respond to 65% of complaints within one month or agreed timescales with the complainant by the end of December 2017, and then to sustain this until the end of the financial year. In August 46% of complaints were responded to on time. 64 responses were sent in total. Complaints responded to on time, by division, is as follows:

	May-17	Jun - 17	Jul - 17	Aug - 17
Trust wide	62%	52%	51%	46%
Medicine	100%	67%	67%	100%
USC	33%	31%	33%	25%
SAC	67%	57%	57%	60%
WACS	56%	42%	31%	20%
Environment	25%	67%	33%	60%
CSS	88%	100%	100%	67%
Corporate	100%	50%	N/A	33%

	Target	Aug-17
% of complainants with verbal communication at the beginning of process (called within 3 working days of receipt of complaint)	95% by Q4	58.0%
% of complaints acknowledged within 3 working days	100%	78.0%

Divisional trajectories for complaints performance have been implemented and monitored through monthly performance reviews.

Nine complaints were reactivated in August; in five cases complainants have requested additional information that was not included in the original complaint and in four cases the complainants have asked for clarification relating to the investigation into the concerns raised.

N/A denotes – no complaints valid for reply to this month.

Intentionally blank

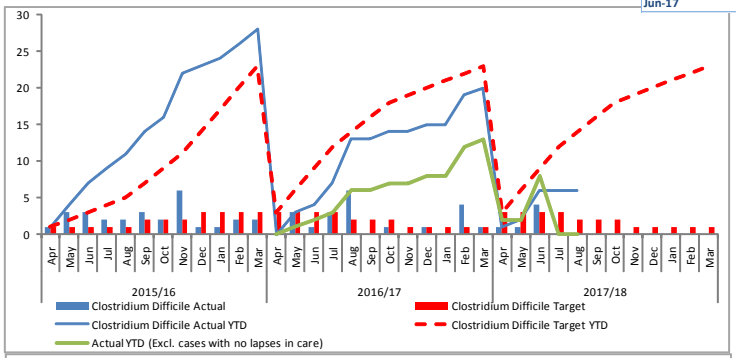
Safe, effective, caring

Reporting sub committee - S&C & COEC

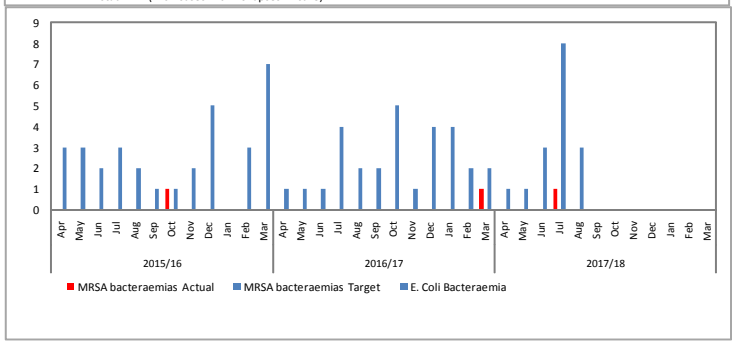
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

Performance relative to targets/ thresholds	Achieving	Not achieving
Aug-17	2	4
Jul-17	4	2
Jun-17	3	3

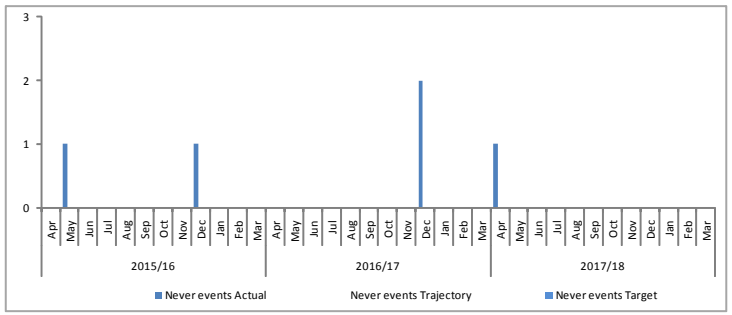
Clostridium Difficile



MRSA bactaraemias and E. Coli Bacteraemia



Never events*



***Clostridium difficile* Infection (CDI)**

The full year target ceiling for WHHT apportioned CDI is 23. No cases of CDI were reported in August, this is a significant improvement as no CDI cases reported 2 months in a row. RCAs have been undertaken for the 6 cases to date. Learning has been shared across all 3 divisions via Divisional Governance, sisters' and matrons' meetings and the IPC panel. Action plans from RCAs will be monitored by the Divisions.

April's CDI case was submitted by the IPCT to the Hertfordshire *C.difficile* appeal panel which provisionally upheld the original outcome that no lapses in care were identified. Confirmation of the outcome from Herts Valleys CCG is awaited.

IPCT continue to undertake antimicrobial rounds, weekly *Clostridium difficile* rounds, and targeted training. There is also increased IPC support to key clinical areas.

MRSA bacteraemia (MRSAb)

The full year target ceiling for MRSAb is 0 avoidable cases. No MRSAb was reported in August. **Key learning July MRSAb:** Failure to screen wounds on admission, phlebitis from cannula site; failure by staff to identify that a patient was known to have MRSA colonisation. The learning from this will be shared across all divisions, supported with targeted education and training. The IPCT are focusing on the education and training to improve management of vascular (peripheral and central) devices including trust wide point prevalence audit in November 2017.

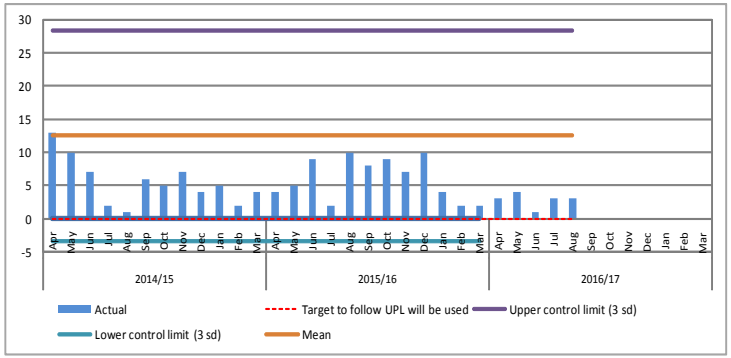
E. Coli bacteraemia (*E colib*)

3 cases of post 48hrs E. colib were reported in August. The target set for the CCG this year is a 10% reduction which equates to 36 cases. There is no target for WHHT. The national DIPC has asked organisations to work together across the whole health and social care sector to jointly develop an improvement plan by September 2017. IPCT have attended the Hertfordshire strategy meeting to agree on the action plan to reduce E coli. The IPCT together with Clinicians are part of the WHHT continence group that reviews post 48hrs E.colib. This will inform WHHT's focus to ensure reduction of the WHHT apportioned *E colib* cases . A new process for undertaking the RCAs has been implemented where clinicians looking after the patients are leading on undertaking the RCAs.

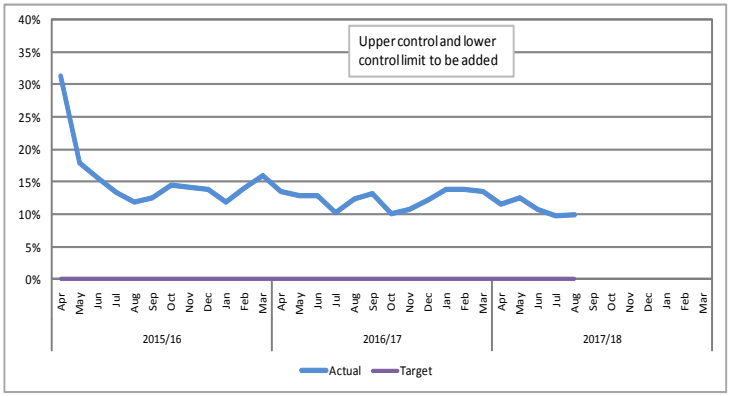
Never event

There were no never events in August 2017.

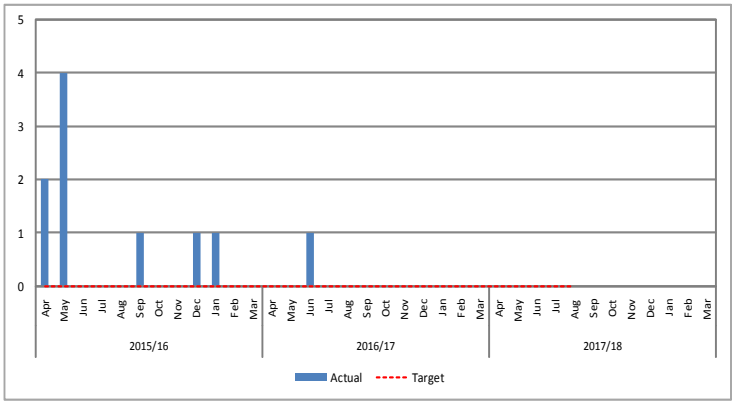
Serious incidents



% of reported patient safety incidents that are harmful



Medication errors causing serious harm*



Serious Incidents
There were 3 Serious Incidents (SIs) declared in August 2017, which is the same number as in July 2017.
The SIs declared were:

I in Clinical Support Services (incorrect interpretation of a CT scan)
1 in the Unscheduled Care Division (grade 3 hospital acquired pressure ulcer)
1 in the Surgery, Cancer & Anaesthetics Division (delayed diagnosis)

At the end of August 2017 the Trust had 17 open SIs. Investigations are complete for 9 of these and they are with Commissioners pending formal closure on StEIS. At the end of August 2017 there were 8 ongoing SI investigations, one of which is overdue for completion as the investigation is ongoing and the remaining 7 within deadline for completion.

Learning from SIs
The following actions and processes are in place to ensure learning from SIs and provide assurance that learning has taken place and changes have been implemented:
45 day review meetings allow the SI draft report to be discussed and challenged by the relevant clinical and management teams prior to the action plan being completed. Each action plan is developed, signed off and monitored by the division leading the investigation into the incident.
The SI review group (SIRG), chaired by the Medical Director, review all closed SI action plans where senior divisional representation provides assurance and evidence that actions have been implemented before the SI is formally closed internally.
A SIRG meeting was held on 28 July 2017. 11 action plans were reviewed and five of these were closed; the outstanding evidence for the action plans which were not closed will be followed up as part of the SIRG action log. A further 6 action plans were closed in the SIRG action log – these are action plans which had been discussed at SIRG before but not closed at the time due to outstanding evidence. The next SIRG meeting is scheduled for 19 September 2017.

% of patient safety incidents which are harmful
9.89% of incidents reported in August 2017 were recorded as harmful, which has increased slightly from 9.69% within July 2017. However incidents reported as harmful have continued to decrease from 13.38% in March 2017 and still remain low.

The level of harm may change following investigation of an incident and charts will be updated for each report to Board to reflect this. 21 incidents were scored as moderate or above in August 2017 of which 13 still require harm validation and therefore are subject to change. This is a slight increase from 18 recorded within July 2017.

Medication incidents causing serious harm
There were no medication errors causing serious harm in August 2017

Safe, effective, caring

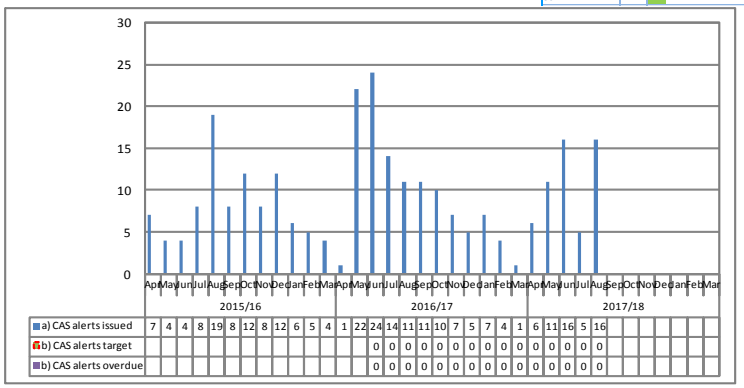
Reporting sub committee - S&C & COEC

Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

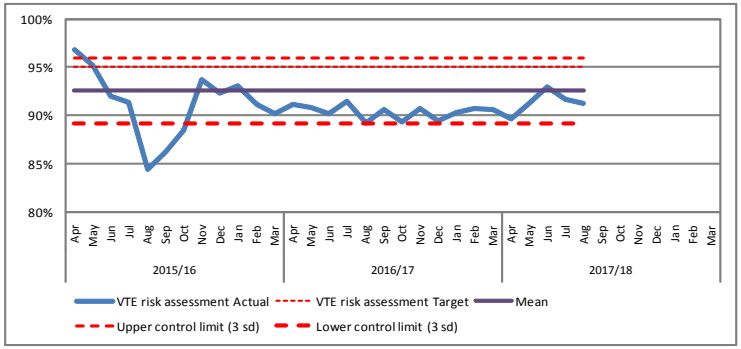
Performance relative to targets/ thresholds		
	Achieving	Not achieving
Aug-17	1	4
Jul-17	1	4
Jun-17	1	4

CAS alerts:

a) number issued per month (not target)
b) number where acknowledgement overdue* (target = 0)
(Class 4: for information only and class 2: Action within 48 hours)



VTE risk assessment*



CAS alerts

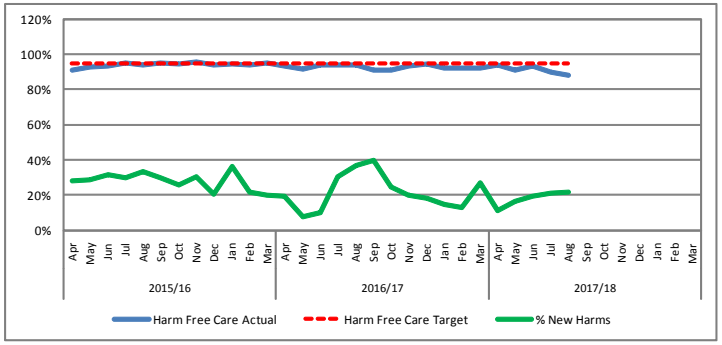
All alerts issued by CAS in August 2017 were acknowledged within the 48hr deadline. There were 16 alerts issued in August 2017. 9 Medical Device alerts and 6 Estate & Facilities alerts, which were sent to the Divisions and Procurement. 1 Patient Safety alert was also issued and the designated lead has been appointed accordingly and actions are now underway. 6 out of the 9 Medical Device Alerts were not applicable to our Trust and are awaiting sign off for closure and the remaining 3 alerts are ongoing in respect of review and action. 1 of the 6 Estate & Facilities alerts requires action and is currently ongoing , 2 have completed all actions and are now closed and 3 have completed all actions and are awaiting sign off for closure. There were no breaches during August 2017 and all alerts with deadlines were closed on time.

Issued by CAS	16
Breached in month	0
Currently overdue	0
CAS alerts not acknowledged within 48hrs	0

VTE

There has been a small sustained percentage increase in initial VTE risk assessment compliance but more work is required to target noncompliant areas.

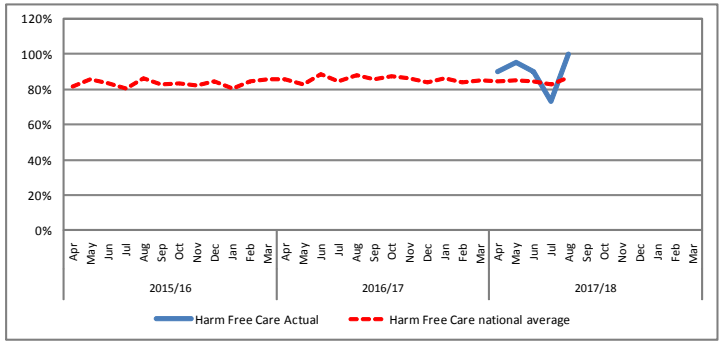
Adult Safety Thermometer: Harm Free Care and New Harms



Adult Safety Thermometer: Harm Free Care and New Harms

August 2017	National	WHHT	Milton Keynes	East and North	The Hillingdon
New Harm Free	97.86	97.64	98.83	99.15	98.71
Pressure Ulcers - New	0.89	0.84	0.47	-	0.52
Catheter & New UTI	0.32	0.67	0.23	0.34	-
Catheters	13.67	14.50	21.31	19.97	19.12
Falls with Harm	0.51	0.51	0.47	0.17	0.26
All New VTEs	0.43	0.51	-	0.34	0.52

Children's Safety Thermometer: Harm Free Care



NB. Indicator reported at WHHT from April 2017

Adult Safety Thermometer

The Adult Safety Thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs. Data are collected through a point of care survey on a single day each month on all patients. 'Harm free' care is defined by the absence of harm in these four areas. In August Harm Free Care was 88.4%, below the national average of 94.1%. This includes harms acquired both inside and outside of the Trust. We have seen an increase in overall harms with catheter & new UTI and VTE being above the national average. However overall new harm free care performance is still improved from this period in the previous two years (see chart opposite). New Harm Free care (harms acquired in the Trust) for August 2017 was 97.64 %, below the national average of 97.86%.

Children and Young People's Services Safety Thermometer

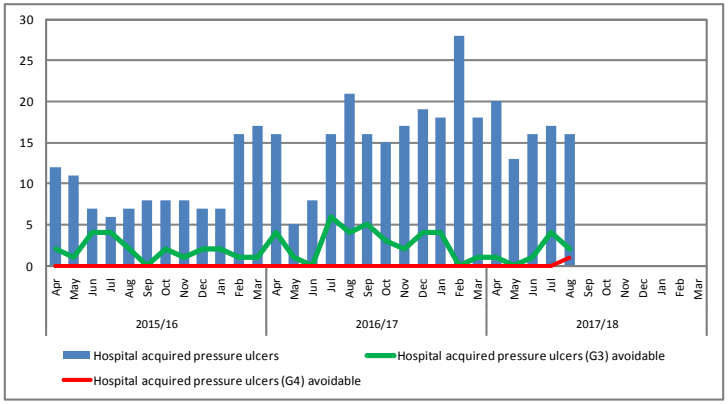
Harm includes patients with a PEWS completed, triggered and not escalated, extravastion, patients in pain at point of survey, any pressure ulcer or any moisture lesion

Harm free care was 100% in August for Acute Children's Services compared to 86.6% nationally. An analysis of the August 2017 survey demonstrated that all patients had a set of observations and had been assessed for an Early Warning Score in the last 12 hours. Of those patients with an intravenous (IV) device, extravasation (leakage of a fluid out of its container) was not observed in any a patient . No patients had a pressure ulcer or moisture lesion at the point of the survey. Zero percent of patients reported pain at the point of survey.

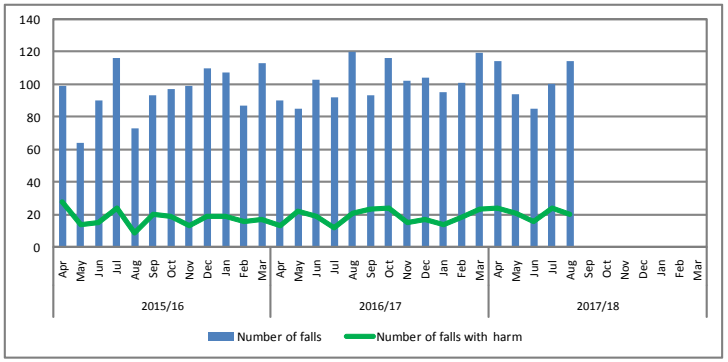
Harm Free Actions

- New Steering group established with Urology meeting bi monthly to drive best practise with urinary catheters and monitor E-coli in conjunction with Infection Prevention and control . Data will be monitored through the group.
- Linking with National programme /NHSI around pressure damage and learning
- Collaborative working with community on harms.
- Falls collaboration with community teams
- Harm free Care focus on Friday prior to Safety Thermometer audits raising awareness.
- Harm free Care tweets on Thursdays and Tuesdays with key messaging
- Target ward teaching
- Implemented pain assessment recording on PEWs charts.

Hospital acquired pressure ulcers



Falls and falls with harm



Hospital acquired pressure ulcers

In August there were 20 new pressure ulcers, 13 grade 2 and 2 grade 3 and 1 grade 4 . All the grade 3 are 4 are deemed avoidable. The grade 2 pressure ulcers are validated by the Matrons for the clinical areas but not differentiated between avoidable and unavoidable.

No patient has had 3 or 4 harms in the Trust.

The Trust has seen an decrease in August with the avoidable Grade 3 pressure ulcers but has experienced its first Grade 4 avoidable pressure ulcer since 2013. A full multidisciplinary approach is being taken to investigate the root causes and learning as part of the Trust wide improvement plan.

When compared to August 16 an improvement can be seen in the total amount of hospital acquired pressure damage .

A trust wide improvement plan is in place to continue the focus on reducing pressure damage as part of harm free care. A multidisciplinary meeting and targeted work to understand the root causes of the Grade 4 is being undertaken.

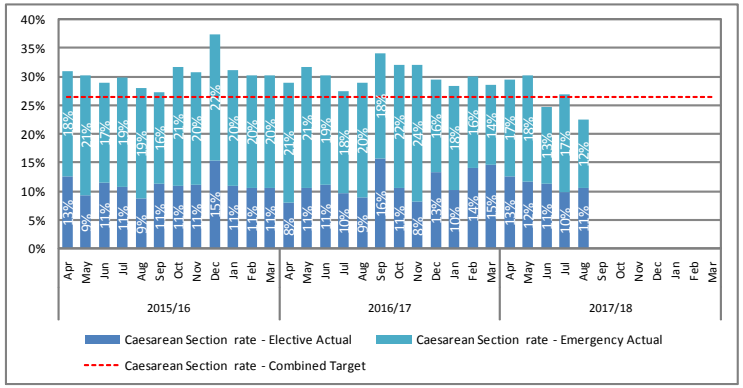
Falls and falls with harm

In August there were 107 falls with 25 resulting in harm – 24 low harm, and 1 severs harm which was fractured neck of femur on a care of the elderly ward.

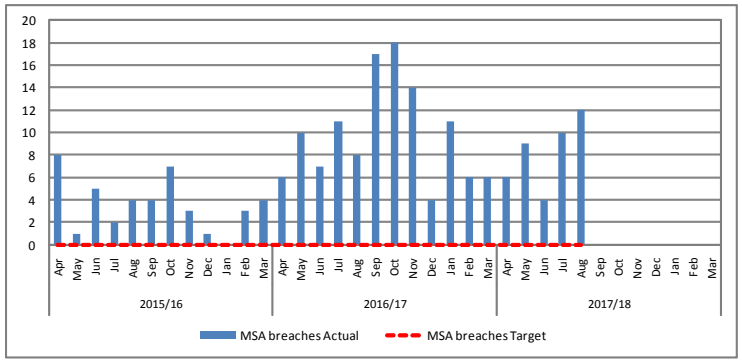
In relation to the numbers of falls – falls with harms remains low.

The Campaign to address falls continues with the Fall Champions, the multidisciplinary falls group, and resource packs for staff being given out.

C-section rate



Mixed sex accommodation



C-section rate

Women are offered greater choice for VBAC and greater access to the Alexander Birthing Centre. The Phoenix team is now established to encourage vaginal births and workshops rolling out the C-section toolkit are underway. An action plan has been completed following a CQC alert to reduce the overall % of C-sections. This includes a new Multi Disciplinary Team meeting weekly to assess suitability of planned inductions and elective sections. The service is assessing every emergency section to ensure the procedure was appropriate and if there was any learning .

A formal programme for CTG training (this test affects decisions made whether to perform a C-Section or not) has been undertaken with 100% compliance for all staff working on the delivery suite. The links with St Georges and their training programme are to continue.

Mixed sex accommodation (MSA)

All breaches occurred in ITU and were due to pressures on the emergency care pathway.

The monitoring and management of patients requiring step down from ITU is reviewed daily as part of the regular operational management meetings, with the intention of reducing where possible, the number of mixed sex accommodation breaches that occur. Advance planning for complex patients requiring side-room capacity is reviewed as part of these meetings.

The Trust policy on mixed sex accommodation has been reviewed and ratified.

Responsive

Reporting sub committee - TEC

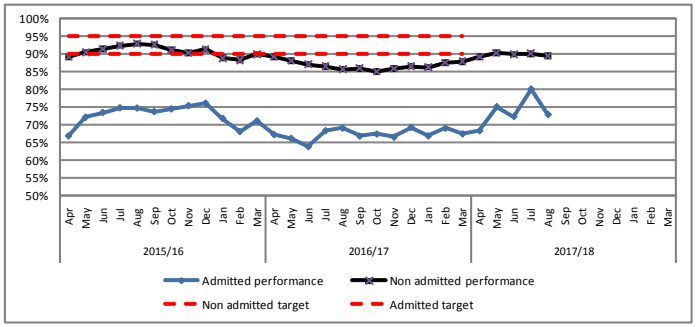
Access indicators - RTT, diagnostics, cancelled operations and outpatient appointments

Executive lead	Clinical lead	Operational lead
Sally Tucker	Jeremy Livingstone	Divisional Managers

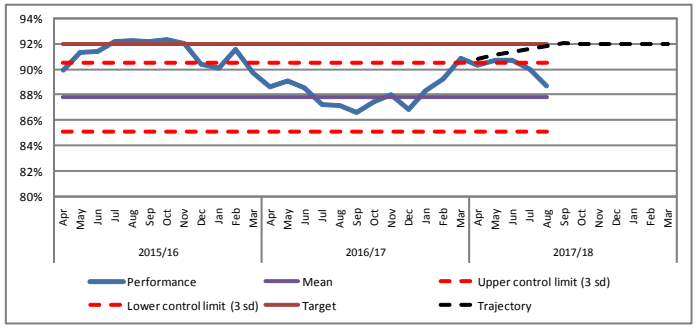
Performance relative to targets/ thresholds		
	Achieving	Not achieving
Aug-17	5	2
Jul-17	5	2
Jun-17	5	2

West Hertfordshire Hospitals NHS
NHS Trust

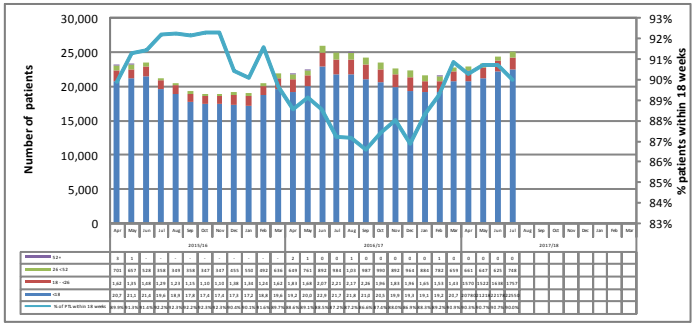
Completed pathways within 18 weeks



Incomplete pathways within 18 weeks



Incomplete pathways WL profile



RTT

Performance for August was 88.8, a further decrease on the previous month (90%). The most recent national data available (July) shows that the Trust's performance in July remained above the national average (89.9%) with 92% achieved at RFT and L&D but not E&NH (87.4%). The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was equal to the national position (6.6 weeks) and better than the 92nd percentile wait time (19.5 vs 19.8 weeks).

Divisional level performance continues to be adversely affected by operational challenges including the requirement to accommodate unplanned theatre ventilation works and pressure from the emergency care pathway. Elective Medicine remains compliant at 95.2%, WACS performance is 96.7%, and in Surgery 83.8% was achieved.

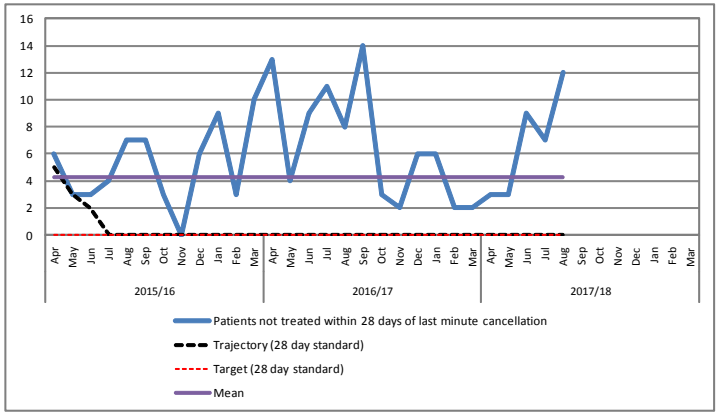
The backlog has increased further and currently represents 11.2% of the total PTL.

Service	18 Weeks Plus	% Under 18 Weeks
GENERAL MEDICINE	0	100.0%
GERIATRIC MEDICINE	0	100.0%
Other	0	100.0%
PAEDIATRIC DERMATOLOGY	0	100.0%
HEPATOLOGY	0	100.0%
PAEDIATRIC CARDIOLOGY	0	100.0%
STROKE MEDICINE	0	100.0%
TRANSIENT ISCHAEMIC ATTACK	0	100.0%
RESPIRATORY PHYSIOLOGY	0	100.0%
MEDICAL ONCOLOGY	0	100.0%
NEONATOLOGY	0	100.0%
OBSTETRICS	0	100.0%
GYNAECOLOGICAL ONCOLOGY	0	100.0%
MIDWIFE EPISODE	0	100.0%
ORTHOPTICS	0	100.0%
NEPHROLOGY	1	99.0%
BREAST SURGERY	4	98.8%
DIABETIC MEDICINE	1	98.6%
GASTROENTEROLOGY	18	98.3%
ENDOCRINOLOGY	5	98.3%
PAEDIATRIC ENDOCRINOLOGY	1	97.9%
GYNAECOLOGY	23	97.6%
CLINICAL ONCOLOGY	1	97.6%
CLINICAL HAEMATOLOGY	8	97.3%

Service	18 Weeks Plus	% Under 18 Weeks
ORTHOTICS	6	96.4%
RHEUMATOLOGY	16	96.1%
PAEDIATRIC OPHTHALMOLOGY	4	95.5%
DERMATOLOGY	114	95.4%
COLORECTAL SURGERY	26	95.2%
RESPIRATORY MEDICINE	32	95.1%
PAEDIATRICS	40	95.1%
PAEDIATRIC CLINICAL HAEMATOLOGY	1	94.7%
PAEDIATRIC EPILEPSY	2	94.6%
PAEDIATRIC GASTROENTEROLOGY	4	94.6%
PAEDIATRIC UROLOGY	7	94.4%
UPPER GASTROINTESTINAL SURGERY	3	94.0%
CARDIOLOGY	103	94.0%
ORAL SURGERY	96	90.6%
NEUROLOGY	103	90.3%
GENERAL SURGERY	216	87.2%
UROLOGY	184	84.5%
TRAUMA & ORTHOPAEDICS	614	84.3%
VASCULAR SURGERY	29	82.8%
PAIN MANAGEMENT	134	80.3%
ENT	470	79.0%
OPHTHALMOLOGY	555	78.2%
ORTHODONTICS	42	65.9%
Total	**2863**	**88.8%**

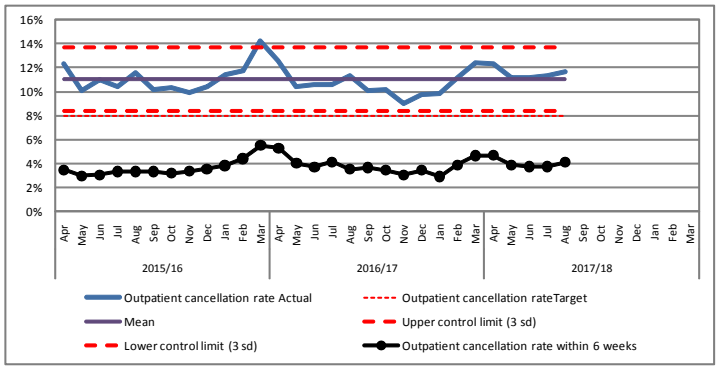
West Hertfordshire Hospitals NHS Trust

Patients not treated within 28 days of last minute cancellation and urgent operations cancelled for 2nd time

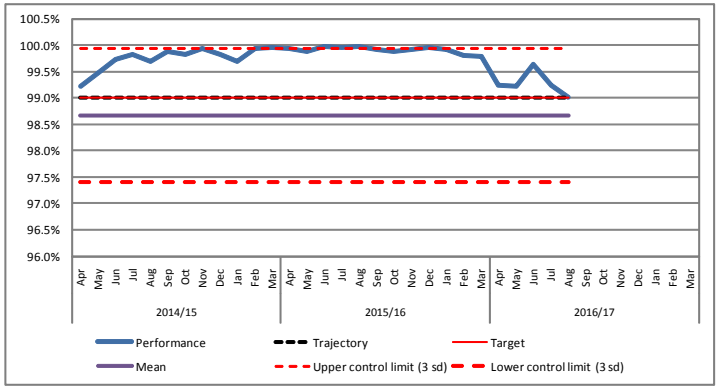


Hospital outpatient cancellations all and % cancelled* within 6 weeks

*(*excluding cancellations to provide earlier appointments, where patients have died, appointments made in error or clinic template changes without a change to a patient's appointment date, time or site)*



Diagnostics



Hospital cancellations – patients not treated within 28 days of last minute cancellation

There were 12 breaches of the 28 day rebooking requirement (7 in July) – Ophthalmology (6), General Surgery (1), Orthopaedics (1), Breast Surgery (1), Gynaecology (1), Oral Surgery (1) and Urology (1). Two breaches were the result of lack of anaesthetic cover. Other reasons included no offer within the required time frame, further cancellations were due to bed capacity/emergency pathway pressures, not booking within the 28 day window or further cancellation because of theatre estate issues.

Hospital cancellations – patients cancelled within 6 weeks and overall

Short notice, hospital initiated cancellation is consistently below the Trust tolerance (5%) at 4.1% (excluding valid cancellations and patient initiated cancellations).

Total cancellations: 25.2%			
Hospital initiated		Patient initiated	
All cancellations	Under 6 weeks	All cancellations	Under 6 weeks
11.7%	4.1%	13.5%	10.5%

NB: Total cancellation rate does not equate to unfilled capacity.

Diagnostic wait times

The diagnostic waiting time standard is that 99% of patients referred for 15 diagnostic tests/procedures, should wait no longer than 6 weeks. This was achieved in August.

Responsive

Reporting sub committee - TEC

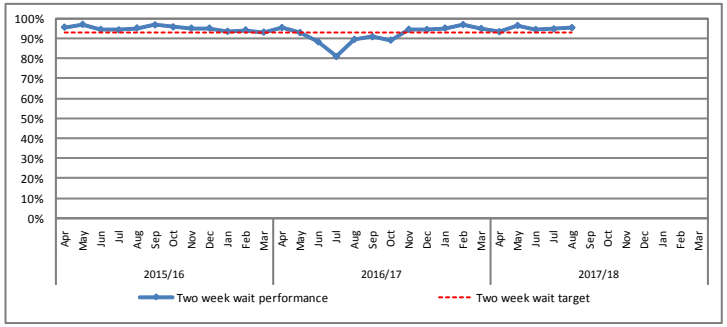
CWTs

Executive lead	Clinical lead	Operational lead
Sally Tucker	Jeremy Livingstone	Divisional managers

Performance relative to targets/ thresholds	Achieving	Not achieving
Aug-17	6	1
Jul-17	6	1
Jun-17	6	1

West Hertfordshire Hospitals NHS Trust

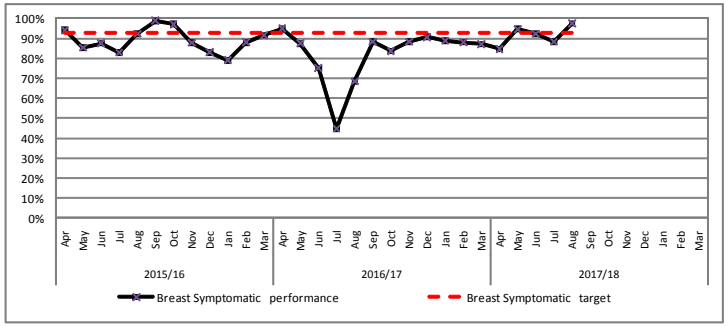
Two week standard



2ww

The provisional position for August is compliant at 95.3%

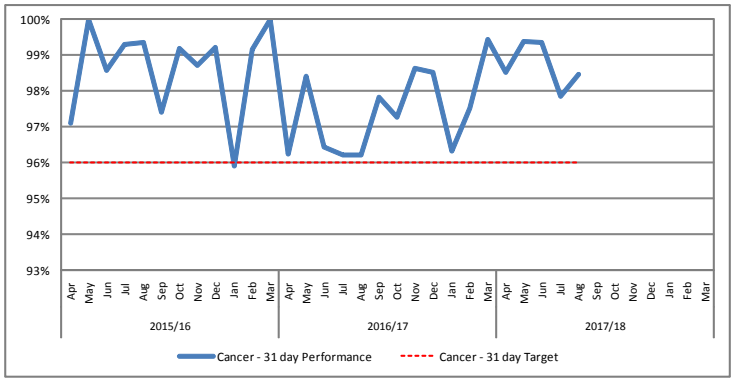
Breast symptom two week standard



Breast symptomatic

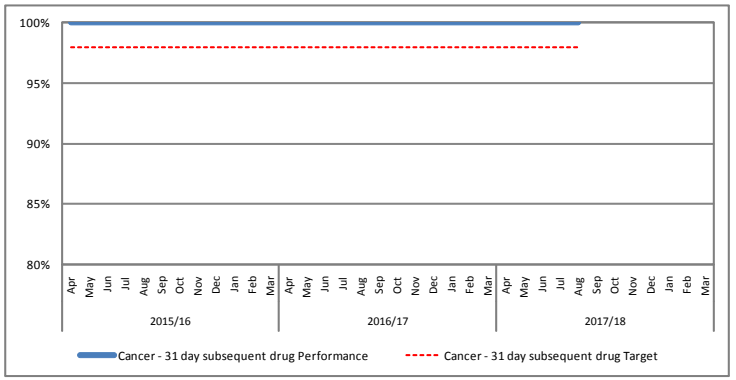
The provisional position for August is compliant at 97.4%.

31 day standard



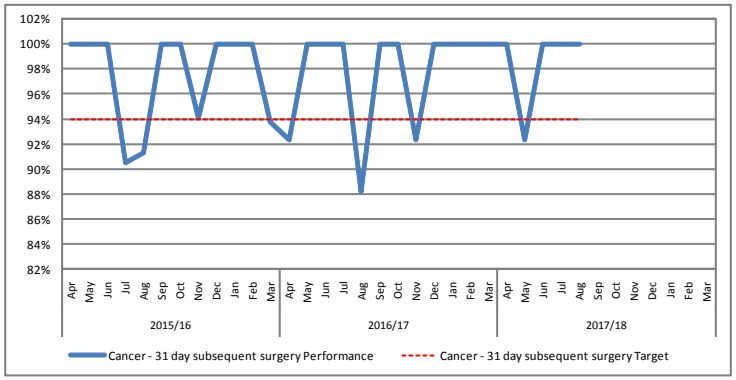
31 day first
The provisional position is compliant at 98.5%

31 day subsequent drug standard



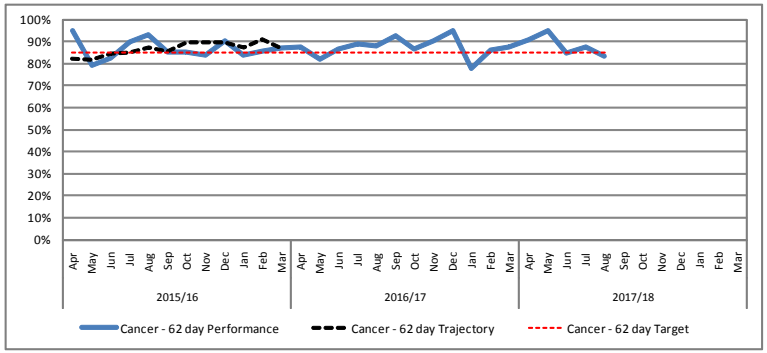
31 Day subsequent - Drug
The position is provisionally compliant at 100%

31 day subsequent surgery standard

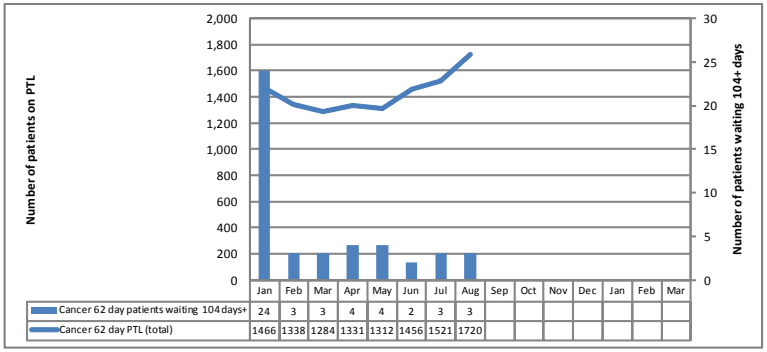


31 day subsequent –Surgery
The position is provisionally compliant at 100%

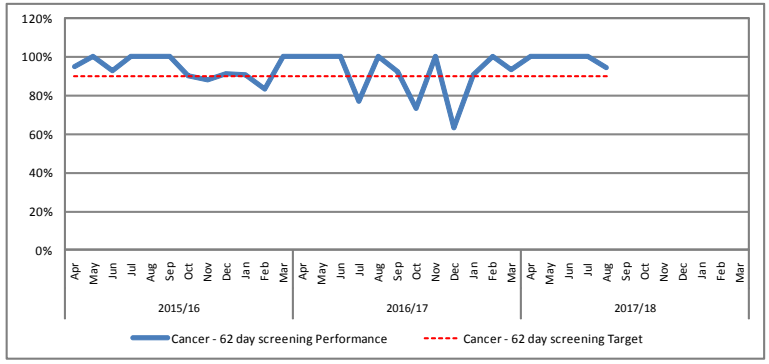
62 day standard



62 day standard number of 104+ day waiters



62 day screening standard



62 day GP – urgent

The provisional position for August is non compliant at 83.6% (target 85%) with 12 breaches. Performance across the tumour types is as follows:

Tumour site	Jul	Aug (prov.)
Breast	96.8	92
Gynaecological	91.7	91.7
Haematological	-	100
Head and Neck	100	100
Lower Gastrointestinal	80	42.9
Lung	60	63.6
Other	100	0
Skin	95.5	100
Upper Gastrointestinal	83.3	100
Urological	80	78.9
Total	**87.7**	**83.6**

Mini RCA style breach analysis is in place for all cancer pathway breaches. These are reviewed by the relevant clinical lead who is required to indicate whether there has been any clinical harm as a result of the delay incurred. If harm is identified, this is taken through the SI process.

104 day waits

For the 62 day GP standard, there were 3 open pathways in August with a wait more than 104 days. As at the week ending 17 September, there were two patients waiting over 104 days. Both patients have treatment dates.

62 day screening

The position was provisionally compliant at 94.4%.

Responsive

Reporting sub committee - TEC

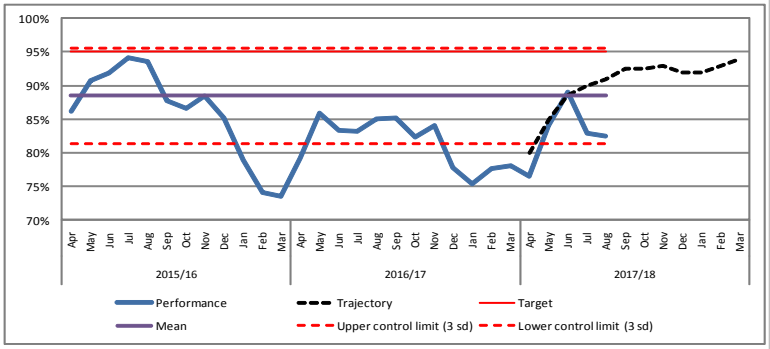
Unscheduled care indicators - A&E, ambulance turnaround and DToC

West Hertfordshire Hospitals NHS Trus

Executive lead	Clinical lead	Operational lead
Sally Tucker	Dr David Gaunt	Divisional managers

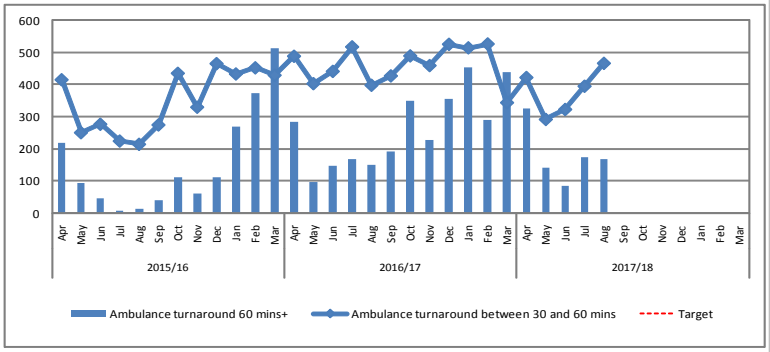
Performance relative to targets/ thresholds		
	Achieving	Not achieving
Aug-17	1	4
Jul-17	1	4
Jun-17	1	4

A&E



** Please note that the A&E trajectory is a working trajectory and awaiting final approval*

Ambulance turnaround time



A&E performance in August remained at a similar level of 82.5% compared with 82.9% in July. Minors performance improved from 90.6% in July to 93.4% in August. CED also improved from 93.2% in July to 96.9% in August. The percentage of A&E attendances that were admitted remained above average at 33.5%, including ambulatory care, and can be linked to the acuity of patients.

An external turnaround team to support the Trust in improving emergency care performance commenced in July. Work has taken place to clarify pathways and response times for A&E patients for specialty teams from Surgery, Trauma & Orthopaedics and Gynaecology. Roles and responsibilities of the Consultant and Nurse in Charge in A&E have been redefined and implemented. Dedicated administrative support is in place to track patient flow accurately and record response times to A&E.

There was a continuing focus on making full use of assessment areas – Medical Assessment Area (MAU), Ambulatory Care, Frailty and Emergency Surgical Assessment Unit (ESAU). However the number of days when there were overnight patients in Ambulatory Care and ESAU increased in August impacting on flow.

Performance continues to be monitored through the Emergency Department Transformation Meeting chaired by the Medical Director.

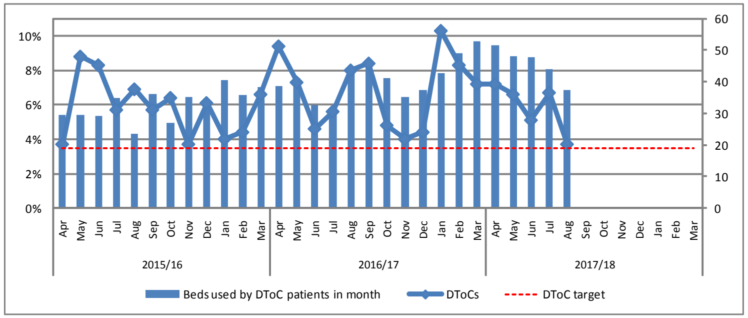
In line with performance against the 95% 4 hour standard, the improvement in ambulance turnaround times was not sustained with the number of ambulances waiting between 30 and 60 minutes increasing. WHHT has increased the resource available to care for patients in the corridor so it can respond flexibly to any queue of ambulances to enable earlier release of crews.

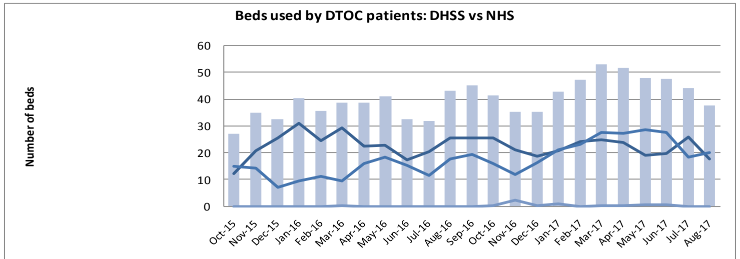
An activity comparison of the current financial period with the same period last year has shown:

- Type 1 attendances are down marginally by -0.2%.
- Ambulance arrivals are down by -4.1%.
- Admission rate from A&E (excluding ambulatory and frailty) is up by 10.7%.
- Discharges (Trust wide) are up by 15.1%

West Hertfordshire Hospitals NHS Trust

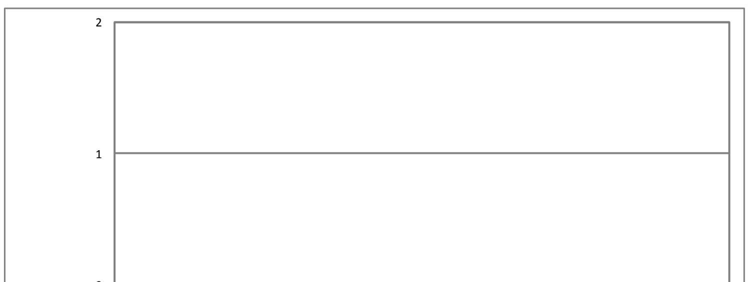
Delayed Transfers of Care (DToC)





	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Total number of beds used by DToC patients	27.1	35.1	32.5	40.5	35.7	38.7	38.6	41.2	32.7	31.8	43.2	45.0	41.3	35.1	35.2	42.7	47.3	52.8	51.6	47.9	47.6	44.0	37.5
NHS Days	12	21	25	31	24	29	23	23	17	20	25	26	25	21	19	21	24	25	24	19	20	26	18
DHSS Days	15	14	7	9	11	9	16	18	15	11	18	19	16	12	16	21	23	28	27	28	27	18	20
Days (BOTH)	-	-	-	-	-	0	-	-	-	-	-	-	0	2	0	1	-	0	0	1	0	-	0

12 hour trolley waits



	2015/16												2016/17												2017/18											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance Target

Delayed Transfers of Care

DToC patients represented 3.7% of occupied beds in August, as measured using the nationally reported method. This is based on a snapshot of the number of patients waiting at a point in time in the month, expressed as a percentage of beds.

The total beds occupied by DToC patients is a helpful measure to illustrate the impact of DToC because it includes all patients waiting in the month. In August DToC patients consumed 1163 bed days, the equivalent of 37.5 beds.

There are regular audits of both DToC and other stranded patients (over 7 day length of stay) to identify issues and remove avoidable causes of delay. The percentage of stranded patients at the end of August was 57%.

Ongoing escalation to system partners via the A&E Delivery Board continues, with significant resource directed to generating additional capacity and improving discharge processes.

An IDT improvement plan is underway. However its impact will be marginal until capacity matches demand for onward health and social care services.

Streamlined processes for data monitoring and reporting have been introduced, as well as daily "live" patient monitoring with board briefings with the discharge planning nurses. Lead roles have been introduced in relation to self-funded patients, and continuing healthcare (CHC) assessments, and a number of staff have been re-allocated to different areas to tackle issues relating to a build up of referrals.

Well led

Reporting sub committee - PSE

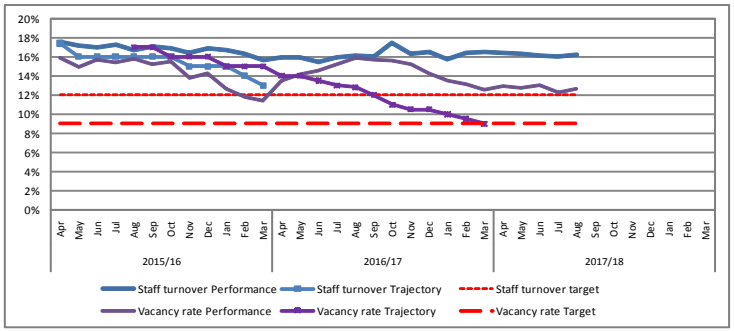
Workforce indicators - staff turnover, sickness, bank & agency, vacancy, appraisal, and mandatory training

Executive lead	Clinical lead	Operational lead
Paul da Gama		

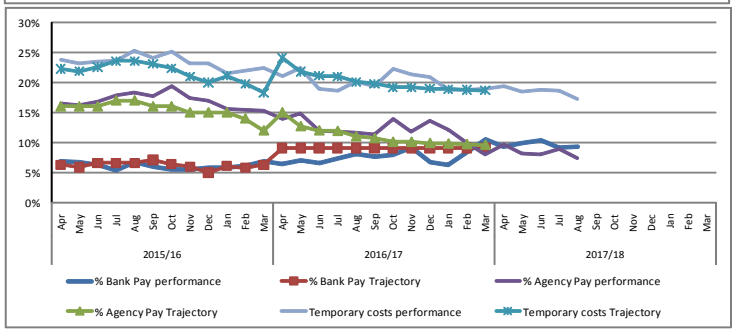
Performance relative to targets/ thresholds

	Achieving	Not achieving
Aug-17	3	4
Jul-17	3	4
Jun-17	2	5

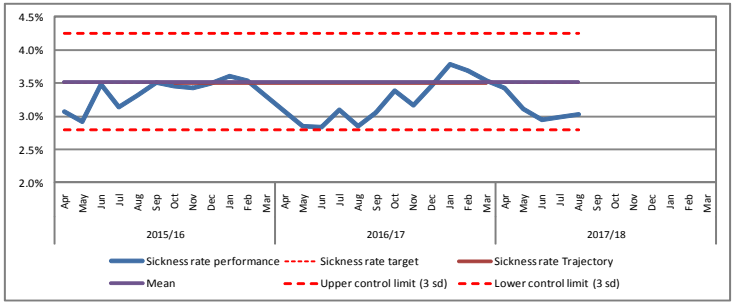
Staff turnover and vacancy rate



% bank, agency and temporary pay



Sickness rate



Turnover and Vacancies

At the end of July the overall Trust vacancy rate decreased slightly to 12.3% from 13% in June, and has increased to 12.7% at August. The trend has been one of a falling vacancy rate over the last 12 months, with a peak of 15.9% in August 2016, and with the rate falling 10 months out of the last 13. Staff-in-post wte has reduced slightly from July, a month in which we saw the highest ever figure for the Trust, at 4,230 wtes. Within the overall figure, the vacancy rate for qualified Nursing & Midwifery posts rose from 17.6% to 20%. Recruitment activity has built up a large pipeline of new N&M recruits (currently 340 registered nurses) and, although many are from overseas with long lead-in times, we expect the nursing vacancy figure to continue to fall over coming months. The 12-month rolling turnover rate remained virtually unchanged at 16.2%; WHHT has the sixth highest turnover (out of 11) compared to Herts & Beds peers and is fractionally below the regional average. Over the last 2 years, turnover has displayed a modest downward trend. WHHT is particular challenge however, with regard to band 5 nurses, where the turnover rate is significantly higher than the Trust average, and the Trust is participating in a national initiative looking at ways to address this issue, presenting a project plan to NHSI which was well received.

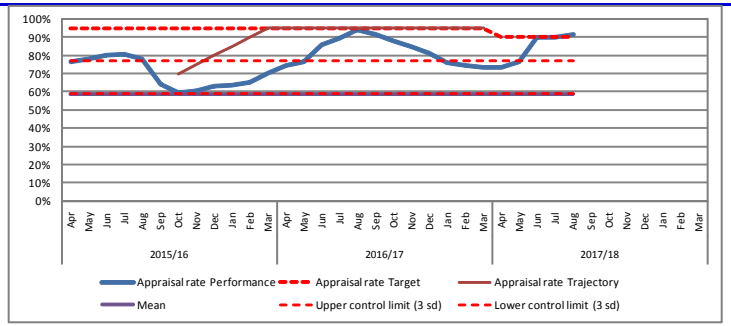
% Bank and Agency Expenditure

Agency spend in August reduced from £1.75m to £1.4m and this spend represented 7.4% of the overall pay-bill compared to 9% in July. Agency spend has reduced considerably however over the last couple of years, with spend in 2016/17 being £10m less than 2015/16. Work continues to keep agency spend as low as possible via the Agency Steering Group, and through partnership working across Herts & Beds, with the latest initiative being the shared staff bank launched on 31st July. There is confidence that the target ceiling of £17m on agency in the current financial year can be achieved. Bank spend as a percentage of payroll has remained steady at 9% - 10% of paybill.

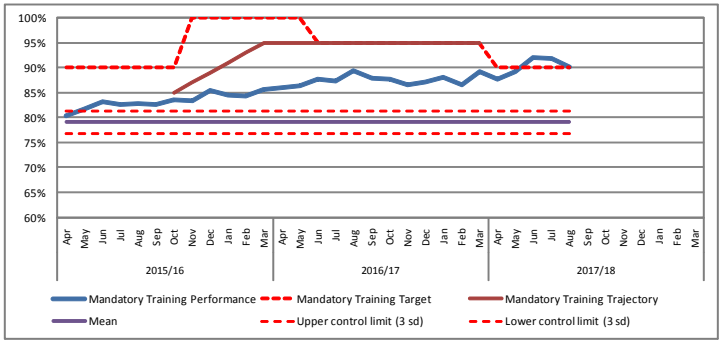
Sickness rate

The sickness absence rate remained at 3% in August, and is comfortably below the Trust target of 3.5%. The Trust is currently well below the Herts & Beds average, which stood at 4% at the end of Quarter 1. Over the last 2 years, sickness absence has remained fairly stable, fluctuating between 3.8% and 2.8%. Average sickness absence in 2015/16 was 3.4%, whereas in 2016/17 it was fractionally lower at 3.2%. It has averaged 3.0% in the current year to date.

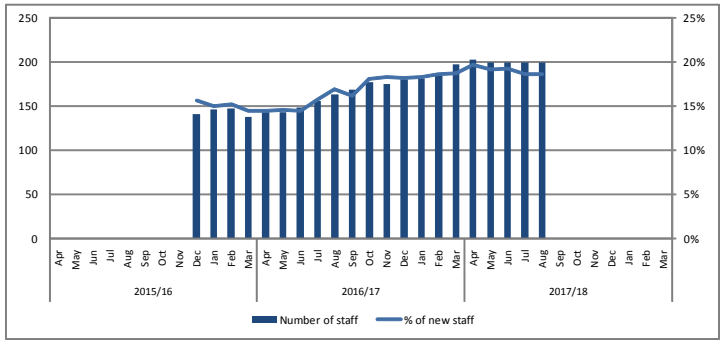
Appraisal rate
(non medical staff only)



Mandatory training



Number of staff leaving within first year (excluding medics and fixed term contracts)



Appraisal – non medical staff

Appraisal rates have increased to 91% but there has been a general improvement trend since April 2017. There is a significant challenge to maintain focus and ensure appraisal dates are aligned to staff increments to further improve organisational performance. HRBPs continue their work with Divisions to develop trajectories and monitor performance and ensure that performance is consistently above the 90% target. HR Business Partners are working with managers with bi-weekly reports to support the transition to effective alignment of appraisals to increments and to plan the completion of all outstanding appraisals.

Mandatory training

Mandatory training compliance is currently at 90%. Retained focus is required to sustain and better compliance rates. The Trust has moved to more intranet based e-learning in place of classroom sessions for subjects that are knowledge based rather than practical. New starters are being asked to complete e-learning prior to commencing in post which is helping to increase compliance rates for new joiners. The new learning management system – 'ACORN' has now been piloted for some user groups including HR, Corporate Nursing and Consultants and based on user experience system improvements are made before the system goes fully live in stages. As a self-serve system this will alert staff to the need to complete training in a timely way and automate many of the processes involved in logging training which should help support increased compliance.

Number of staff leaving within first year

The Trust is closely monitoring staff leavers and is gathering data about staff reasons for leaving. The reconnect sessions continue following corporate induction, bringing new starters back together and offering an opportunity to resolve any issues and gather information to further improve staff experience in the first year in post. Key work is also under way to support retention of Band 5 nurses which is the group with the highest turnover. This also form s a part of the Nursing retention project with NHSI, where Band 5 nursing leavers have been identified as a key workforce to reduce leavers.

Workforce BAF scorecard

Workforce Indictors - Progress Table

Progress against target - Aug 2017

KPI	Benchmark average	Performance 12 months ago	Performance 3 months ago	Current performance	Target	Distance to target	Better / worse than 3 months ago	distance from target as %	Remaining Progress to target needed (%)
Vacancy	13.30%	15.9%	12.4%	12.7%	9.0%	3.7%	↗	41%	41%
Turnover	15.37%	16.4%	16.3%	16.2%	12.0%	4.2%	↘	35%	35%
Total Sickness	4.06%	2.9%	3.1%	3.0%	3.5%	-0.5%	↘	-14%	-14%
Sickness Short Term		1.3%	1.2%	1.3%	1.75%	-0.5%	↗	-26%	-26%
Sickness Long Term		1.6%	1.9%	1.7%	1.75%	-0.1%	↘	-3%	-3%
Non-Medical Appraisal	83.00%	92.0%	74.0%	91.0%	90.0%	1.0%	↗	-1%	-1%
Medical Appraisal		99.0%	99.0%	89.0%	99.0%	-10.0%	↘	10%	10%
Core Skills Framework	86.00%	89.0%	89.0%	90.0%	90.0%	0.0%	↗	0%	0%
Agency as a % of Paybill	7.68%	11.6%	8.2%	7.4%	8.0%	-0.6%	↘	-8%	-8%
Friends and Family Test	60.00%	57.0%	59.1%	53.7%	66.0%	-12.3%	↘	19%	19%
Overall Summary									

a minus figure indicates over-performance

Key	
Achieving 80% of the target	
Achieving 60% to 80% of the target	
Achieving 40% - 60% of the target	
Achieving 20% to 40% of the target	
Achieving Under 20% of the target	

Overall Scoring Key	
Red	2 or more indicators Red
Green	One amber indicator, all other indicators Green
Amber	All other combinations

The Board Assurance Framework shows key workforce indicators in the context of current performance, performance 12 months and 3 months ago, Trust workforce targets, the distance to these targets and a RAG rating based on 5 scales. It also has benchmarking data taken from NHS healthcare providers in the Hertfordshire and West Essex and Bedford, Luton and Milton Keynes STPs.

The RAG rating is based on distance to targets – if current performance is within 0% to 20% (or exceeds) its target then the RAG rating is green. If performance is within 60% – 80% of target then the rating is yellow. This is repeated at 20% intervals for amber and brown until performance is over 80% from the target when the RAG rating is red. If 2 indicators are rated red, then the overall rating is red. If all indicators are rated green, or one is amber then the overall rating is green. Any other combination is amber.

There are 8 (8 last month) indicators rated Green, with performance of 80% or over towards targets. There is 1 indicator is within 60% to 80% of the target. (Turnover), and 1 indicator within 40 – 60% of target (Vacancies). However, both vacancies and turnover rates are lower than the rates were 12 months ago.

Trust targets now reflect benchmarking of targets of other comparable acute Trusts, including those rated as 'outstanding' by the CQC. Appraisal and Core Training compliance is now 90% rather than 95% previously. Agency costs as a % of pay bill have changed from 10% to 8% as this reflects the Trust's NHSI agency target. Medical Appraisal compliance has reduced to 89%, but this is still within 80% of target.

For appraisals and core Training, the Trust has achieved its target of 90% for the third month in a row.

For sickness the Trust has achieved its target of a rate less than 3.5%

For agency, costs, the current agency pay bill percentage is 7.4%, slightly lower than the 8% target.

Turnover rates are 16.2, less than 3 months and 12 month s ago.

The latest Q1 FFT score shows a reduction compared to Q4, although the current score is still within 20% of the target.

Benchmark averages are taken from Q1 17/18 data.

Safe, effective, caring

Well led

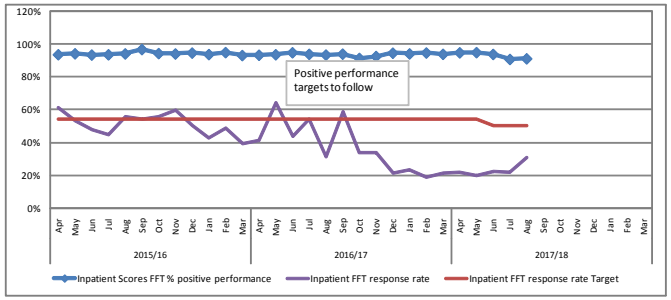
Reporting sub committees - PSQ and PSE

Friends and family

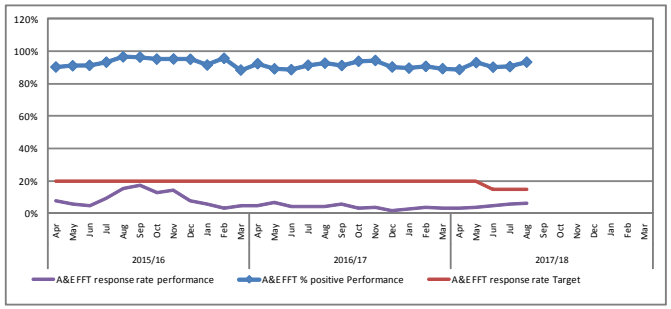
Executive lead	Clinical lead	Operational lead
Tracey Carter and Paul Da Gama		

Well led	Achieving		Not achieving	
Aug-17	0		3	
Jul-17	0		3	
Jun-17	0		3	

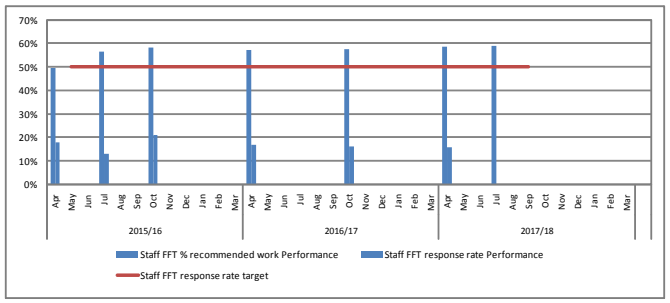
Inpatient scores (% positive and negative) and response rate



A&E scores (% positive and negative) and response rate



Staff scores (% reccommended and not recommended) and response rate



Inpatients

The response rate has increased by 6.8% this month with no change in the positive rate of responses and an increase in negative responses. The themes from patient feedback was: staff behaviour and staffing levels (mainly nurses), communication issues and waiting for a bed or procedure. The number of patients commenting about these areas was 45/60 comments received.

A&E

The response rate has improved again this month, by 2.0%. The positive rate of response increased by 1.8% and the negative rate of response reduced by 1.8% also.

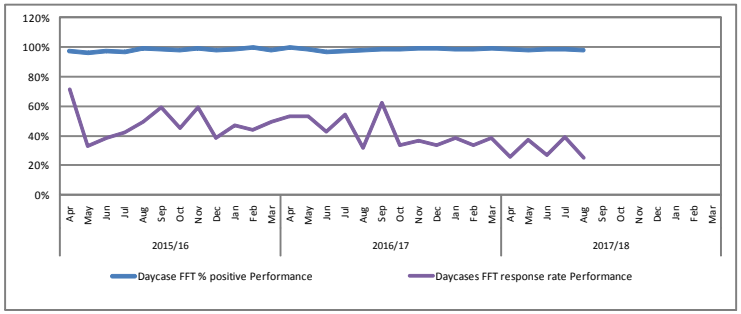
Staff

The Staff Friends and Family Test for quarter 2 ran from 21st August to 11th September 2017. There were 901 responses which is an of 63% increase on the number of responses in Quarter 1. Our overall Trust engagement score has remained the same as the last quarter at 3.55. In summary, compared to the last quarter, slightly more staff would recommend the Trust as a place for treatment and to work. Day to day issues as a source of frustration have decreased. The number of staff that would recommend this organisation as a place to work was 53.9%. The number of staff that would recommend this organisation if friends and family needed care was 64.5%.

Trust Totals - FFT Questions - Work Q2 17/18

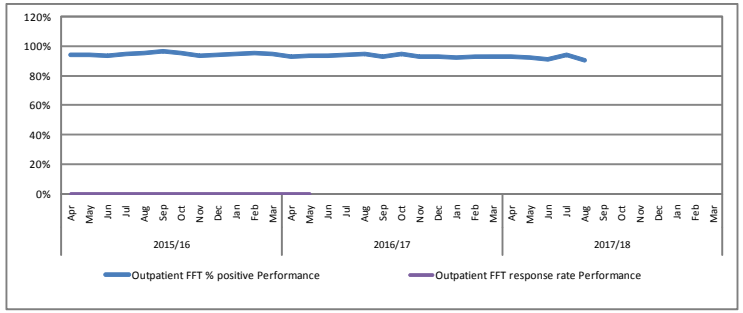
Question	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't know	Total	Engagement Score Q4 16/17	Engagement Score Q1 17/18	Engagement Score Q2 17/18	Change on Last Quarter	*% rating as likely or extremely likely*
Q1. How likely are you to recommend this Trust to friends and family if they needed care or treatment?	166	416	193	69	50	8	902	3.70	3.59	3.62	↗	*64.5%*
Q3. How likely are you to recommend this Trust to friends and family as a place to work?	148	338	196	114	101	4	901	3.49	3.32	3.34	↗	*53.9%*
Q5. I am able to do my job to a standard I am personally pleased with?	180	433	133	123	33		902	3.75	3.73	3.67	↘	
Q6. My manager asked for my opinion before making decisions which affect my work?	177	335	204	117	69		902	3.56	3.55	3.48	↘	
Q7. Over the last month I have felt that day to day issues which cause frustration and get the the way of me doing my job are resolved?	79	269	238	201	115		902	3.15	2.97	3.00	↗	
Q8. I generally feel well informed about what's going on within the Trust	150	441	186	88	37		902	3.52	3.61	3.64	↗	
Q9. I generally feel well informed about what's going on in my local place of work	164	442	154	95	47		902	3.63	3.61	3.64	↗	
Q10. I feel proud to work for WHHT	193	377	235	69	27		901	3.79	3.73	3.71	↘	
Q11. I feel proud to work within my local place of work	249	400	170	57	25		901	3.94	3.88	3.88	↘	
Overall Engagement Score								3.615	3.550	3.550	→	

Daycases scores (% positive and negative) and response rate



Day case
The Trust is now measuring both the main DSU at SACH and also the Surgical admission lounge at WGH.

Outpatient scores (% positive and negative) and response rate

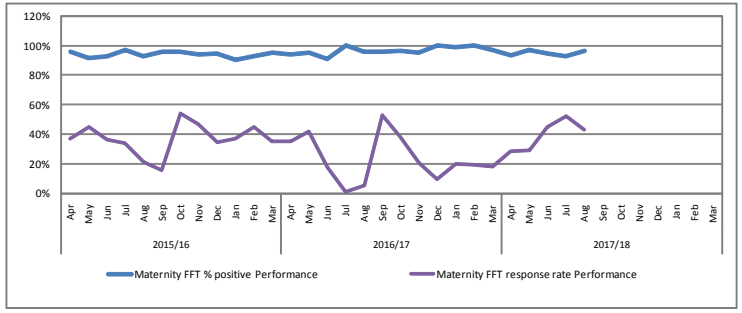


Outpatients
The total number of responses has reduced this month.

The positive response rate has reduced and the negative response rate has increased.

A review of the 47 negative comments indicates waiting times as most commonly cited with 17/47 and parking with 8/47. The lack of communication about delays and not being seen by a Consultant were both commented on 5/47.

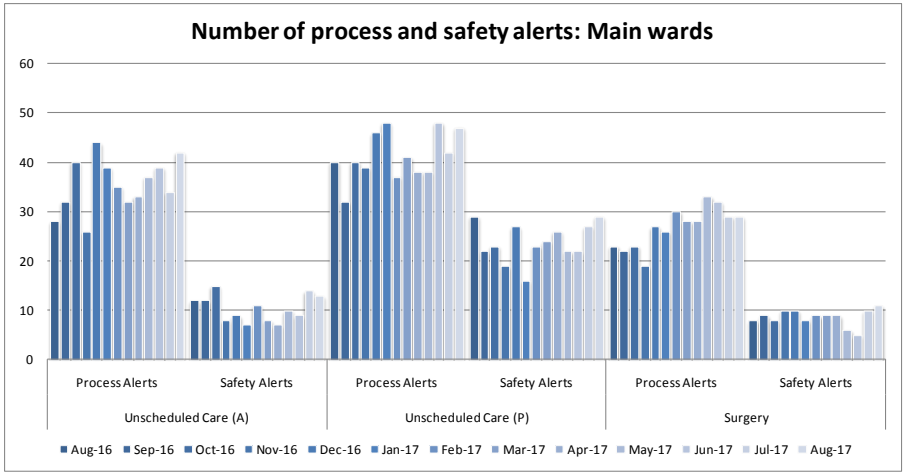
Maternity (Q2) scores (% positive and negative) and response rate

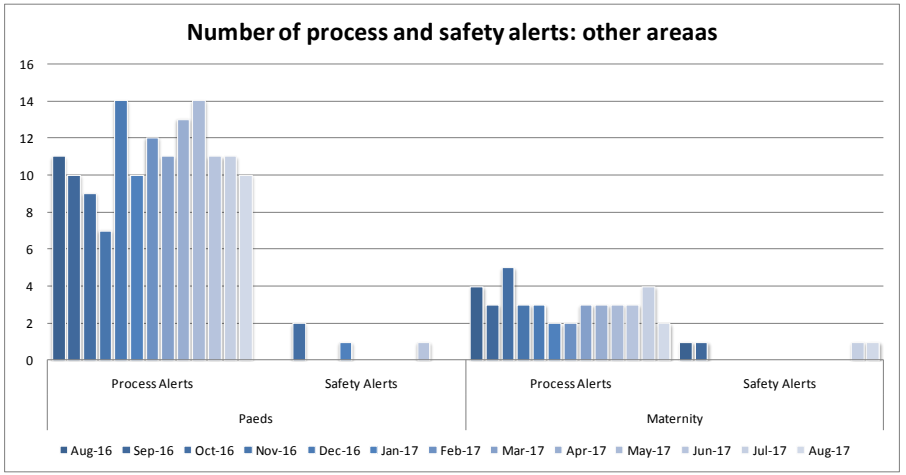


Maternity Question 2
The rate of response has reduced by 10% this month but the positive rate of response increased by 3.7% and the negative response rate has reduced by 0.7%. A review of feedback for all areas has been completed and no themes were identified.

Ward scorecard

Indicator	Performance (August)	Last month
Number of areas with safety alerts	54	52
Number of areas with process alerts	130	120





What is causing the variance

In the Divisions Unscheduled Care (A) Unscheduled Care (P) Surgery and Paediatrics the ***Process Alerts*** are the FFT response rate and workforce indicators such as red flag shifts less than 8 hours planned of an RN.

Safety Alerts include numbers of falls, falls with harm, the response of 'extremely likely' to FFT being under 90% and avoidable pressure ulcers.

Summary:

- Paediatrics have no safety alerts
- Maternity safety alert is % extremely likely response rate for FFT for one area. Overall response rate for maternity has improved and extremely likely to recommend is in line with the national average.
- There are fewer safety alerts occurring in Surgery.
- There are more Process Alerts across the Trust this month. The two areas with a higher trend of alerts have improvement plans in place.

What actions have been taken to improve performance

- After care project in Unscheduled care and ED focus groups to improve the level of feedback for FFT
- Recruitment and Retention meeting. Targeted project focused on the band 5's RN's. Rotational programmes. Overseas recruitment
- Reviewing support mechanisms for staff such as care certificates, Band 6 and Band 7 development courses.
- Patient Footwear changed over for all of the Trust following a successful pilot as part of falls prevention.
- Targeted ward teaching on Falls prevention and management
- Falls Resource Folders for clinical areas due out September 2017
- Targeted training in relation to Pressure ulcers with wards – purchased a body map that highlights pressure points
- Harm Free Care promotion such as Newsletters, Mr B Harmfree – key messages, and Trolley dashes and use of simulation.

Ward Scorecard August 2017

West Hertfordshire Hospitals NHS Trust

Alert Trigger Point		<90%	<90%	<90%	<90%	>0	>4	>0	<90%	<90%	>0	>0	<90%	<54%	>0	>1	<90%	<95%	n/a	Number of Alerts	
Number of Alerts	Process	8 / 29	4 / 28	11 / 32	11 / 29				2 / 26	4 / 35				24 / 33		29 / 32	22 / 27	15 / 29	n/a		
	Safety					12 / 35	11 / 29	14 / 29			0 / 38	1 / 38	16 / 35		0 / 32						
Division	Ward	Matron Quality Checks/Patients	Matron Quality Checks/Staff	TYC Overall	TYC/TVN section	Pressure Ulcers	No. of Falls	Falls with Harms	Commode Audit	Hand Hygiene Audit	Hospital acquired C.diff	Hopsital acquired MRSA isolate	% Extremely Likely>90	FFT Response >54%	Red Flag Number of shifts less than 2 RN's on shift	Red Flag Number of shifts more than 8 hours less than planned	% of Supervisory filled Hours	Overall Fill Rate	Care hours per patient	Safety	Process
Unscheduled Care	AAU B/Y 3	✗ 75%	! 82%	✗ 71%	✗ 72%	✓ 0	✗ 5	✗ 2	✗ 75%	✓ 100%	✓ 0	✗ 1	✓ 100%	! 52%	✓ 0	✗ 34	✓ 92%	! 93%	7.49	3	8
	AAU B1	! 89%	! 80%	! 84%	✗ 77%	✓ 0	! 3	✓ 0	✓ 100%	✓ 91%	✓ 0	✓ 0	✗ 70%	✗ 17%	✓ 0	✗ 20	✗ 0%	! 90%	8.03	1	8
	AAU G1	! 86%	! 89%	✓ 94%	✓ 94%	✗ 3	! 1	✓ 0	✓ 100%	✓ 97%	✓ 0	✓ 0	! 85%	✗ 19%	✓ 0	✗ 5	✗ 39%	✓ 95%	8.38	2	5
	AAU P1	✓ 92%	✓ 93%	✓ 98%	✓ 92%	✓ 0	! 1	✓ 0	✓ 100%	✗ 77%	✓ 0	✓ 0	! 83%	✗ 40%	✓ 0	✗ 27	✗ 35%	✗ 86%	8.95	1	5
	AAU Y1	! 84%	✓ 93%	✓ 100%	✓ 99%	✗ 1	! 2	✗ 1	✓ 100%	✓ 96%	✓ 0	✓ 0	! 81%	! 50%	✓ 0	✗ 26	✗ 24%	✗ 87%	6.71	3	5
	CCU/ P/G 3	✓ 93%	✓ 100%	✓ 100%	✓ 99%	✓ 0	✗ 7	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 97%	✗ 43%	✓ 0	✗ 33	✓ 98%	✓ 98%	6.91	2	2
	A&E	Not done	Not done	! 89%	✗ 77%	✓ 0	! 1	✓ 0	! 89%	✓ 100%	✓ 0	✓ 0	! 87%	✗ 3%	✓ 0	✗ 2	NA	NA	NA	1	5
	MIU	Not done	Not done	Not done	Not done	✓ 0	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 2%	✓ 0	✓ 0	NA	NA	NA	0	1
	UCC	Not done	Not done	Not done	Not done	✓ 0	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 94%	✗ 11%	✓ 0	✓ 0	NA	NA	NA	0	1
	Frailty	Not done	Not done	✓ 91%	! 83%	✓ 0	✓ 0	✓ 0	NA	✓ 96%	✓ 0	✓ 0	✓ 100%	✗ 17%	NA	NA	NA	NA	NA	0	2
Medicine	Aldenham	✓ 92%	✓ 97%	✓ 97%	✓ 98%	✓ 0	! 2	✗ 1	✓ 100%	✓ 96%	✓ 0	✓ 0	✓ 91%	✓ 62%	✓ 0	✗ 36	✗ 61%	✓ 95%	6.26	1	2
	Bluebell	✗ 78%	✓ 91%	! 81%	✗ 66%	✗ 1	✗ 7	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 47%	✓ 0	✗ 60	✗ 68%	✓ 98%	11.61	3	6
	Cassio	✓ 95%	✓ 100%	✓ 98%	✓ 96%	✓ 0	! 2	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	! 84%	✓ 64%	✓ 0	✗ 25	✗ 30%	✓ 96%	5.31	2	2
	Croxley	✓ 92%	✓ 97%	! 87%	✓ 96%	✗ 1	✗ 6	✗ 1	✓ 100%	! 86%	✓ 0	✓ 0	✗ 70%	✗ 22%	✓ 0	✗ 12	! 78%	✓ 99%	6.87	4	5
	Heronsgate & Gade	✓ 98%	✓ 97%	! 86%	! 88%	✗ 1	✗ 7	✗ 2	✓ 100%	! 85%	✓ 0	✓ 0	! 87%	✗ 28%	✓ 0	✗ 26	! 88%	! 91%	5.46	4	7
	Oxhey	✓ 92%	✓ 90%	✓ 90%	! 84%	✗ 2	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 83%	✓ 96%	✓ 0	✗ 2	✗ 70%	✓ 106%	8.26	2	3
	Red	! 84%	✓ 97%	! 84%	✗ 58%	✓ 0	✗ 8	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	! 88%	✓ 56%	✓ 0	✗ 6	✗ 57%	✓ 116%	7.09	3	5
	Sarratt	✓ 92%	✓ 100%	✓ 95%	✓ 95%	✗ 3	✗ 8	✗ 3	✓ 100%	✗ 75%	✓ 0	✓ 0	✗ 72%	✗ 31%	✓ 0	✗ 33	✗ 53%	✓ 96%	6.29	4	4
	Stroke	✓ 99%	✓ 97%	✓ 100%	✓ 100%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 90%	✓ 63%	✓ 0	✗ 12	✗ 65%	✓ 96%	7.54	0	2
	Tudor	! 83%	! 85%	! 85%	✗ 77%	✗ 1	✗ 10	✗ 4	✓ 100%	✓ 100%	✓ 0	✓ 0	✗ 44%	✗ 7%	✓ 0	✗ 61	! 82%	! 94%	7.02	4	8
	Winyard	✗ 74%	✓ 92%	✓ 92%	✓ 94%	✓ 0	✗ 6	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 81%	✓ 87%	✓ 0	✗ 9	✗ 59%	✓ 104%	6.32	2	3
Surgery	Cleves	Not done	Not done	✓ 100%	✓ 100%	✓ 0	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 92%	✗ 46%	✓ 0	✗ 12	✗ 70%	✓ 98%	6.08	1	3
	DLM	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✗ 1	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 98%	✗ 46%	✓ 0	✗ 55	✓ 114%	! 92%	10.85	1	3
	Flaunden	✓ 97%	✓ 100%	✓ 97%	✓ 97%	✓ 0	✗ 6	✓ 0	✓ 100%	✓ 95%	✓ 0	✓ 0	✓ 91%	✗ 45%	✓ 0	✗ 20	✗ 65%	! 91%	4.75	1	4
	ICU	✓ 94%	✓ 97%	✓ 97%	✓ 100%	✗ 2	✓ 0	✓ 0	✓ 100%	✓ 99%	✓ 0	✓ 0	✓ 100%	✓ 89%	✓ 0	✗ 31	✓ 100%	! 95%	24.41	1	2
	Langley	✓ 100%	✓ 100%	✓ 98%	✓ 99%	✓ 0	! 1	✓ 0	✓ 100%	✓ 90%	✓ 0	✓ 0	✓ 93%	✗ 46%	✓ 0	✗ 25	✗ 72%	! 95%	5.62	0	4
	Letchmore	✓ 100%	✓ 100%	✓ 99%	✓ 100%	✗ 1	! 4	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	! 80%	✗ 17%	✓ 0	✗ 24	! 83%	✓ 107%	5.42	3	3
	Ridge	✓ 91%	✓ 96%	! 80%	! 77%	✗ 1	✗ 5	✗ 1	✓ 100%	✓ 96%	✓ 0	✓ 0	✓ 92%	✗ 45%	✓ 0	✗ 36	✗ 52%	✗ 88%	5.79	3	6
	Elizabeth	✓ 95%	✓ 100%	✓ 98%	✓ 99%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 86%	✗ 32%	✓ 0	✗ 37	✗ 65%	✗ 85%	4.86	1	4
Paeds	SCBU	✓ 95%	Not done	✓ 95%	✓ 96%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 69%	✓ 0	✗ 38	NA	✗ 83%	10.93	0	2
	Starfish	✓ 97%	✓ 94%	! 87%	✗ 67%	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 11%	✓ 0	✗ 14	✗ 74%	✗ 87%	12.18	0	6
	CED	✓ 97%	✓ 97%	✓ 97%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 97%	✗ 10%	✓ 0	✗ 23	NA	NA	NA	0	2
	Safari	✓ 100%	✓ 100%	NA	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 99%	✓ 56%	✓ 0	✓ 0	✓ 100%	NA	NA	0	0
Maternity	Delivery Suite	NA	NA	! 89%	NA	✓ 0	NA	NA	NA	✓ 91%	✓ 0	✓ 0	✓ 97%	NA	NA	NA	NA	! 95%	29.12	0	2
	Katherine	NA	NA	✓ 98%	NA	✓ 0	NA	NA	NA	✓ 93%	✓ 0	✓ 0	! 88%	NA	NA	NA	NA	✓ 116%	5.33	1	0
Green		>=90	>=90	>=90	>=90	0	0	0	>=90	>=90	0	0	>=90	>=54	0	0	>=90	>=95	n/a		
Amber		80-89	80-89	80-89	80-89	n/a	1-4	n/a	80-89	80-89	n/a	n/a	80-89	50-53	1	n/a	75-89	90-94	n/a		
Red		<=79	<=79	<=79	<=79	>=1	>=5	>=1	<=79	<=79	>=1	>=1	<=79	<=49	>=2	>=1	<=74	<=89	n/a		

West Hertfordshire Hospitals NHS NHS Trust

Ward Scorecard (Other/ Non Adult Inpatient) August 2017

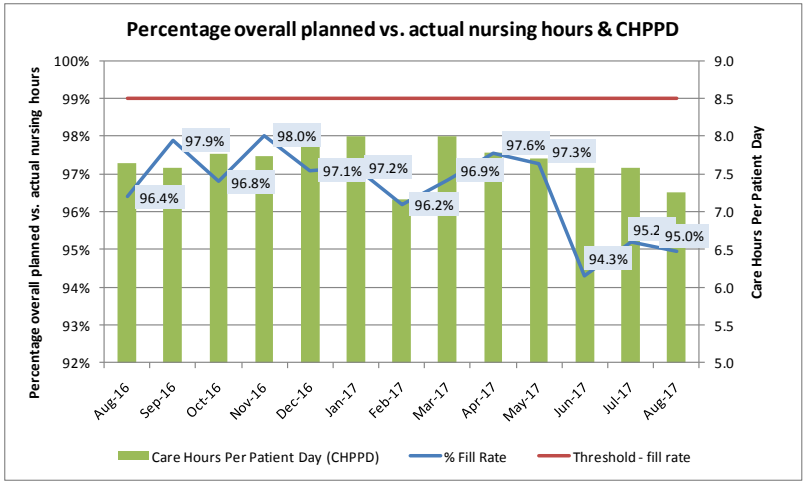
Alert Trigger Point		<90%	<90%	>0	>4	>0	<90%	<90%	>0	>0	<90%	<54%	>0	>1	<90%	<95%	n/a	Number of Alerts	
Number of Alerts	Process	3 / 29	2 / 3				1 / 3	1 / 20				5 / 7		4 / 7	1 / 2	3 / 4	n/a		
	Safety			0 / 9	0 / 3	0 / 3			0 / 32	0 / 32	6 / 27		0 / 7						
Division	Ward	TYC Overall	TYC/TVN section	Pressure Ulcers	No. of Falls	Falls with Harms	Commode Audit	Hand Hygiene Audit	Hospital acquired C.diff	Hopsital acquired MRSA isolate	% Extremely Likely>90	FFT Response >54%	Red Flag Number of shifts less than 2 RN's on shift	Red Flag Number of shifts more than 8 hours less than planned	% of Supervisory filled Hours	Overall Fill Rate	Care hours per patient	Safety	Process
Unscheduled Care	A&E	! 89%	✗ 77%	✓ 0	! 1	✓ 0	! 89%	✓ 100%	✓ 0	✓ 0	! 87%	✗ 3%	✓ 0	✗ 2	NA	NA	NA	1	5
	MIU	NA	NA	✓ 0	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 2%	✓ 0	✓ 0	NA	NA	NA	0	1
	UCC	NA	NA	✓ 0	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 94%	✗ 11%	✓ 0	✓ 0	NA	NA	NA	0	1
Paeds	SCBU	✓ 95%	✓ 96%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 69%	✓ 0	✗ 38	NA	✗ 83%	10.93	0	2
	Starfish	! 87%	✗ 67%	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 11%	✓ 0	✗ 14	✗ 74%	✗ 87%	12.18	0	6
	CED	✓ 97%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 97%	✗ 10%	✓ 0	✗ 23	NA	NA	NA	0	2
	Safari	NA	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 99%	✓ 56%	✓ 0	✓ 0	✓ 100%	NA	NA	0	0
Maternity	Delivery Suite	! 89%	NA	✓ 0	NA	NA	NA	✓ 91%	✓ 0	✓ 0	✓ 97%	NA	NA	NA	NA	! 95%	29.12	0	2
	Katherine	✓ 98%	NA	✓ 0	NA	NA	NA	✓ 93%	✓ 0	✓ 0	! 88%	NA	NA	NA	NA	✓ 116%	5.33	1	0
	Community	✓ 91%	NA	✓ 0	NA	NA	NA	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	ABC	✓ 100%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	NA	NA	NA	NA	NA	NA	NA	0	0
clinical support	Radiology WGH	✓ 91%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 91%	NA	NA	NA	NA	NA	NA	0	0
	Radiology HHGH	✓ 100%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Radiology SACH	✓ 95%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 91%	NA	NA	NA	NA	NA	NA	0	0
	Radiology AAU	✓ 100%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	NA	NA	NA	NA	NA	NA	NA	0	0
Medicine	Outpatient WGH	✓ 100%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	! 83%	NA	NA	NA	NA	NA	NA	1	0
	Outpatient SACH	✓ 100%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	! 82%	NA	NA	NA	NA	NA	NA	1	0
	Outpatient HHGH	✓ 100%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 92%	NA	NA	NA	NA	NA	NA	0	0
	Endoscopy HHGH	✓ 95%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Endoscopy WGH	✓ 97%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 96%	NA	NA	NA	NA	NA	NA	0	0
	Cath lab WGH	✓ 100%	NA	NA	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology WGH	✓ 98%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	! 88%	NA	NA	NA	NA	NA	NA	1	0
	Dermatology SACH	✓ 97%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 93%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology HHGH	✓ 100%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Helen Donald WGH	✓ 100%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
Surgery	Day surgery SACH	✓ 91%	NA	NA	NA	NA	NA	✓ 97%	✓ 0	✓ 0	✓ 99%	NA	NA	NA	NA	NA	NA	0	0
	Opthalmology WGH	✓ 95%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 93%	NA	NA	NA	NA	NA	NA	0	0
	Pre Op HHGH	✓ 94%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	! 80%	NA	NA	NA	NA	NA	NA	1	0
	Theatres WGH	✓ 96%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	NA	NA	NA	NA	NA	NA	NA	0	0
	Theatres SACH	✓ 97%	NA	NA	NA	NA	NA	! 86%	✓ 0	✓ 0	NA	NA	NA	NA	NA	NA	NA	0	1
	Theatres Delivery WGH	✓ 99%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	NA	NA	NA	NA	NA	NA	NA	0	0
	Pre Op WGH	✓ 100%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 92%	NA	NA	NA	NA	NA	NA	0	0
Green		>=90	>=90	0	0	0	>=90	>=90	0	0	>=90	>=54	0	0	>=90	>=95	n/a		
Amber		80-89	80-89	n/a	1-4	n/a	80-89	80-89	n/a	n/a	80-89	50-53	1	n/a	75-89	90-94	n/a		
Red		<=79	<=79	>=1	>=5	>=1	<=79	<=79	>=1	>=1	<=79	<=49	>=2	>=1	<=74	<=89	n/a		

West Hertfordshire Hospitals NHS Trust

West Hertfordshire Hospitals NHS
NHS Trust

Safer staffing

Indicator	Performance (August)	Threshold	Trend	Forecast next month
% Nursing hours versus planned	95.0%	>95%	Up	>99%
Care hours per patient day	7.3	n/a	Stable	7.2



Indicator by shift and skill mix	Shift	RN	Care staff
% Nursing hours versus planned	Day	85.5%	106.6%
	Night	92.1%	109.2%
Care hours per patient day	All	4.5	2.8

What actions have been taken to improve performance

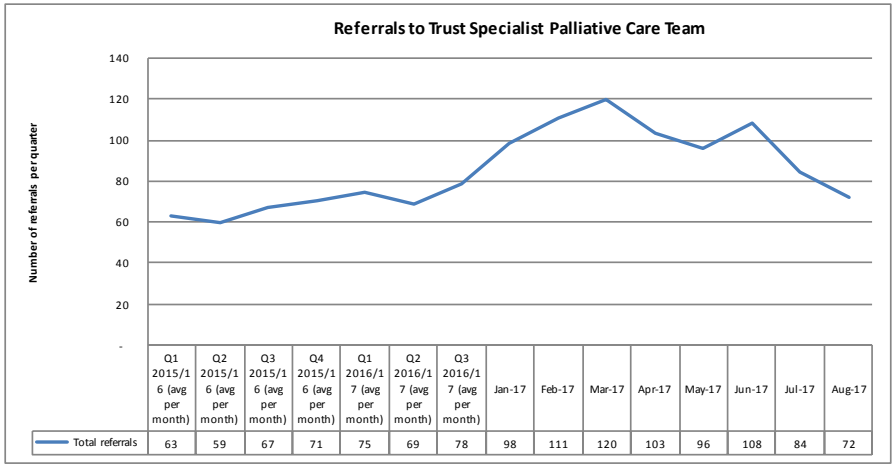
- Enhanced care needs team commenced 13 May 2017
- Castle – 12 beds as a surge area closed 15th June
- Local and international recruitment initiatives continue.
- Trust Recruitment Group formed chaired by Exec HR/Chief Nurse
- Use of Bank/Agency to cover enhance care whilst recruitment and evaluation of the impact of this team.
- Shared bank approach across four Trusts to commenced 31st July.

What is causing the variance

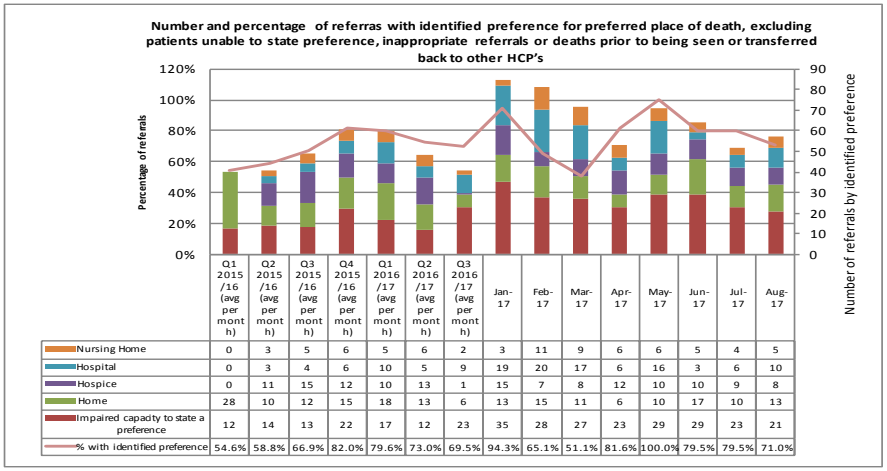
Overall the Trust % fill rate for August was 95%, which was a decrease of 0.2%in the fill rate from last month but is in line with the national threshold . The fill rate within the medicine/USC division was 95.8% decrease of 1.6% from last month. This has been a trend over the last 6 months with falling fill rates in this Division against increasing vacancies on the wards. Within the division of surgery, the fill rate was 93% a decrease of 7.2% from last month. The fill rate within WACS was 93.3% an increase 3.7% from last month. In August there 7267 shifts requested to be filled via NHSP through bank and agency ; and against the requested shifts the fill rate was 79.1%, with 20.9% not filled. The following additional surge areas were open in August, ESAU 11 days, Ambulatory Care 12 days, Elizabeth 17 days, Oxhey increased to 12 patients for 7 days. A total of 231 patients were cared for in these surge areas. The current band 5 turnover rate is 25.8% in this group of staff, a number of band 5s have transferred to the speciality areas in the Trust such as AE; ITU and theatres. Recruitment is ongoing with an overseas recruitment plan with skype interviews in Europe and a scheduled visit to the Philippines in October. In August 215 patients had enhanced care needs identified. There were no red flags for adult, child or maternity for August. The % Trust shifts days and night RAG Rated Green = 72% a decrease of 5.8% from last month, % Trust shifts day and night RAG rated amber = 27.6% decrease 7.6% from last month. Trust shifts day and night RAG rated red were 9 (0.4%) Sarratt x 4, Stroke x 1, Letchmore x 2 and Flaunden x 1. Mitigations were put into place ranging from the ward sisters working long days and the movement of staff to maintain safety. Datix was completed for all Red rated shifts and no harms were recorded. A total of 744 (32.4%) shifts reporting Red Flag more than 8 hours less than planned an increase of 8.1% from last month. Following review of the SITREP with HOM fill rates for maternity are now above the national threshold. CHPPD as a staffing indicator is being used in the adult inpatient establishment and this month's performance is 7. 3 a decrease of 0.3 from last month The overall Trust Supervisory Hours Lost in August was 27.6% an increase of from 7.5% from last month.

End of Life Care

Number of patients who are referred to the palliative care team and who have an identified preferred place of death



	Q1 2015/16 (avg per month)	Q2 2015/16 (avg per month)	Q3 2015/16 (avg per month)	Q4 2015/16 (avg per month)	Q1 2016/17 (avg per month)	Q2 2016/17 (avg per month)	Q3 2016/17 (avg per month)	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Total referrals	63	59	67	71	75	69	78	98	111	120	103	96	108	84	72



	Q1 2015/16 (avg per month)	Q2 2015/16 (avg per month)	Q3 2015/16 (avg per month)	Q4 2015/16 (avg per month)	Q1 2016/17 (avg per month)	Q2 2016/17 (avg per month)	Q3 2016/17 (avg per month)	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Nursing Home	0	3	5	6	5	6	2	3	11	9	6	6	5	4	5
Hospital	0	3	4	6	10	5	9	19	20	17	6	16	3	6	10
Hospice	0	11	15	12	10	13	1	15	7	8	12	10	10	9	8
Home	28	10	12	15	18	13	6	13	15	11	6	10	17	10	13
Impaired capacity to state a preference	12	14	13	22	17	12	23	35	28	27	23	29	29	23	21
% with identified preference	54.6%	58.8%	66.9%	82.0%	79.6%	73.0%	69.5%	94.3%	65.1%	51.1%	81.6%	100.0%	79.5%	79.5%	71.0%

In 2008, the End of Life Care Strategy (Department of Health) was published and one of the insights from this was that people weren't supported to die in their place of choice; and although progress has been made this has been evidenced in many other reports. In July 2014 just over 50% of respondents to the National Survey of Bereaved People (VOICES-SF) felt that their relative had died in a place of their choice (Office of National Statistics, 2014).There is now a national focus on reducing the numbers of patients dying in hospital and offering everyone who is approaching the end of their life the opportunity to express and share their preference for where they want to die as well as any goals that are important to them (National Palliative and End of Life Care Partnership, 2015).

In August, the number of referrals to the Trust Specialist Palliative Care Team was 72. The number of patients seen by the Specialist Palliative Care Team with an identified preferred place of death (PPD) was 36 out of the 51 patients who had capacity and were appropriate to have this discussion. This equates to 71.0%.

There were six patients who died at West Herts with home as their preferred place of death. This was due to their physical symptoms not permitting the patient to be at their preferred place for five of the patients and an unexpected deterioration in one patient.

The measures of success in the Trust end of life strategy are being reviewed and will form part of the Trust Board committee dashboard from December.

Trust data quality, by exception

Data Quality RAG key

Red – Data accuracy is not known, it is incomplete and inconsistent

Amber – Data is assumed to be complete and accurate, although there may be limitations or unresolved queries

Green – Data is complete, accurate and consistent with the standards set for the specific indicator

Domain	Indicator	Data Quality RAG	Description of issues	Improvement action plan	Target date for 'Green' rating
Safe, Effective, Caring	% Complaints responded to within one month or agreed timescales with complainant	R	Operational and clinical pressures has meant it has been challenging to find the time for clinical and operational staff to respond to concerns on time.	The Unscheduled Care Division are recruiting a 0.5 WTE position to assist clearing the backlog. The team are recruiting a new complaints manager and have approach NHSP and agencies to fill the vacancy. The Surgery Division has held a complaints workshop to address backlog. The same will be done in Unscheduled Care. The Women and Children's Division are recruiting a post to deal with complaints. The Environment and Medicines Division have improved their response times considerably.	Recruitment expected to be completed by end of Summer. Improvements are hoped to be seen by end of 2017.
Safe, Effective, Caring	Complaints - rate per 10,000 bed days	R	Capturing complaints across the Trust.	All complaints are captured and triaged daily. All complaints are logged daily and there are systems in place to capture all complaints received through the CEO, executive assistants, through NHS net and on social media. Reminders are sent to all staff about forwarding complaints received in clinical areas. There is a system for auditing all new complaints taken through triage on the following day.	This risk is being minimised as much as possible.
Safe, Effective, Caring	Reactivated complaints	R	Increase in reactivated complaints	We telephone every reactivated complaint to talk through concerns. We consider if someone independent needs to investigate. We send reactivated complaints to external investigators in complex cases. We invite complainants to meetings to discuss their concerns. We now record the reason for reactivated complaints and will audit this. We have asked Healthwath Hertfordshire to review a pool of complaints and provide feedback. We will ask that they include a small pool of reactivated complaints also.	This risk is being minimised as much as possible.
Safe, Effective, Caring	VTE risk assessment*	A	Paper based VTE forms used for assessing compliance by clinical coding team. Evidence elsewhere within notes demonstrating compliance not on form not previously identified.	Clinical Advisory Group has approved new process for coding team to assess VTE compliance. Electronic system required to improve compliance to green.	July 2017 (Amber). Electronic system date of implementation TBC (for Green)
Safe, Effective, Caring	Caesarean Section rate - Combined*	A	Perception that there is a difference between caesarean section rate on CMiS compared to what has been clinically coded	Review of clinically coded notes and comparison to CMiS to review discrepancies	July 2017
Safe, Effective, Caring	Caesarean Section rate - Emergency*	A	As above	As above	As above
Safe, Effective, Caring	Caesarean Section rate - Elective*	A	As above	As above	As above
Safe, Effective, Caring	Stroke patients spending 90% of their time on stroke unit *	A			
Responsive	Ambulance turnaround time between 30 and 60 mins	R	Identified inaccuracies in timing of Ambulance Service data	Ongoing work with ambulance service	TBA
Responsive	Ambulance turnaround time > 60 mins	R	As above	Ongoing work with ambulance service	TBA
Well Led	Sickness rate	A	1. Potential for under reporting 2. There can be issues with data recorded on ESR but this will be fixed with the implementation of the new ESR 2 system.	1. HR undertook a number of audits to look into areas who were reporting 0% sickness throughout 2016 and have implemented learning from those audits, including a new process for capturing absences if medical staff. 2. implementation of the new ESR 2 system.	September 2017 (linked to the ESR implementation). There will also be ongoing audits to ensure that absence data is still being accurately recorded

Trust Board Meeting

5th October 2017

Title of the paper	**Quality Improvement Plan Progress Update (August data)**
Agenda item	10/52
Lead Executive	Tracey Carter, Chief Nurse and Director of Infection Prevention and Control
Author	Rita Oye – Head of PMO
Executive summary	*The aim of this paper is to provide information and assurance on the delivery performance of the quality improvement plan (QIP) submitted to the Care Quality Commission (CQC) on 8 October 2015 in response to the inadequate rating and entering special measures. The QIP has been consistently updated with a full review post the September 2016 inspection and subsequent report in March 2017.* There are 15 projects reported through the QIP reporting cycle this month. The overall status for the QIP at the end of August is green; the forecast status for September is also green. Two projects are rated red (ICT), with nine red actions (largely relating to the ICT projects). For the month of August 6 actions were closed, resulting in a total of 37 open actions for this reporting period. The progress updates and indicators contained in this report reflect August data, providing the Board with the most up to date information with regards to QIP delivery.
Where the report has been previously discussed, i.e. Committee/Group	Strategy Delivery Board (TEC) 13th September 2017

Action required:

The Trust Board is asked to accept this paper for ***information*** and ***assurance.***

Link to Board Assurance Framework (BAF)	**PR1** Failure to provide safe, effective, high quality care **PR2** Failure to recruit to full establishments, retain and engage workforce **PR3** Current estate and infrastructure compromises the ability to deliver safe, responsive and efficient patient care **PR4a** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – IM&T **PR4b** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – Information and information governance **PR5a** Inability to deliver and maintain performance standards for Emergency Care **PR5b** Inability to delivery and maintain performance standards for Planned Care(including RTT, diagnostics and cancer) **PR7b** Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure **PR8** Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation.
Trust objectives	X To deliver the best quality care for our patients X To be a great place to work and learn To improve our finances X To develop a strategy for the future
Benefits to patients/staff from this project/initiatives The QIP will deliver significant quality and safety improvements across the Trust in response to the CQC recommendations which will result in improved outcomes and patient experience.	

Trust Board – 5th October 2017

Quality Improvement Plan Progress Update (August)

Presented by: Tracey Carter, Chief Nurse and Director of Infection Prevention and Control

1. Purpose

1.1 The purpose of this paper is to provide information and assurance that the quality improvement plan (QIP) is being delivered effectively.

1.2 The QIP was formally submitted to the CQC and the Trust Development Authority (TDA), now NHS Improvement, on 8th October 2015 and is published on the Trust's website www.westhertshospitals.nhs.uk/CQC/. The QIP was refreshed following the full CQC re-inspection in September 2016 and a further full review has been completed in response to the publication of the CQC Quality Report in March 2017.

1.3 The QIP has been migrated onto the new project management software, PM3, which will be used for all major projects, including the QIP. The High Level Reports (HLRs) that detail the key actions and milestones for each project have been uploaded into the software and QIP Project Managers have been supported by the PMO team through 1-2-1 sessions in completing QIP HLRs on the new tool. QIP reporting from PM3 commenced from June reflecting the April data, this will continue through the monthly reporting cycle.

2. Background

2.1 To date (including this reporting period), eleven projects have been completed: Vision, Safe Staffing, Information Governance, Data, Recruitment, Caring for our most acutely unwell patients, Outpatients, Patient Flow, Capital Programme, Environment Estates and Facilities, Safety Equipment and Security. Clinical Training (Nursing).

2.2 The QIP is designed to deliver improvements in outcomes and key performance measures; the report shown at Appendix 1 contains the agreed key performance measures for the QIP as a whole.

2.3 This report summarises the progress of the QIP projects at the end of August 2017 and is reported using the Red, Amber and Green (RAG) rating.

2.4 There are 15 projects reported through the QIP reporting cycle this month. The overall status for the QIP at the end of August is green; the forecast status for September is also green.

3.0 QIP Programme Analysis

The Portfolio Performance Report below highlights the status of each project (Active plans), the status of each key milestone and the number, and status, of the risks and issues associated with each project. Information presented as Changes in the Active Plans and Key Milestones is a sample of the projects in the QIP and the full detail is presented in section 4 of this report.

Portfolio Performance Report - August 2017

Portfolio Name: QIP

Activity Trends

Active Plans - Delivery Status Trends

Current	Previous	Trend
2	2	—
0	0	—
14	14	—

Active Plans - Changes

Plan Name	Current	Previous
ICT and Information		
ICT Transformation		
Clinical Training		
End of Life Care		
Enviroment 2016 CQC review Action Plan		
Harm-free Care		
Leadership		
Maternity		
Medicine Management		

Risks

Risk	By When
The Sign Up to Safety PM left at sh...	
Health records library space issue	
Assessment areas are all bedded d...	
Partners ability to reduce no of DT...	
Delay to rollout of Estate Manage...	
CMIS system migration to the CGI ...	
Reduced establishment of Speciali...	
Potential not to capture learning fr...	
There is an action for Surgery to re...	

Risks - Trends

Current	Previous	Trend
0	0	—
0	0	—
28	33	▼
15	10	▲

Key Milestones - Status Trends

Current	Previous	Trend
12	9	▲
2	4	▼
23	30	▼

Key Milestones - Changes

Key Milestone Name	Current	Previous
Information collected and presented at compassionate care end of life car...		
Report indicator on monthly Integrated Performance Report. Indicator to ...		
Ward DNACPR champions to do a daily audit confirming that any patient ...		
Commence roll out of improved accessibility to Trust developed protocols ...		
Complete roll out of electronic medical records tracking programme (iFIT)		
Commence roll out of electronic assurance of diagnostic result review by c...		
Telephony (including Unified comms and Lync) rollout set up (in part)To re...		
End User Device Roll out including VDI rolled out to all End Users across ...		
Migrate clinical applications to new resilient offsite data centres (business...		

Issues

Issue	By When
CHC fast tracking funding	
PAS to CMIS Interface	
System Number	
There is no Project Manager in pos...	31/07/2017
IT in place to enable widespread e-...	
IT delays impacting upon impleme...	
Not achieving 24 hour discharge ta...	
DNACPR - Incompletion of the DN...	
Current learning management syst...	

Issues - Trends

Current	Previous	Trend
2	2	—
0	0	—
19	19	—
2	2	—

3.1 Activity Trends

3.2 In the current reporting period there are 15 QIP projects under the 1 QIP Programme making a total of 16 active plans this reporting period.

3.3 Of the 15 active QIP projects reported against in August 2017, there are 13 projects rated as green and 2 projects reporting as red; the red projects are the IT Transformation and IT Information projects (previously collectively known as ICT project).

3.4 Both IT projects are currently red. The reason for the overall red rating for the two IT projects is due to the impact of the response to recent cyber-threats, resource conflicts due to a raised number of priority 1 service incidents requiring remediation, and issues with supplier performance.

3.5 There are currently 4 projects with completed action plans. Medicine management and Environment 2016 CQC Review action plan projects will be formally closed this month. Safeguarding and Surgery will both remain as active projects as futher actions are due to be added to the projects

3.6 The PMO continues to work with the project managers to close or review the forecast delivery dates of the outstanding actions.

3.7 Key Milestones – Status Trends

3.8 There are 37 open actions within the QIP in this reporting period, this is a reduction from the 43 open actions last reporting period. 23 of the 37 actions are currently rated as green and are on track to deliver as agreed in the milestones, 2 milestones are rated amber, and 12 of the 37 open actions are rated as red; compared to 4 amber actions and 9 red actions in the previous reporting period. 6 actions have been completed in the month of August and closed.

4.0 Project Activity Detail – RAG Status and Expected Project Completion month by Project

Project Activity Details

							2017				2018													
							Q3	Q4			Q1			Q2			Q3			Q4				
Portfolio Name	Plan Type	Parent Plan ID	ID	RAG Summary Rationale	Sponsor	Plan Name	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		
QIP	Programme		213			QIP																		
	Project/ Scheme	213	252	Project Closed	Kevin How ell	Capital Programme																		
	Project/ Scheme	213	229	Project on Track	Tracey Carter	Clinical Training																		
	Project/ Scheme	213	227	Project on Track	Tracey Carter	End of Life Care																		
	Project/ Scheme	213	1019	Project on Track		Enviroment 2016 CQC review Action Plan																		
	Project/ Scheme	213	255	Project Closed	Kevin How ell	Environment, Estates, and Facilities																		
	Project/ Scheme	213	223	Project on Track	Tracey Carter	Harm-free Care																		
	Project/ Scheme	213	266	Project currently running behind schedule	Lisa Emery	ICT and Information																		
	Project/ Scheme	213	1168	Project currently running behind schedule	Lisa Emery	ICT Transformation																		
	Project/ Scheme	213	221	Project on Track	Paul Da Gama	Leadership																		
	Project/ Scheme	213	219	Project on Track	Tracey Carter	Maternity																		
	Project/ Scheme	213	217	Project on Track	Mike van der Watt	Medicine Management																		
	Project/ Scheme	213	215	Project on Track	Arla Ogilvie	Outpatients																		
	Project/ Scheme	213	1788	Project on Track	Tracey Carter	Paediatrics																		
	Project/ Scheme	213	235	Project on Track	Tracey Carter	Patient Feedback																		
	Project/ Scheme	213	277	Project Closed	Sally Tucker	Patient Flow																		
	Project/ Scheme	213	233	Project on Track	Tracey Carter	Quality & Risk																		
	Project/ Scheme	213	225	Project on Track	Tracey Carter	Safeguarding																		
	Project/ Scheme	213	286	Project Closed	Kevin How ell	Safety, Equipment, and Security																		
	Project/ Scheme	213	231	Project on Track	Jeremy Livingston	Surgery																		
	Project/ Scheme	213	237	Project Closed	Tammy Angel	Urgent & Emergency Care																		

4.1 The table above shows the current RAG status of each of the 15 live QIP projects. The table also details expected completion month by Project. Projects with no completion month are either red project; projects that have actions with no planned completion date detailed in their plan; or project with all actions completed and waiting to be formally closed (see 3.5). Work continues to deliver the approved actions. The PMO will work closely with project leads to agree planned completion dates.

5.0 Recommendation

5.1 The Trust Board is asked to accept this paper for ***information*** and ***assurance.***

Tracey Carter

Chief Nurse and Director of Infection Prevention and Control
September 2017

Appendix 1

Oversight Metrics Performance Challenges

A&E performance *(WGH time to initial assessment % within 15 mins) No baseline however, A&E performance declined again this month from June's 91.4%, 89.0% in July to 88.9% in August. This continues to be below the target of 95%*

Mandatory training compliance has declined slightly from 92.1% in June, 91.7% in July to 90.1% in August. HR continues to implement the new e-learning system although the 90% target has not been achieved in August as planned.

Outpatients Appointments:

Cancelled appointments increased in August to 4.1% from June's figure of 3.8%.

Vacancy rate:

The vacancy rate has increased slightly this month from 12.3% in July to 12.7% in August. Vacancy rate continues to be behind the trajectory.

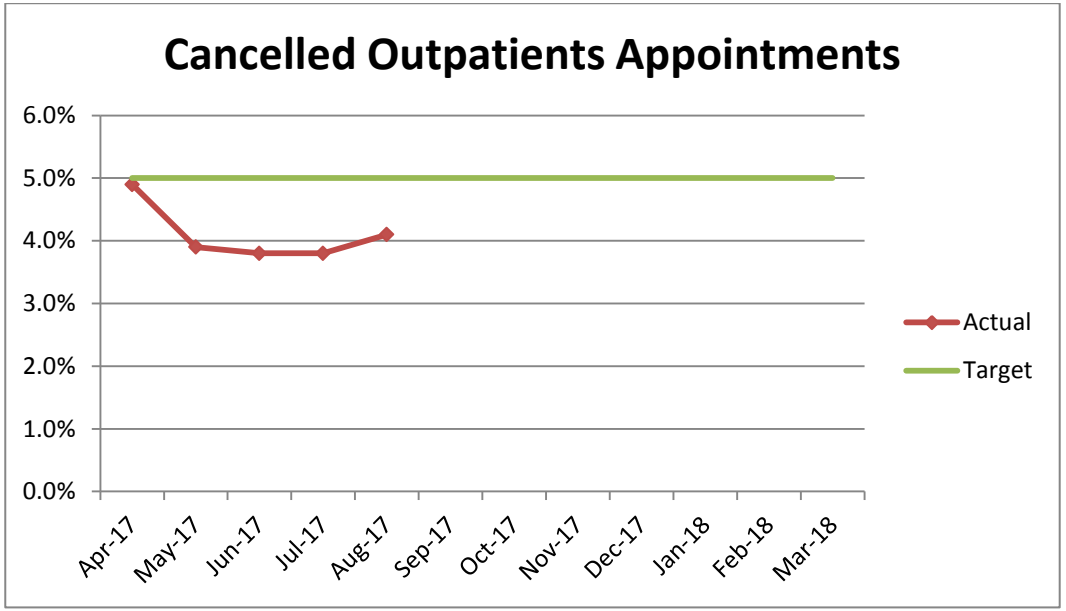
Harm Free care (Test Your Care):

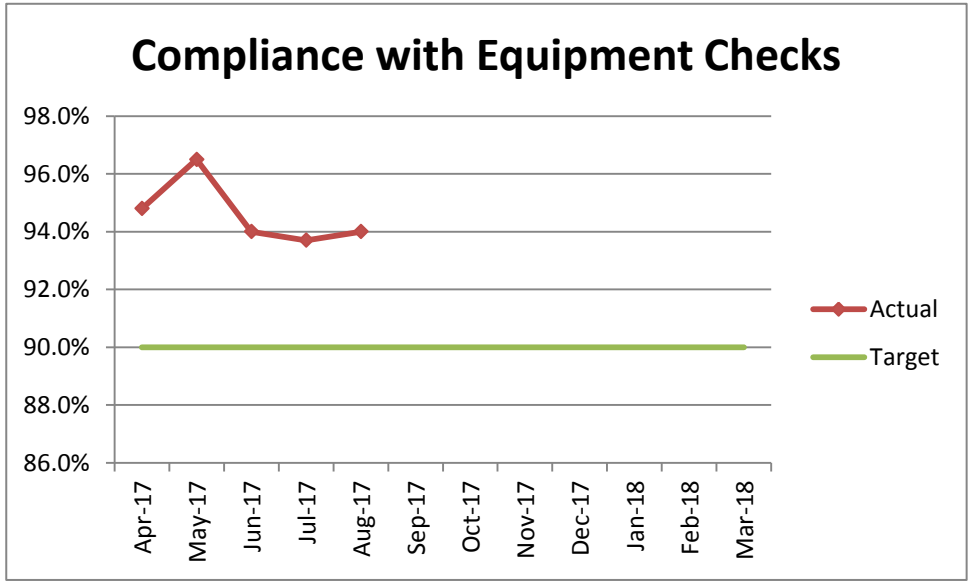
Compliance with equipment checks (Test Your Care excluding Maternity, Oxhey and Gade) continues to be above target at 93.7% in July to 94% in August (Target is 90%). Accurate Record Keeping improved slightly this month from 92.0% in July to 92.4% in August.

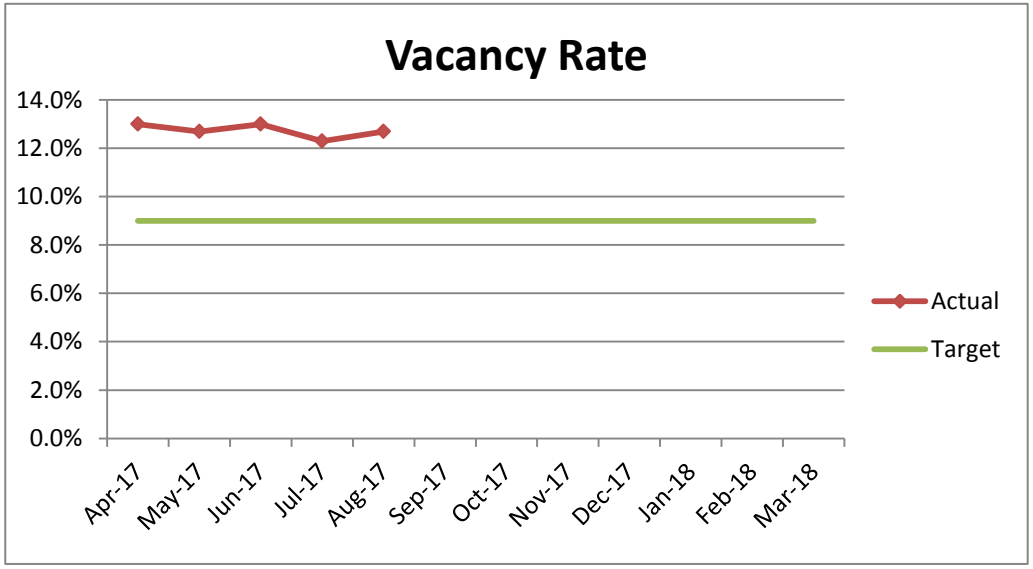
Appendix 1 – Oversight Metrics – August data

Theme	Project	Metric	Target	Performance														Trend
				Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	
Our People	Leadership and People Development	Mandatory Training	90.00%	86.0%	86.4%	87.7%	87.4%	89.4%	87.9%	87.7%	86.6%	87.2%	88.1%	86.5%	89.1%	87.7%	89.2%	92.1%	91.7%	90.1%	
Our People	Recruitment and Induction	Vacancy rate	9.0%	13.5%	14.2%	14.5%	15.2%	15.9%	15.7%	15.6%	15.2%	14.3%	13.5%	13.1%	12.5%	13.0%	12.7%	13.0%	12.3%	12.7%	
Our People	Leadership and People Development	Appraisal rate (non-medical staff only)	90.0%		76.5%	85.7%	89.2%	94.0%	91.7%	87.9%	84.6%	80.9%	75.9%	74.6%	73.2%	73.3%	76.5%	90.0%	90.0%	91.2%	
Our People	Safe Staffing	Red rated shifts (8 RN hours+ less then planned)	< 20%	8.6%	6.4%	8.8%	15.8%	19.4%	16.4%	14.2%	10.8%	17.2%	20.1%	16.6%	20.8%	21.0%	18.1%	19.3%	24.3%	32.4%	
Getting the Basics Right	Information Governance	IG breaches - Level 1	5	3	5	4	5	5	3	4	4	3	4	2	8	3	5	15	10	7	
Getting the Basics Right	Information Governance	IG breaches - Level 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Getting the Basics Right	Harm Free Care	Compliance with equipment checks (Test Your Care excluding Maternity, Oxhey and Gade)	90%	88.6%	90.1%	93.2%	93.6%	93.4%	93.3%	91.4%	94.0%	94.4%	92.2%	94.6%	94.9%	94.8%	96.5%	94.0%	93.7%	94.0%	
Getting the Basics Right	Harm Free Care	Medicines audits - (Drug omissions from quarterly Pharmacy audit)	5%		5.0%			5.4%	5.4%		7.1%					5.2%					
Patient Focus	Caring for our acutely ill patients	A&E performance (WGH time to initial assessment % within 15 mins)	95%	75.4%	75.0%	73.9%	76.4%	78.8%	79.5%	74.9%	80.4%	75.0%	78%	76.9%	75.8%	75.9%	87.3%	91.4%	89.0%	88.9%	
Patient Focus	Caring for our acutely ill patients	Returns to ITU within 48 hours		2	3	2	5	2	2	4	400.0%	7	1	5	7	3	4	2	5	3	
Patient Focus	Outpatients	Cancelled appointments with less than 6 weeks' notice by the hospital^	5%	5.3%	4.1%	3.8%	4.2%	3.7%	3.8%	3.7%	3.2%	3.6%	3.1%	4.1%	4.8%	4.9%	4.0%	3.8%	3.8%	4.1%	
Infrastructure	Environment, Estates and facilities	Completed Fire and H&S risk assessments	95%	98.9%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Infrastructure	Environment, Estates and facilities	Security - completed checkpoints	95%	92.2%	92.0%	87.7%	96.1%	99.5%	99.8%	99.0%	1	98.0%	99.0%	98.0%	99.0%	99.0%	100.0%	98.0%	97.0%	98.0%	
Governance, risk management and informed decisions	Quality Governance	Accurate record keeping (Test Your Care excluding Maternity, Oxhey and Gade)	90%	84.7%	85.6%	89.3%	90.0%	89.7%	89.5%	89.6%	1	91.6%	89.5%	92.2%	91.9%	93.1%	94.2%	90.8%	92.0%	92.4%	
Governance, risk management and informed decisions	Quality Governance	Number of SIs submitted to the CCG within time	95%			88.9%				66.7%	33.0%	83.0%	60.0%	50.0%	67.0%	29.0%	0.0%	100.0%	25.0%	100.0%	
Governance, risk management and informed decisions	Risk Processes	Risk - Completed SIs and complaints investigations with documented actions on Datix.	90%			100.0%				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Oversight Metrics Target v Actual – August Data







Appendix 2

REFERRAL TO TREATMENT PERFORMANCE IMPROVEMENT

August 2017 (July performance)

Plans must be put in to place to ensure referral to treatment (RTT) times continue to improve so that they are similar to or better than the England average

…to improve the percentage of patients to be seen within 18 weeks of referral from a GP for an outpatient appointment

Submitted performance

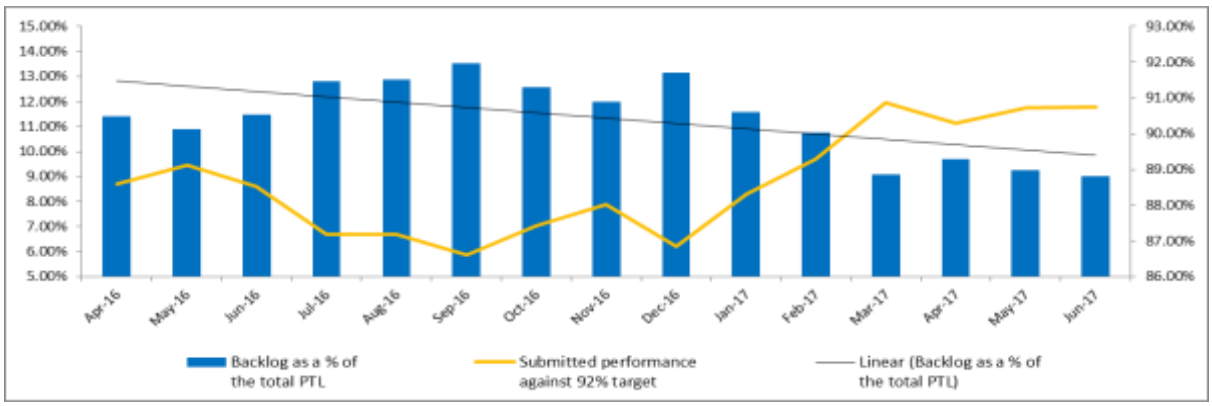
RTT performance for July was 90% a slight deterioration from June (90.7%). Recovery has been adversely affected largely as a result of several simultaneous operational challenges which have impacted elective theatre and bed capacity including the temporary unplanned closure of theatre 1 at WGH, the ongoing remedial ventilation works at SACH and emergency pathway pressures. In addition concerns regarding Orthopaedic surgical site infection have resulted in a restriction of elective activity while plans to create a discrete elective ward space and workforce are implemented.

However, WHHT continues to perform above the latest available national average, with performance in June at 90.7% against a national position of 90.3%.

Recovery trajectory 2017/18

	Apr-07				May-17					Jun-17				Jul-17				
Week commencing	03/04/2017	10/04/2017	17/04/2017	24/04/2017	01/05/2017	08/05/2017	15/05/2017	22/05/2017	29/05/2017	05/06/2017	12/06/2017	19/06/2017	26/06/2017	03/07/2017	10/07/2017	17/07/2017	24/07/2017	31/07/2017
Week	1	2	3	4	5	6	7	8	9	10	11	12	13	1	2	3	4	5
Operational standard	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Actual performance	89.6%	90.2%	89.9%	89.5%	89.5%	90.0%	90.5%	90.4%	90.2%	89.8%	89.7%	89.5%	89.9%	90.0%	89.8%	89.3%	89.1%	90%
Backlog to clear to achieve 92%	587	464	539	643	634	504	391	406	473	578	606	674	559	541	607	737	782	831

Performance and PTL 2017/18



Trust Board Meeting
05 October 2017

Title of the paper	**Annual report on Complaints and Patient Advice and Liaison Service (PALS)**
Agenda item	**11/52**
Lead Executive	**Tracey Carter, Chief Nurse**
Author	**Ian Stevens, Head of Litigation & Claims, SIs, Complaints and PALS**
Executive summary **(including resource implications)**	The annual complaints and Patient Advice and Liaison Service (PALS) report is presented to the Trust Board for information and noting. The report sets out the significant improvements that have been made to way that the trust responds to and learns from complaints and concerns raised. The report sets out the key themes and the learning that has been taken from the investigations into the concerns raised and highlights the priorities for the service for 2017/18.
Where the report has been previously discussed, i.e. Committee/Group	Safety and Compliance Committee – 10 August 2017 Quality and Safety Group - 22 August 2017

Action required:

- The report is provided for information and noting.

Link to Board Assurance Framework (BAF)	*[Please indicate which Principal Risk this paper relates to by double clicking on the corresponding box]* ☒ **PR1** Failure to provide safe, effective, high quality care ☐ **PR2** Failure to recruit to full establishments, retain and engage workforce ☐ **PR3** Current estate and infrastructure compromises the ability to deliver safe, responsive and efficient patient care ☐ **PR4a** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – IM&T ☐ **PR4b** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – Information and information governance ☐ **PR5a** Inability to deliver and maintain performance standards for Emergency Care ☐ **PR5b** Inability to delivery and maintain performance standards for Planned Care(including RTT, diagnostics and cancer)

	☐ **PR7a** Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency programmes ☐ **PR7b** Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure ☒ **PR8** Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation. ☐ **PR9** Failure to deliver a long term strategy for the delivery of high quality, sustainable care ☐ **PR10** System pressures adversely impact on the delivery of the Trust's aims and objectives PR6 – business continuity has been closed (incorporated into PR1)
Trust objectives	*[Double click on the box to mark as appropriate]* ☒ To deliver the best quality care for our patients ☐ To be a great place to work and learn ☐ To improve our finances ☒ To develop a strategy for the future

Benefits to patients/staff from this project/initiatives

Reviewing contacts with the patients/members of the public in the local community in which we serve provides a useful insight into what they think of our services and this analysis provides us with the tools to ascertain the areas for the coming financial year to concentrate on to ensure we delivery high quality and responsive care that meets the local populations needs.

Risks attached to this project/initiatives and how these will be managed

Failing to learn from incidents, concerns and compliments raised in connection with the organisation.
Failing to listen to the local population.
Inability to provide a responsive service, which responds in real time to feedback provided.

ANNUAL COMPLAINTS REPORT

Analysis of Formal Complaints

2016-2017

1. INTRODUCTION

Complaints, patient surveys, feedback forms and Patient Advice and Liaison Service (PALS) contacts are useful feedback tools about the care and treatment West Hertfordshire Hospitals NHS Trust provides to our patients.

The PALS and complaints team work closely together to resolve concerns that can be addressed quickly outside of a formal complaint response. All formal complaints received have been investigated through the Trust's complaints procedure.

The trust launched its inaugural Patient and carer experience strategy in November 2016 setting out four key priorities that will ensure the experience our patients and carers have will continue to improve.

West Hertfordshire Hospitals NHS Trust received 822 complaints in 2016/17 (down from 850 in the previous year). In the same time we responded to 597 complaints where consent was received. We still investigated 52 complaints where we did not receive consent in order so that we can identify any learning and manage any risks. We responded to, on average, 42% of all complaints on time during 2016/2017 (an increase in the average response time from the previous year). Of the complaints we responded to with consent 72% of complaints were upheld or partially upheld, which is a 13% increase on the previous year.

There were 14 complaints referred to the Parliamentary Health Service Ombudsman (PHSO) during the year. We received 13 draft reports and 16 final reports from the PHSO. 8 were upheld or partially upheld by the PHSO, which is 50% of all the files decided upon during the same period.

The CQC re-inspected the Trust in September 2016 and the results were published in March 2017. During their inspection, the Care Quality Commission (CQC) found that complainants were not responded to in a timely way. . The CQC said the Trust lacked a systematic approach to the reporting and analysis of complaints and there was little evidence of trust wide learning and limited actions to improve patient's safety across the Trust. In response to this the team has introduced a number of initiatives, including learning events, a new approach to triaging, new techniques for reporting information and monitoring complaints and better scrutiny.

Complaints will often trigger improvements to our processes resulting in improved services as staff endeavour to learn from negative patient experience. Work continued throughout 2016/17 to ensure that complaints data was shared across Divisions and with subject expert leads, for example end of life care team. Trust wide monitoring of complaints and concerns is monitored in order to ensure appropriate improvement actions are identified, monitored and discussed at relevant committees.

Complaints and their responses are seen by members of the Trust Board and all are signed off by either the Chief Nurse or the Medical Director and the Chief Executive.

The purpose of this report is therefore to:

- Provide assurance that the Trust follows its Policy for the Management of Concerns and Complaints
- Provide an overview and analysis of complaints and PALS concerns received in 2016/17
- Show examples of complaints which have been used to assist in learning lessons and to improve the quality of patient care during the year
- Set out recommendations where further improvements could be made to both the complaints and PALS process and how the Trust learns from formal and informal complaints received from patients and their carers

2. Overview of compliance with the Trust Management of Concerns and Complaints Policy

2.1 Complaints performance, themes and trends are monitored by the trust board via the Patient and Staff Experience Committee (PSEC) and the Safety and Compliance Committee. Complaints performance is monitored in the Divisional Governance Meetings and the Divisional Performance Meetings, chaired by the Chief Operating Officer. Complaints are monitored and tracked weekly by the Complaints Manager.

2.2 Whilst significant improvements in the way complaints are responded to has been acknowledged both internally and externally, the risk to fully complying with the regulatory requirement to respond to, and learn from complaints, was recognised as a corporate risk in quarter two of 2016/17. The risk was captured and accepted onto the corporate risk register, where the mitigating actions, controls and assurances which included the monitoring of a 90 day improvement programme, were monitored through the Risk Review Group.

2.3 Building on the internal audits that were completed in 2015/16 the trust internal auditors, RSM, completed an audit of the learning in relation to complaints. The results will be available in quarter 1 of 2017/18. Healthwatch Hertfordshire have also been invited back to follow up on their successful qualitative review completed in 2015/16.

2.4 To strengthen the trusts approach to the management of complaints a 90 day improvement plan was completed in quarter two, resulting in the introduction of a new approach to responding to Ombudsman investigations, improvements in the way data is recorded in relation to complaints and coupled with a strengthened approach to triaging complaints, reflecting national guidance and ensure that risks associated with managing of complaints are managed.

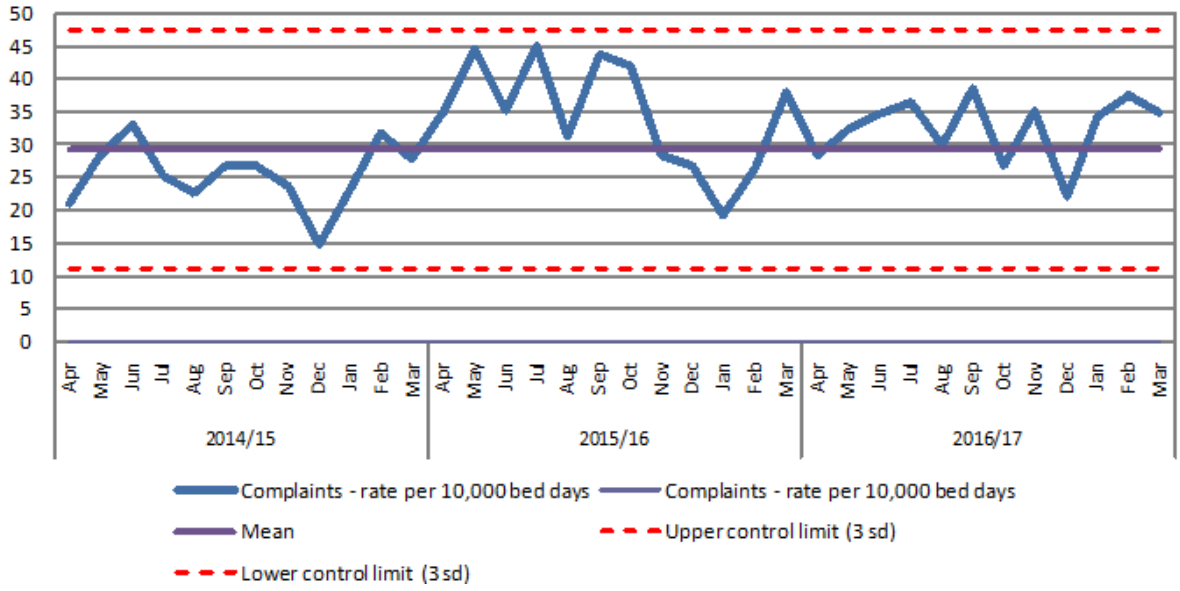
3. Analysis of complaints and concerns received in 2016/17

3.1 In 2016/2017 there was a large focus on the quality of data recorded in order to ensure we provide robust assurances to the Board, commissioners and regulators. This included a series of exercises validating and updating existing data and identifying areas of poor data quality. We introduced new data sets, and projects to improve how we inform the Board of themes and trends in relation to complaints received and this information is available in real time on the datix dashboard for all staff to access. This will enable staff to act decisively and manage risks to the service. Comparing data with the themes and trends should be done with caution as the quality of the data has improved.

3.2 The successful upgrade of the Datix software has led to improved coding including expanding the outcome codes, reasons for complaints reopening, clarity over complaints referred to the Ombudsman and when complainants contact the media, their MPs, our commissioners and regulators.

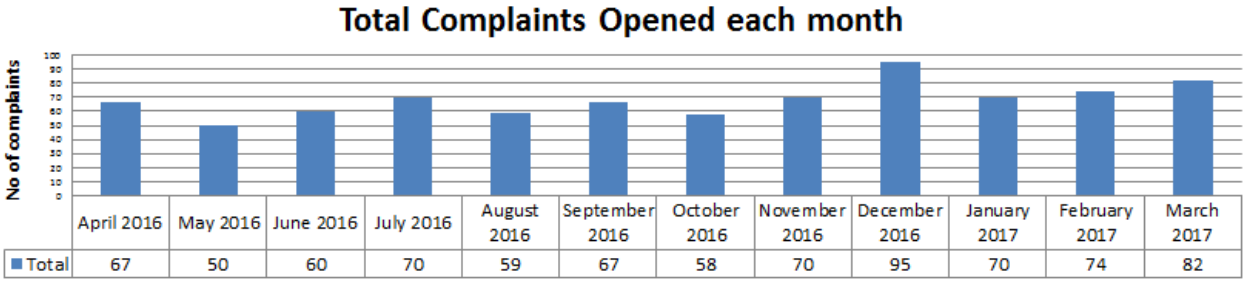
3.3 The chart below **(Fig 1)** records complaints per 10,000 bed days, this is reported monthly to the Trust Board and allows for national benchmarking. Following 2015/16 the number of complaints does not fluctuate so profoundly. The seasonal peaks in complaint rates are consistent with what is seen nationally. The changes in responses reflect seasonal leave periods and operational pressures.

Fig 1: Number of complaints – rate per 10,000 bed days



3.4 The Trust received ***822 complaints*** (down from 850 in the previous year) as highlighted in **Fig 2**.

Fig 2: Number of complaints opened each month



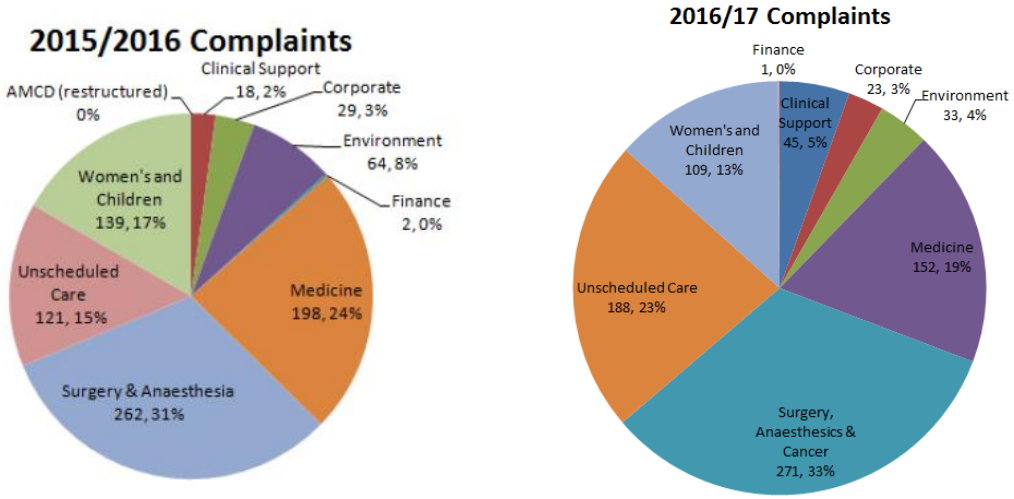
The spike in complaints received in December 2016 reflects the work done throughout the 90 day improvement plan which includes validating the unclassified and unrecorded complaints and PALS contacts.

3.5 Complaints that are Serious Incidents

There were 2 complaints investigated as a serious incident.

3.6 The charts below (Fig 3) show the complaints received by division. The changes in divisional structures need to be taken into account with the large variation between the two years for the medicine and USC divisions.

Fig 3: The pie charts below shows the complaints by division in 2015/16 & 2016/17



3.7 **Fig 4 & Fig 5** shows the number of complaints broken down by clinical and non-clinical division. Within the environment division the most complaints received were about car parking. Within the clinical support services the most complaints received were in connection with the radiology department. Within the corporate division the most complaints were around discharge planning. Within the finance team the complaint was about overseas charges.

In Surgery, Anaesthetics and Cancer, Trauma and Orthopaedics (34%) received the highest number of complaints followed by General Surgery (22%) and then Ear, Nose and Throat Services (12%).

In Unscheduled Care, Emergency Care (55%) followed by Care of the Elderly (24%) and then General Medicine (18%) received the most complaints

In Medicine, General Medicine and Sub Specialties (27%) received the highest number of complaints, followed by Cardiology (19%), Respiratory (9%)and then Gastroenterology (9%).

In Women's and Children's the department of Midwifery received the most complaints(49%) followed by Gynaecology (23%).

Fig 4: chart showing number of complaints by support divisions by month

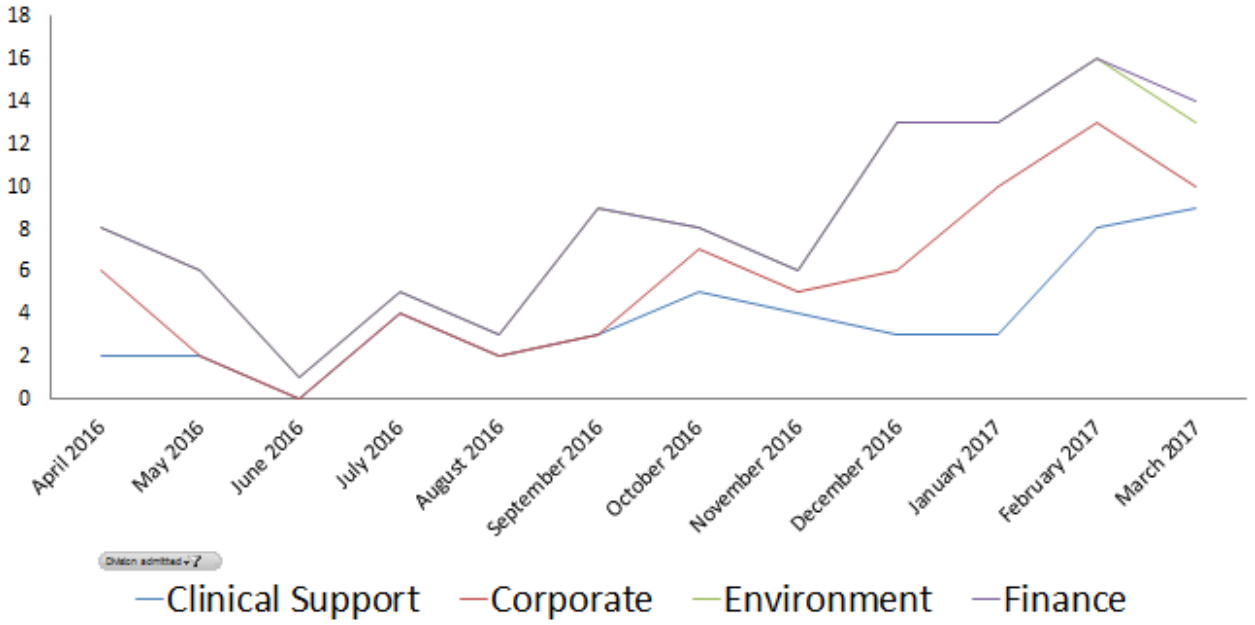
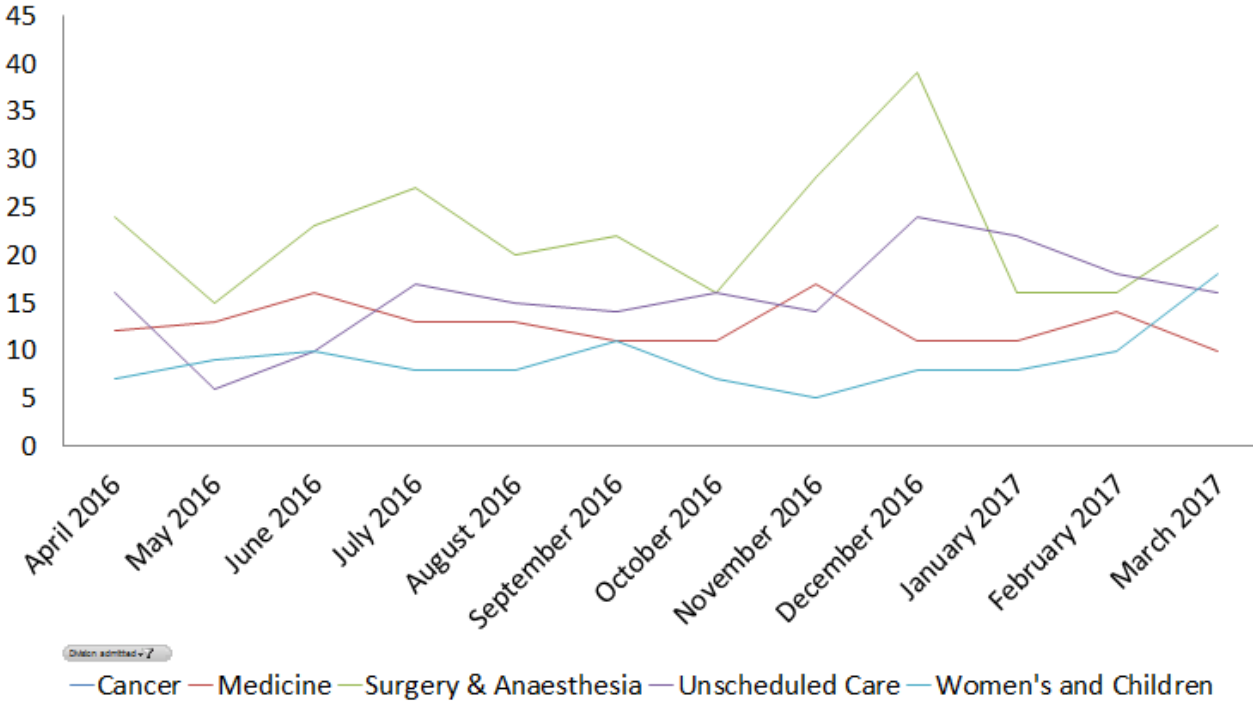


Fig 5: chart showing number of complaints by clinical division by month



3.8 During 2016/17 we dealt with 68 complaints via a local resolution meeting. **Fig 7** shows the number of LRMs by division and **Fig 8** shows the % as per complaint. Face to face resolution of concerns is considered the most effective way to resolve concerns and with the most positive outcome.

Fig 6: The chart below shows the number of LRMs in 2016/17 for each quarter

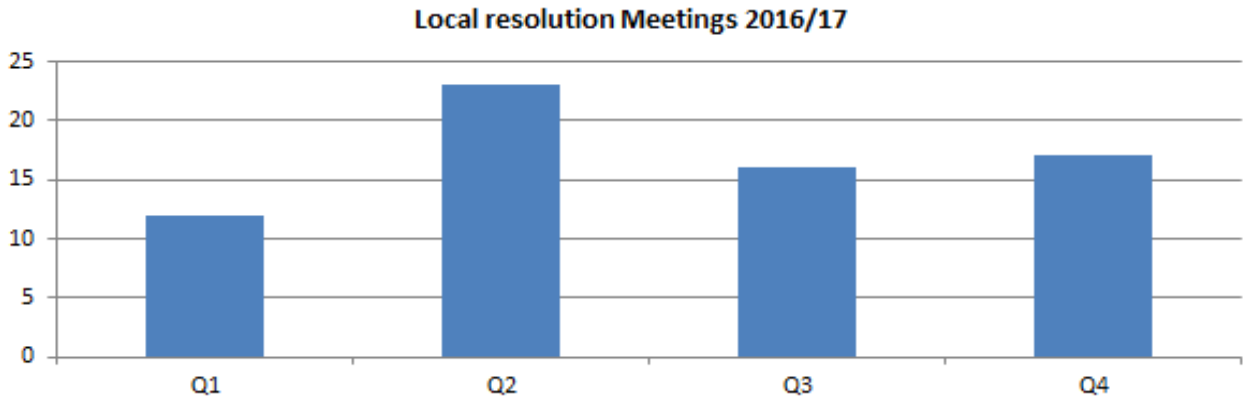


Fig 7: The table below shows LRMs held by divisions and % total of their total complaints.

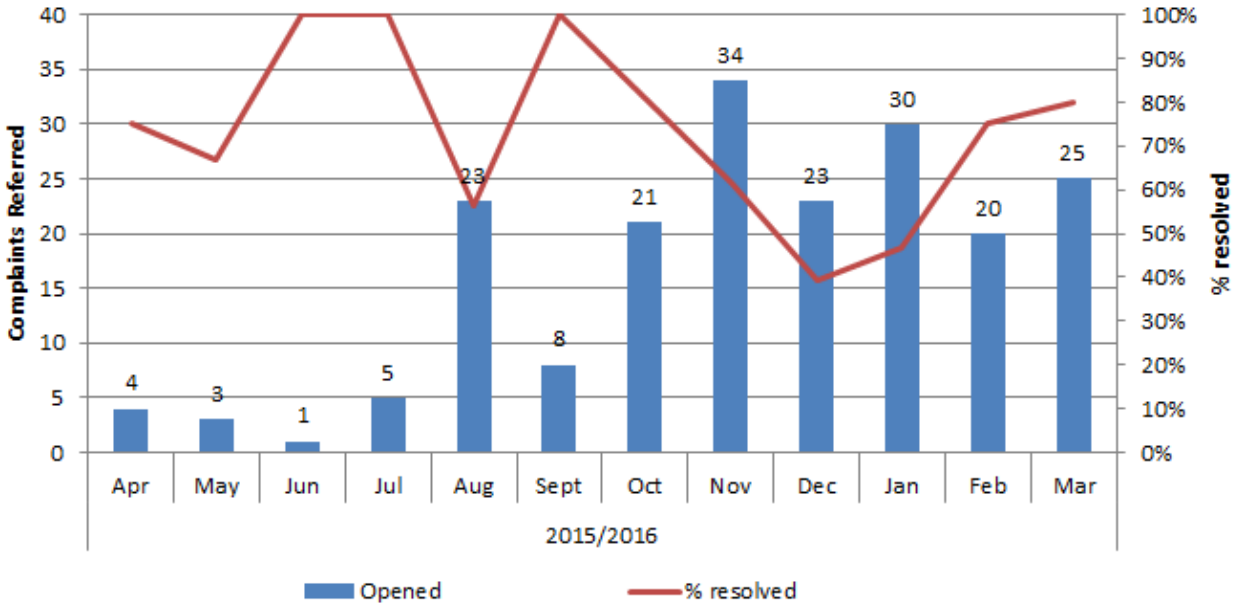
	Q1	Q2	Q3	Q4	Total	%
Clinical Support			1	1	2	
Corporate			1		1	
Environment		1			1	
Medicine	1	2	3	2	8	5%
Surgery & Anaesthesia	2	6	5	3	16	6%
Unscheduled Care	6	5	1	3	15	8%
Women's and Children	3	9	5	8	25	23%
Grand Total	12	23	16	17	68	

*Note it is not common practice to hold an LRM for any of the support divisions.

The women's and children's division use this approach more than any other division. All aspects of clinical treatment is the subject of most complaints handled by way of a local resolution meeting. Followed by complaints about staff attitude and communication.

3.9 The Trust continues to promote early face to face communicating with complainants to allay their concerns and establish a local resolution. We continue to use the Lead Nurse for Resolution as a means to achieve this. The Lead Nurse for Resolution also now leads the Patient Advice and Liaison Service and bridges that gap between PALS and Complaints offering that support to capture informal concerns before they escalate to become a complaint. **Fig 8** shows the number of referrals to the lead nurse and & resolved. This chart demonstrates that this is a proven successful way of resolving concerns and within an acceptable timeframe, with all referrals resolved in 65% of all cases on average last year. We accept that in August and December there is a dip in success when the Lead Nurse takes the majority of her annual leave.

Fig 8 The chart below shows the number of referrals to the lead nurse and % resolved within 25 working days.

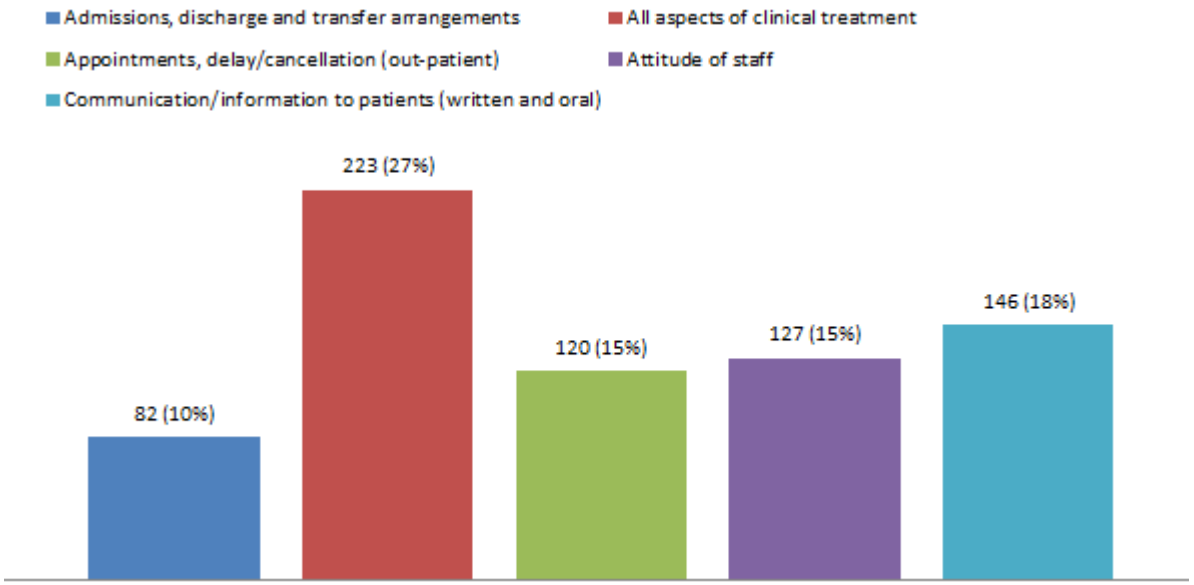


3.10 What do our patients and their relatives complain about?

We use nationally reported subjects (KO41s) to analyse the main reasons for patients complaining. We do however also use a separate subject matter list of reasons to drill down into the information further.

**Note, we include complaints we are unable to investigate, where consent has not been provided or where the complaint has been withdrawn to ensure we capture all areas of risk within the organisation, which people are complaining about.

Fig 9: shows themes and trends of Trust wide complaints (KO41s)



Clinical Care and treatment is the main reason why service users complain about our services. Followed by communication, then attitude of staff and thereafter appointments.

Fig 10: shows the top 5 themes by clinical division

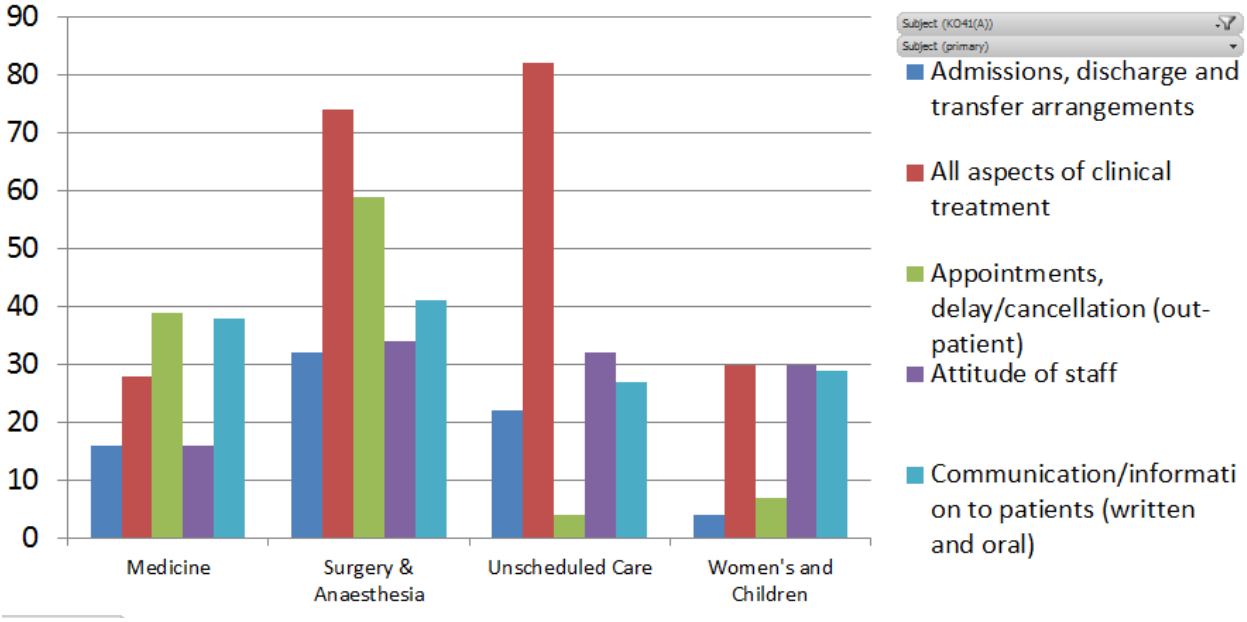


Fig 11: Table showing breakdown of top 5 themes in each clinical division (%)

	Admissions, discharge and transfer arrangements	All Aspects of clinical treatment	Appointments, delay/ cancellations	Attitude of Staff	Communication (information to patients, written and oral)
Medicine	12%	20%	28%	12%	28%
Surgery, Anaesthetics and Cancer	13%	31%	25%	14%	17%
Unscheduled Care	13%	49%	2%	19%	16%
Women's and Children's	4%	30%	7%	30%	29%

Clinical Care was the highest for nearly all of the divisions, however in keeping with challenges around appointments and patients complaining they are unable to speak to someone directly to allay their concerns, communication and appointments were also considerably higher than previous years.

3.11 Where and why did patients and relatives complain about Clinical Care?

The location with the highest number of concerns was in Accident & Emergency Department. The ward that received the highest number of complaints was Sarratt Ward;

this is also one of our largest wards caring for the largest number of patients. The speciality receiving the most complaints about clinical care is the Emergency Department (20%) followed by Trauma and Orthopaedics (13%) and thereafter General Surgery (8%), Care of the Elderly (8%) and Midwifery (8%). 56% of complaints relates to the doctors, 35% related to nursing staff.

3.11 Where and why did patients and relatives complain about the attitude of our staff and the way we communicate and provide information?

The location with the highest concerns raised about attitude of staff was again in the Accident & Emergency Department, followed by outpatients. The place where patients considered our communication poorest was also in outpatients. The speciality with the poorest communication was Emergency Care (13%), followed by midwifery (12%) and then Trauma and Orthopaedics (9%).

3.12 Where and why did patients and relatives complain about the delay to appointments and cancellation of clinical care?

The location where the highest number of complaints around appointments is in outpatients. With the Surgery, Anaesthetics and Cancer Division with the highest number of complaints in this area, followed by Medicine. Women's and Children's have very few in comparison. The Trauma and Orthopaedic Service has the most complaints in this area (20%), followed by Ear Nose and Throat (12%) and Cardiology (12%) Service had the most complaints about appointments. Ophthalmology (7%) also had a higher than other services complaints in this area.

3.13 Where and why did patients and relatives complain about their experience relating to their admission, discharge and transfer of care?

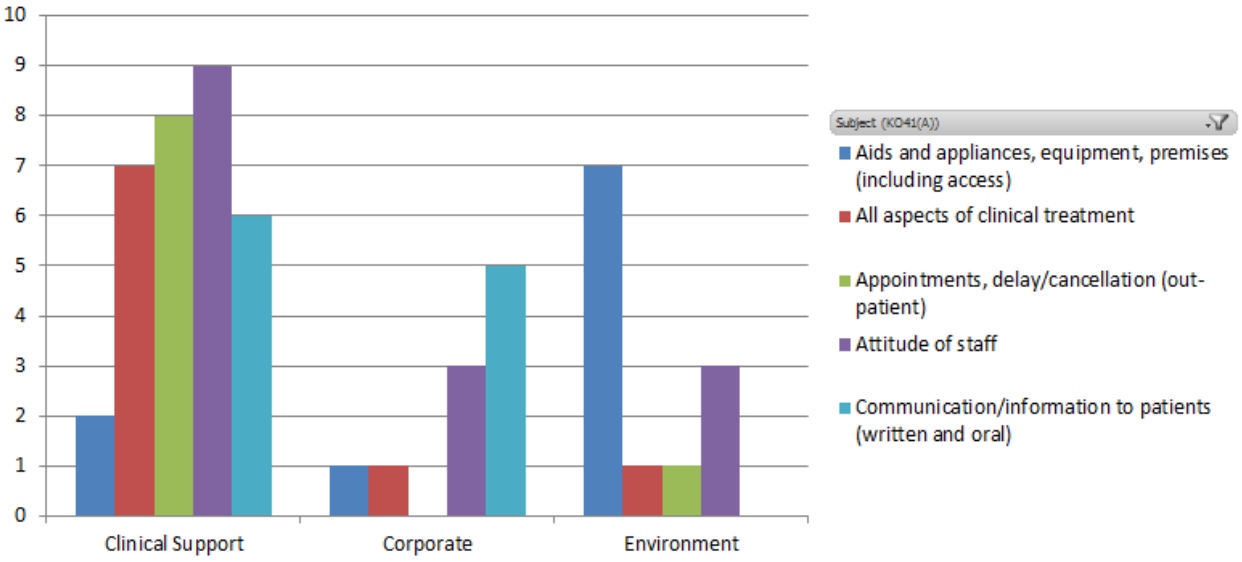
The Division with the highest of complaints in this area was the Surgery, Anaesthetics and Cancer Division, followed by the Unscheduled Care Division. The specialities who had the most complaints about admissions, discharge and transferring of care were Emergency Care (19%), Trauma and Orthopaedics (18%), General Surgery (16%). 49% of all complaints in this area relates to the doctors.

3.14 Comparison with the previous year.

Complaints connected with the Trauma and Orthopaedic Department and General Surgery Department remain the highest. Although there has been significant improvement for the Trauma and orthopaedic department around appointment. Attitude of staff for the care of the elderly service did not feature in this year's report, where it was the highest in the previous year.

3.15 Where and why did patients complain about our support services?

Fig 12: The graph below highlight top themes around our complaints received within the support division.



Within environment division he majority of the complaints are around transport issues, with delays in transport providers being the most contacted reason for complaints followed by complaints around parking and state of repair of the facilities, including the car park and transport facilities.

3.16 Where in the Trust are patients and relatives complaining about?

Following validation of some of the data we are able to consider what parts of the Trust receive the most complaints as oppose to the highest subjects of complaints. This area of recording has been changed to be mandatory on all newly opened complaints. This will mean that in all future reports we can pin point the exact location patients are complaining about.

110 (13%)of all complaints related to the Accident and Emergency Department. 17 relate to clinical practice and 15 of them relate to staff attitude.

63 (8%) of all complaints related to the Outpatient department. With the majority of these around appointments and communication.

The wards with the highest complaints were Sarratt Ward (2%) and Elizabeth Ward (2%). With the highest complaints around communication and nursing care.

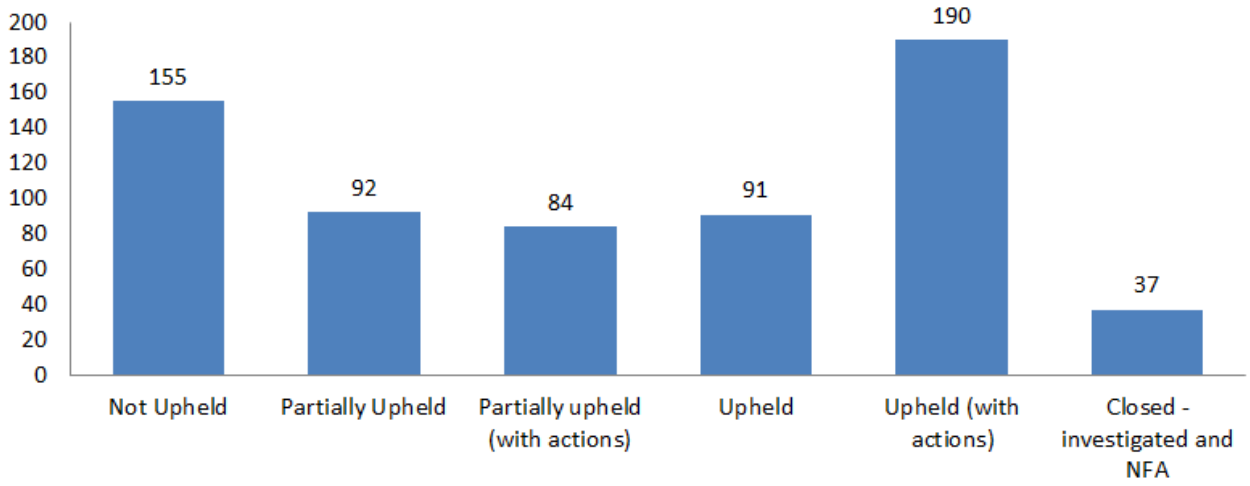
3.17 Which staff group receives the most complaints concerning communication and attitude?

Representing the Trust's values is very important and is central to the Trust's yearly values based appraisal assessment. Learning where we are receiving complaints about staff attitude is an important tool to learn where leadership in the Trust's values may require some additional support.

54% of complaints about communication relate to the doctors (outpatients scoring the highest), 29 % relate to nursing staff (Elizabeth Ward receiving the highest, followed by the Accident and Emergency Department).

4. Complaint Outcomes

Fig 13: The graph below shows the outcomes of complaints Trust wide



Note that we no longer use the outcome code – 'Closed – No Further Action (NFA)'. It has instead been replaced by 'Closed – Investigated and NFA'. With the addition of new outcome codes, this number has dropped considerably and is now used to show how many complaints we investigate where there is no action to take.

The divisions with the highest number of upheld/partially upheld are as follows:

Surgery, Anaesthetics and Cancer – 77%

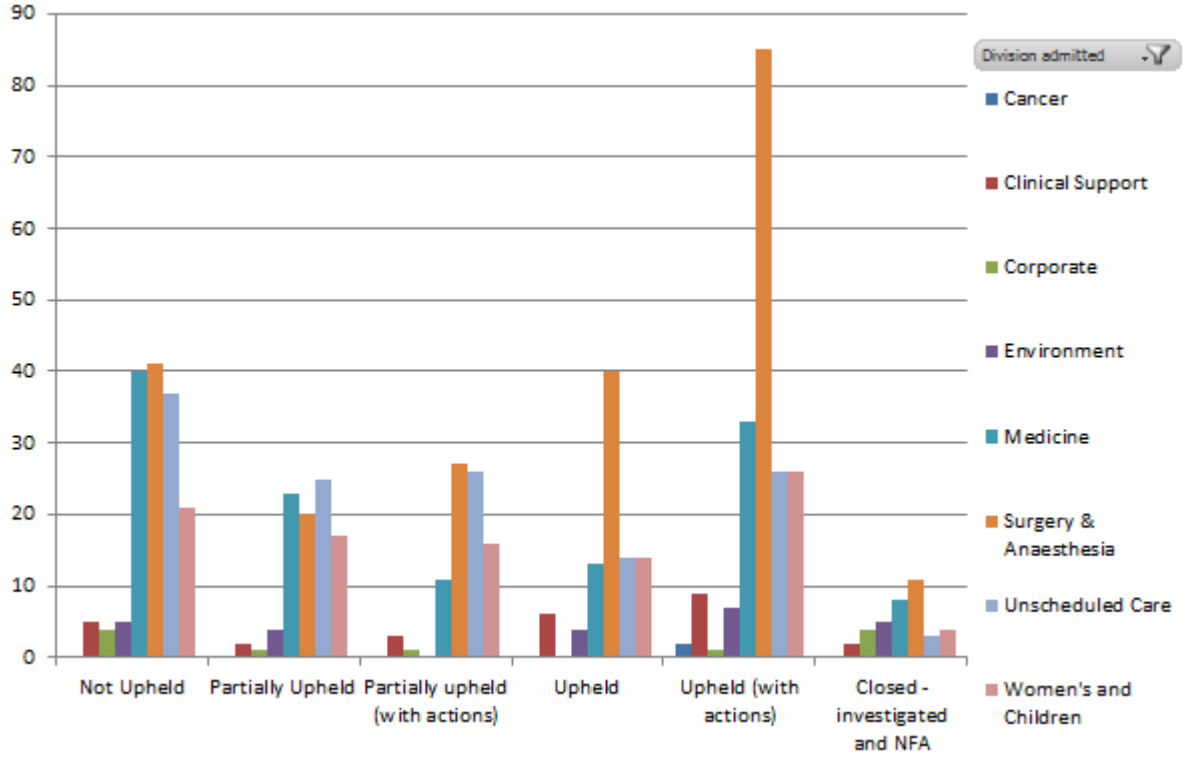
Women's and Children's – 75%

Unscheduled Care – 70%

Medicine – 63%

Environment – 60%

Fig 14: Outcome broken down by Division



4.1 **Fig 15: Top 5 subjects for complaints – upheld or partially upheld per division**

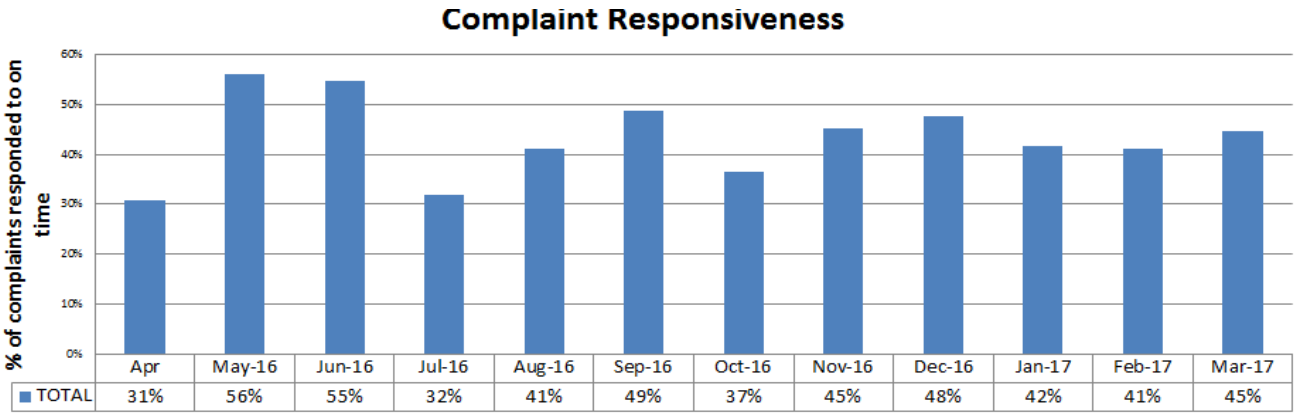
	Medicine	Surgery, Anaesthetics and Cancer	Unscheduled Care	Women's and Children's	Clinical Support Services
Admissions, discharge and transfer arrangements	8	28	13	5	2
All aspects of clinical treatment	12	40	33	18	3
Appointments, delays and cancellations	28	46	2	7	2
Attitude of Staff	5	20	15	14	4
Communication	21	27	16	26	3

5. Complaints Performance

5.1 The Trust has set a target, one that has been mutually agreed with our commissioners, to respond to 85% of all complaints within agreed timescales. The Trust sets deadlines of 25 working days for standard complaints, 35 working days for complex complaints and 20 working days for local resolution meetings to be held.

5.2 Of the 719 complaints closed during this period 43% of those that could be responded to were responded to on time. This is an increase from 36% in the previous year.

5.3 **Fig 16: Complaint response compliance during 2016/2017**



	Apr	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
TOTAL	31%	56%	55%	32%	41%	49%	37%	45%	48%	42%	41%	45%

5.4 Complaints performance is monitored weekly using a RAG tracker, which is cascaded throughout the Trust. The document provides an overview of all open complaints within the organisation and indicates performance by way of 'Red' to highlight complaints which have breached an agreed response timeframe, 'Amber' for those complaints which are due within 7 days of the tracker being generated and 'Green' for complaints which are under investigation but still in time. The Tracker also shows which complaints have been scheduled for an LRM following agreement with the complainant.

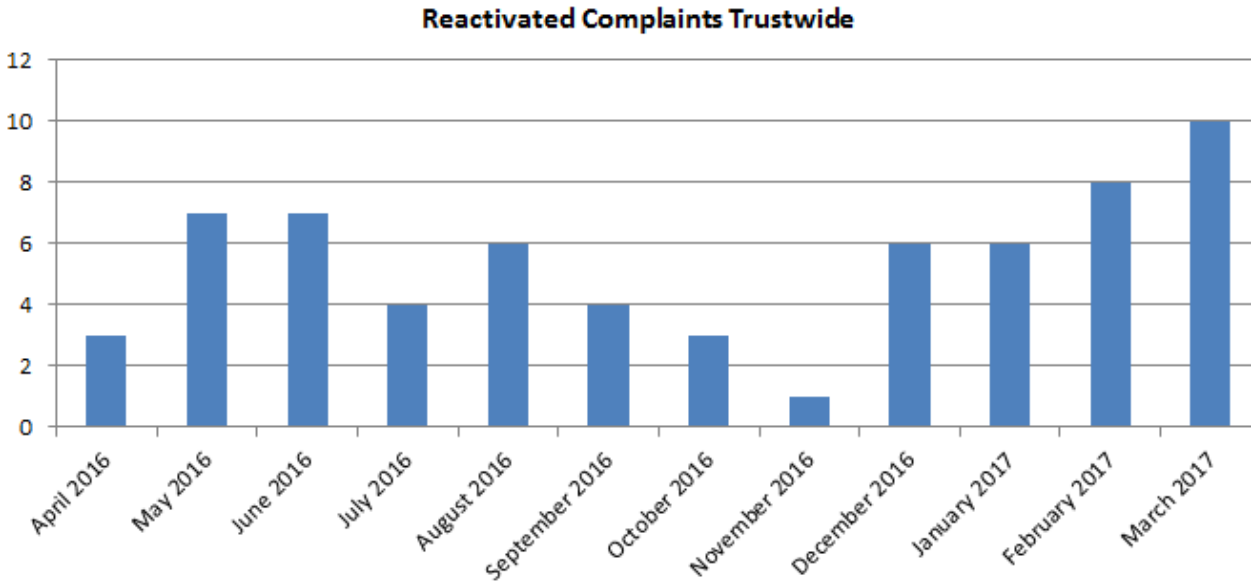
5.5 The Corporate Complaint Advisors, who are each assigned responsibility over a particular division, meet on a weekly or fortnightly basis with their divisional colleagues to address the performance of complaint investigations.

5.6 The Corporate Complaints team have met with individual Divisions to assist and support them with clearing a backlog. However, with operational pressures this isn't consistently followed through and maintaining a good level of response times is a challenge.

5.7 Using a new system of triage since December 2016 we decide when the complaint is received the best course of action for dealing with the complaint. A discussion is had among the Corporate Complaints team the best course of action and agreed deadline for responding. The Complaint Administrator logs the complaint and ensures the date is correct. The Complaints Manager then validates the newly logged complaint to ensure correctness and offer any support or suggestions to the plan formulated. This process takes place daily and since its introduction has proved most effective for ensuring the appropriate management of concerns as and when they are received.

6. Reopened Complaints

Fig 17: The graph below shows the number of reopened complaints by division for the year.



6.1 As part of the new triaging process, when there is a reactivated complaint the team ensure it is flagged as reactivated immediately, so to ensure correctness of data. This new approach and consistent application we believe is the reason for an increase in the number of reopened complaints and not because of poor quality of responses. We have introduced a new field where we can record the reason for the complaint being reopened. 33% of the responses reopened were because the complainant was dissatisfied with the response. Whereas only 5% was because they felt the response was incomplete. However, the completeness of this data has not undergone a data validation exercise.

6.2 Of all of the complaints reopened only three subjects stand out. The largest was all aspects of clinical care, followed by Attitude of staff and then communication. There has been a considerable reduction in reopened complaints as a result of appointments and we put this down to a new and more dedicated approach to doing out utmost to organise appointments for patients. In addition to this the Trust has organised additional clinics, recruited more clinicians and out sourced patient's surgeries to local private units in order so to manage any issues with capacity.

7. MPs, CCGs, CQC and Media contact

7.1 This year we have introduced a new optional field for adding when a complainant has contacted their local MP, the commissioners, regulators or the media. We can now record who has contacted the media and there are plans to introduce a way of recording when this happened also. It is not possible to review all historic complaints to ensure accuracy of this information. It was introduced in quarter 4 of this year.

7.2 For all complaints opened in 2016/17.

- 5 complainant's also contacted our Commissioners (Herts Valley CCG). 3 of those complaints related to appointments and waiting time for appointments. 2 related to clinical care. In only 1 of the complaints did the complainant contact the Trust before contacting the CCG.

- 4 complainant's contacted the Care Quality Commission (CQC). In 1 of the responses, the complainant has reopened their complaint because they felt the response was incomplete. We also did not uphold their complaint.

- 24 complainant's contacted their local MP to support them. There is no clear indication of the type of complaint where people would involve their MP. They involved clinical care and appointments as the highest subjects. 5 had reopened complaints.

- 3 complainant's involved the media. 1 complainant gave no warning and went straight to the media. Another is a well-known complainant whose expectations have been difficult to manage and has raised several complaints over many years and is well known to front line staff.

7.3 In all of the complaints where outside interest was sought, a local resolution meeting was either not offered or offered and refused in every case. It is currently not possible to determine if someone contacted their MP when they first complained or after they first complained. This is an improvement intended to be introduced in the coming year.

Parliamentary Health Service Ombudsman (PHSO)

7.4 There were 14 complaints referred to the Parliamentary Health Service Ombudsman (PHSO) during the year. We received 13 draft reports and 16 final reports from the PHSO. 8 were upheld or partially upheld by the PHSO, which is 50% of all the files decided upon during the same period. There are currently 5 open referrals where a decision has not been made at the time of writing.

7.5 None of the complaints referred to the Ombudsman have been recorded as reopened. This is more likely because improvements to the management software had not been introduced to record this.

7.6 In nearly all of the PHSO files referred they related to complaints around the clinical care as the primary reason for the complaint.

7.7 7 (50%) of the files referred relate to complaints connected with the Surgery, Anaesthetics and Cancer Division. 4 of those relate to Trauma and orthopaedics and 3 relate to General Surgery. 4 relate to Unscheduled Care, 1 relates to women's and children's, midwifery.

7.8 In all of the referrals, which were upheld or partially upheld the Trust has been asked to write a letter of apology and confirm what actions have been taken as a result of the findings of an investigation report.

7.9 In 1 referral we are challenging the findings of the independent expert and a decision is likely to be made in the next year whether this will be accepted or not.

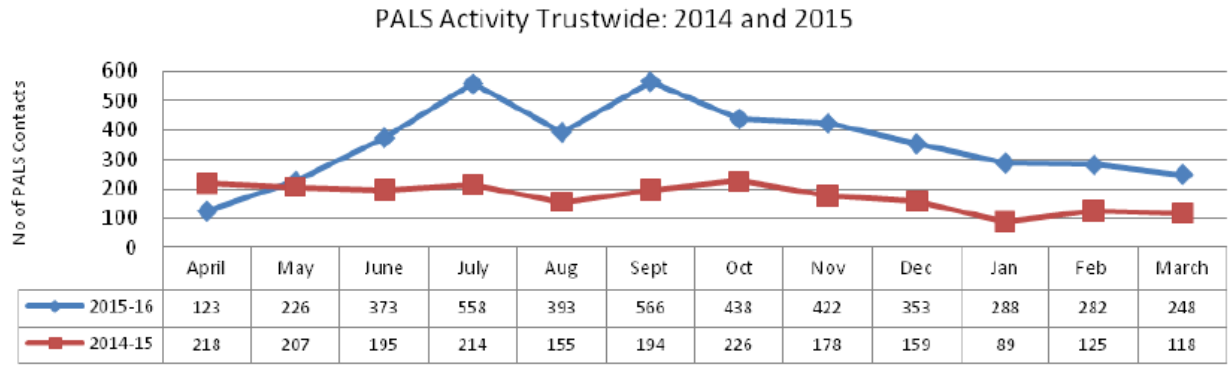
8. Patient Advice and Liaison Service (PALS)

8.1 PALS is the first point of contact to help patients and visitors with questions, concerns and suggestions about our services. PALS provide professional, friendly, confidential services and offers on the spot support to help resolve any problems. PALS continues to be an integral part of the service we provide to our patients, relatives, carers, acting as a vital channel for feedback. The PALS team also deal with requests for interpreters. The PALS teams target is to respond with queries within 24-48 hours of contact.

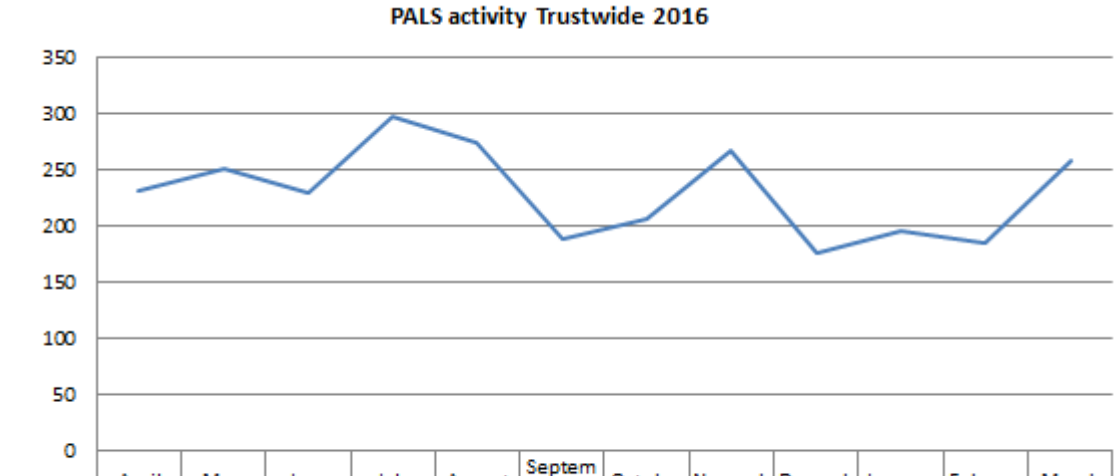
8.2 For the period year ending 31 March 2017 the number of contacts received was 2752, which is a reduction from 3300 in the same period in the previous year. The PALS team also received 2095 interpreter requests, which is almost a 100% increase to the previous year*.

*previous data may not be reliable. Data is now obtained from our providers of interpreter services to verify figures.

8.3 **Fig 18: PALS activity data during 2014 and2015 compared to 2016/17**



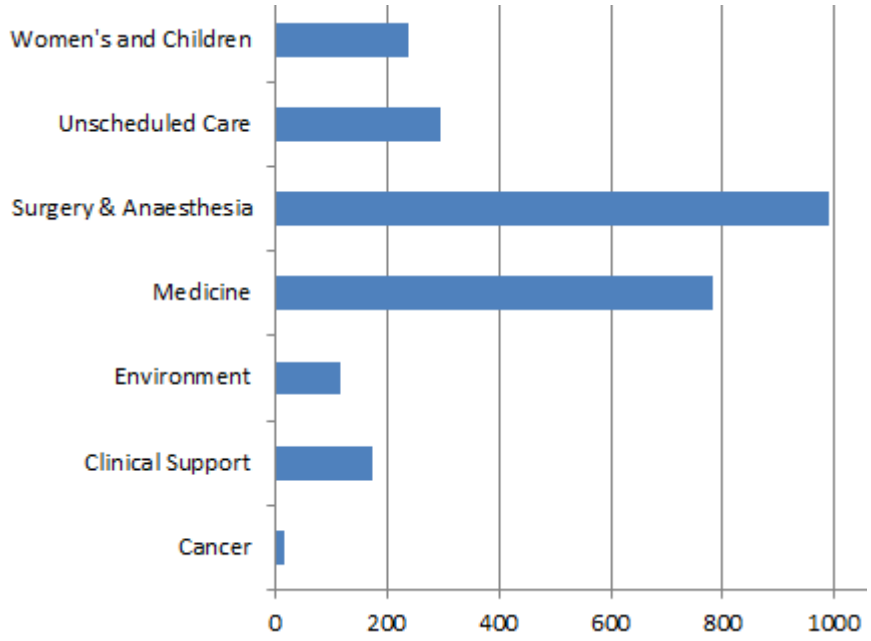
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2015-16	123	226	373	558	393	566	438	422	353	288	282	248
2014-15	218	207	195	214	155	194	226	178	159	89	125	118



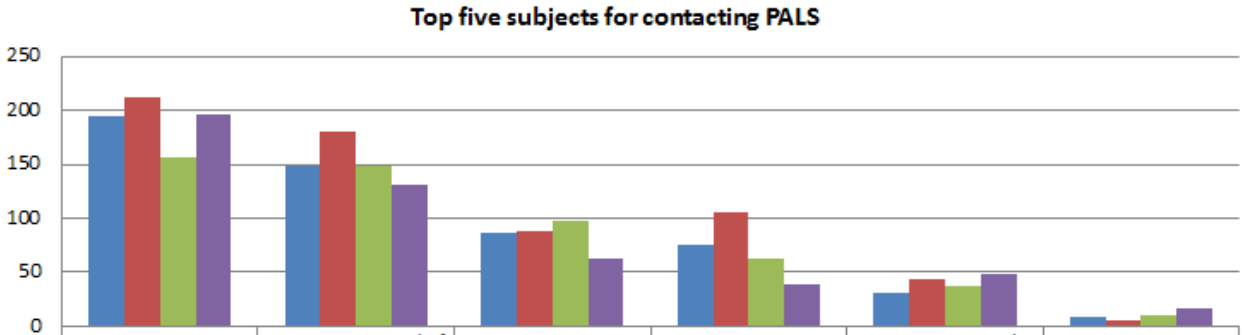
	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Total	230	251	229	296	273	188	205	267	176	195	184	258

8.4 PALS activity drops around the same time complaints activity drops.

8.5 **Fig 19: PALS activity by Division**



8.6 **Fig 20: Chart showing the top 5 reasons for contacting PALS by type Trust wide**

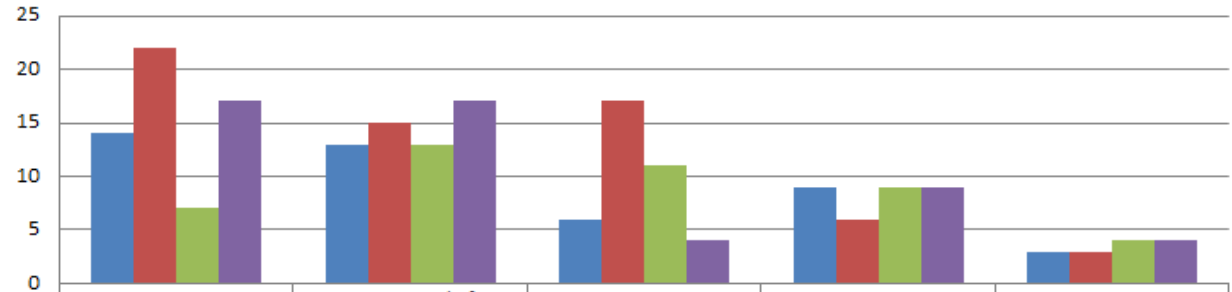


	Appointment	Communication/information	Clinical Care	Complaint	Waiting times / delays	Transport
Q1	195	149	87	76	31	8
Q2	212	181	88	106	44	5
Q3	157	149	98	62	37	10
Q4	196	131	62	38	48	16

8.7 'Appointments' is the main reason patients contact the PALS service, followed by concerns around communication and clinical care. We have included transport as the Trust has seen a number of issues with transport providers fulfilling what they are expected to do.

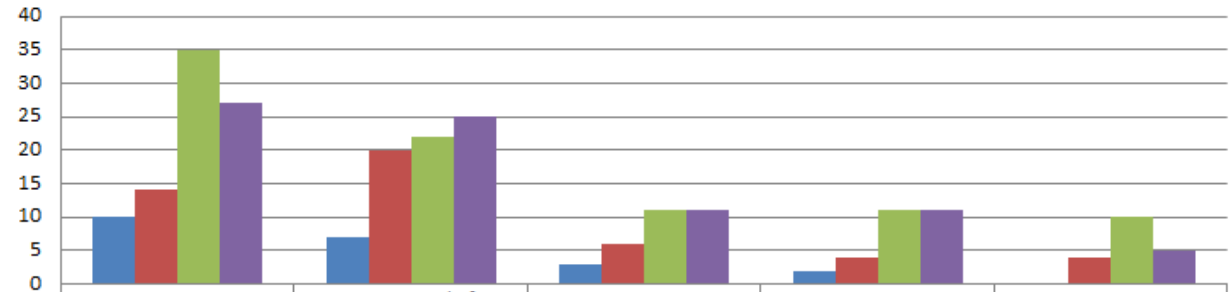
8.8 **Fig: 21: Charts which show the top 5 reasons for contacting PALS by Division**

Top five subjects for contacting PALS - Women's and Children's



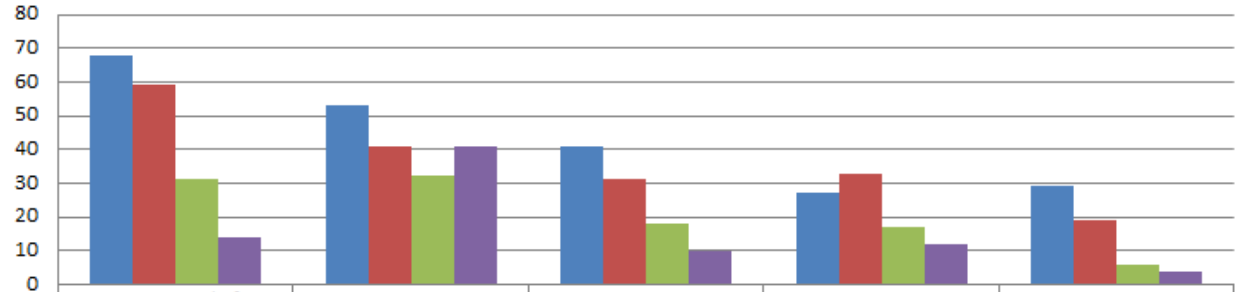
	Appointment	Communication/information	Complaint	Clinical Care	Attitude
Q1	14	13	6	9	3
Q2	22	15	17	6	3
Q3	7	13	11	9	4
Q4	17	17	4	9	4

Top five subjects for contacting PALS - Unscheduled Care



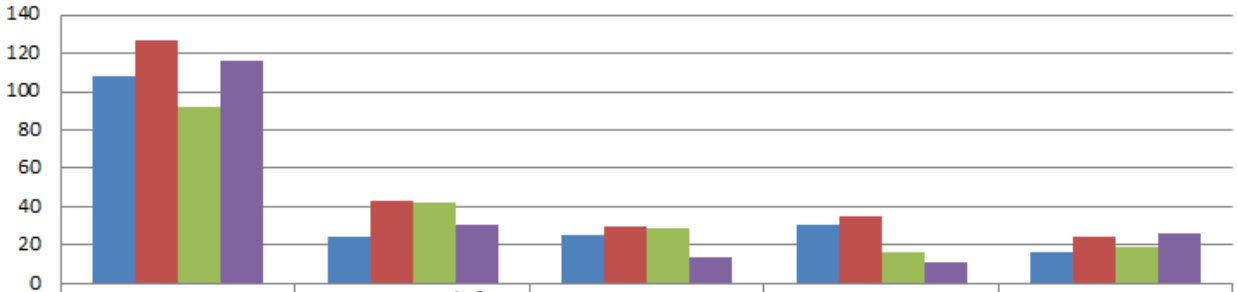
	Clinical Care	Communication/information	Discharge	Theft/Lost property	Complaint
Q1	10	7	3	2	
Q2	14	20	6	4	4
Q3	35	22	11	11	10
Q4	27	25	11	11	5

Top five subjects for contacting PALS - Medicine



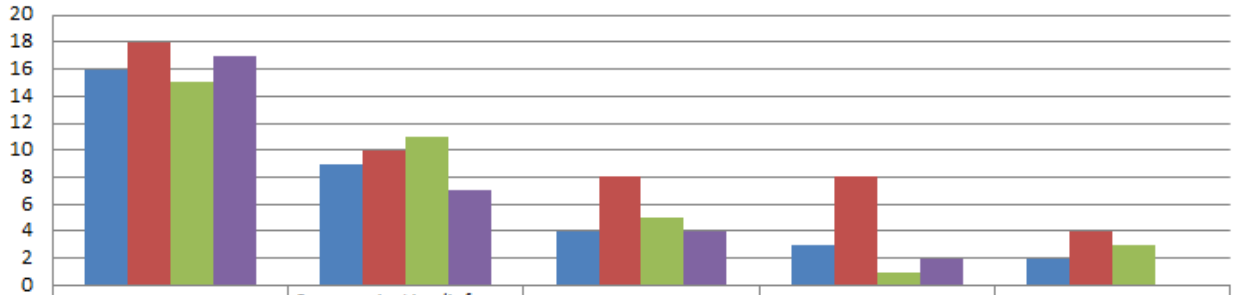
	Communication/information	Appointment	Clinical Care	Complaint	Discharge
Q1	68	53	41	27	29
Q2	59	41	31	33	19
Q3	31	32	18	17	6
Q4	14	41	10	12	4

Top five subjects for contacting PALS - Surgery, Anaesthetics and Cancer



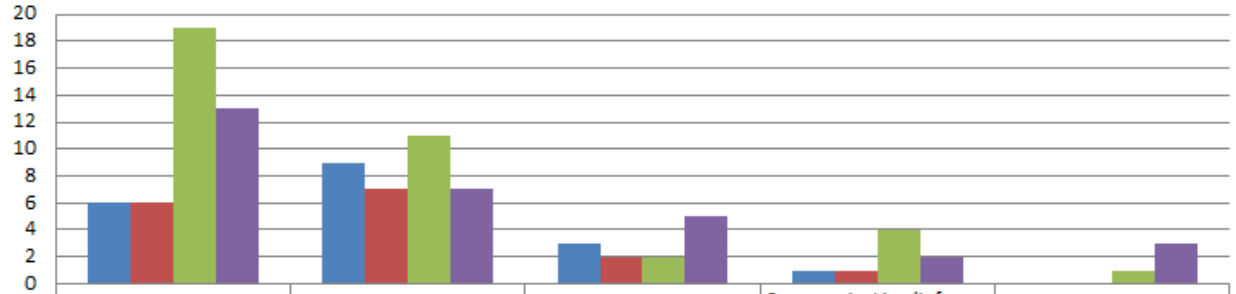
	Appointment	Communication/information	Clinical Care	Complaint	Waiting times / delays
Q1	108	24	25	31	16
Q2	127	43	30	35	24
Q3	92	42	29	16	19
Q4	116	31	14	11	26

Top five subjects for contacting PALS - Clinical Support Services



	Appointment	Communication/information	Waiting times / delays	Complaint	Clinical Care
Q1	16	9	4	3	2
Q2	18	10	8	8	4
Q3	15	11	5	1	3
Q4	17	7	4	2	

Top five subjects for contacting PALS - Environment



	Parking	Estates & Facilities	Transport	Communication/information	Catering/Domestic
Q1	6	9	3	1	
Q2	6	7	2	1	
Q3	19	11	2	4	1
Q4	13	7	5	2	3

8.9 With each of the clinical divisions appointments and communication featured high on the reasons why patients and relatives contacted PALS for support with the exception of the Medicine Division who engaged with the PALS team earlier in the year to discuss how we can improve on the patient's experience trying to organise their appointments and cancellations.

8.10 Staff attitude did not feature on any of the divisions with the exception of Women's and Children's, which Elizabeth Ward sits under.

8.11 It should be noted that in the Unscheduled Care Division unlike any other division the patients contact PALS on matters of theft of personal belongings.

9. Learning from complaints

9.1 Learning from complaints and concerns received continues to be a focus for the trust and we the have been opportunities for patients to tell their story to the trust board and at our quarterly learning events. Embedded the learning and sharing more widely remains the key priority for 2017/18.

9.2 Other examples of complaints learning are that in response to the number of contacts around appointments, the Head of Complaints and PALS and Lead Nurse for Resolution met with the outpatient manager and service managers to brain storm how we can resolve these concerns being raised in the quickest and resource effective ways. We have now introduced direct access authorisation for the PALS team to contact the outpatient supervisors directly in matters that may escalate to a complaint. The Service Managers have also agreed to receive phone calls directly from patients on matters where they are unable to get through to appointment lines.

9.3 When a complaint is upheld or partially upheld, an action plan is developed to highlight any specific issues, steps necessary to resolve and prevent a recurrence of the issue, an individual assigned responsibility to oversee the action and the timeframe within which the action is expected to be completed.

9.4 Reconfiguration of the Trust's risk management database allows the Trust to monitor all complaints where action plans have been developed. In 2016/17 60% of all complaints where actions were taken have been recorded on Datix. This needs reviewing and updating further in 2017/18 to ensure we capture 100% of all actions taken.

9.5 The action plans are reviewed at the Divisional monthly Quality and Governance meetings where actions are monitored and tracked. Divisions are responsible for ensuring that learning from complaints and incidents is shared widely with front line staff. All Divisions have been asked to develop local communications materials and plans to ensure that learning is disseminated widely, drawing on good practice already established in some areas. In addition to circulation within the Division, action plans are presented monthly to the Quality and Safety Group.

9.6 Complaint learning events were held three times in the previous year with aspirations to hold these quarterly every year going forward. At these events divisions are invited to share examples where direct learning has stemmed from complaints. Examples include when operational pressures in the ED led to an increase in complaints the department created queue nurses to improve communication and ensure the safety of patients waiting to be seen. Work has been done with the East of England Ambulance Service to create an agreed approach regarding responsibilities of WHHT and EoE staff when there is an increase in patient volume. Also in response to some of the complaints patients have been invited to staff meetings to share how they felt when caught up in times of Trust operational pressures.

9.7 We also learn from complaints to ascertain how corporate functions can be improved to better serve our patients. Staff working in PALs and the division reflected when an informal concern became a formal complaint by meeting and discussing how they could work better together to ensure the expectations of our patients are met without them feeling that they had to formally complain to obtain the outcome they were expecting. From this an agreement was reached with all Divisions as to an appropriate point of contact for queries and how they can be escalated.

9.8 A string of complaints around lost property led to a paper being commissioned writing around how we manage patient's property when they use our services and a review

of our claims process in the event of property being lost. This is anticipated to being completed in July 2017.

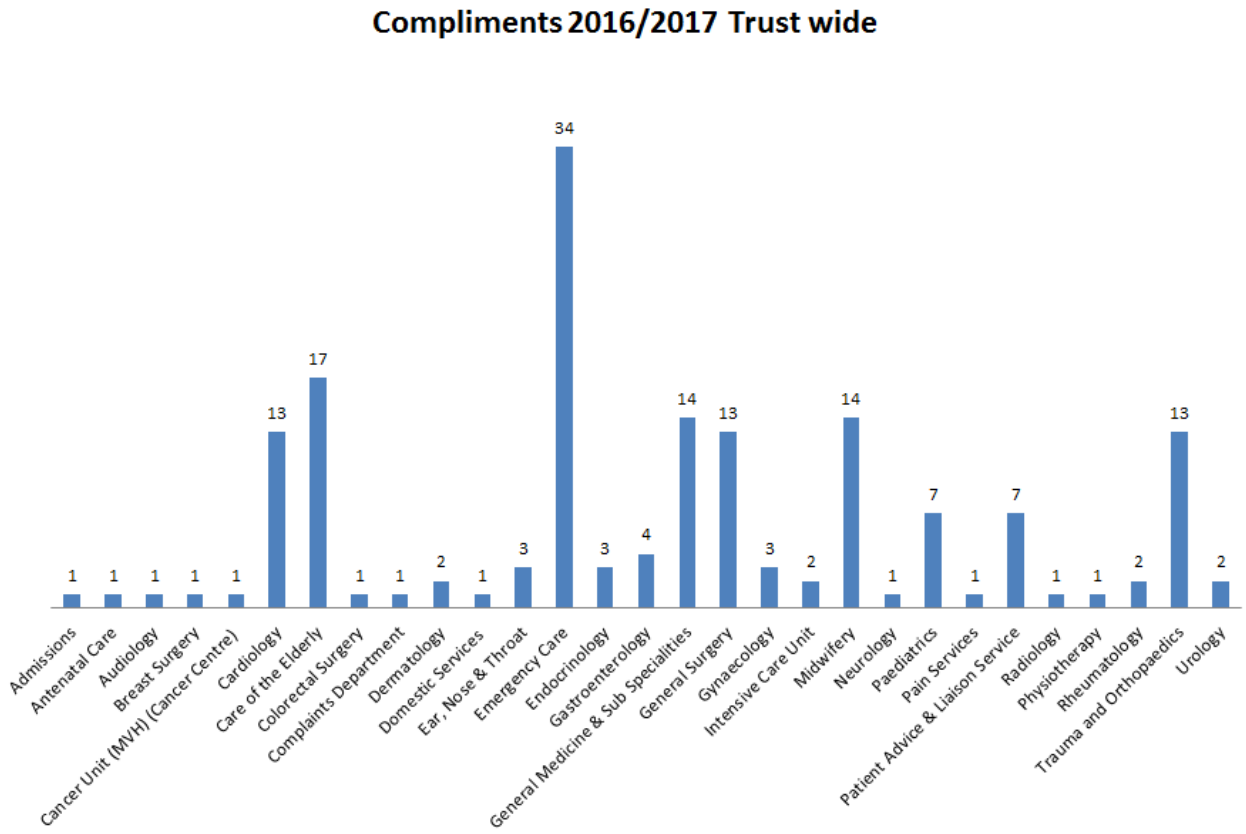
9.9 We have amended our approach to consent for obtaining post mortems when a complaint was received around the handling of concerns raised and the delivery of the findings of a post mortem. Now there are clearly defined responsibilities and accountability and ensuring that the findings are delivered in a face to face meeting with relatives of the deceased.

9.10 Consideration was given to replicating the same system used in the Serious Incident team where actions from complaints are signed off only when evidence of completion of the action has been provided and assurance given to the Board. However, it was considered that this model will not be possible with 10 times as many investigations.

10. Compliments

10.1 When compliments are received these are logged using Datix. At present we do not capture all compliments as we know many more are received on the ward and whilst we ask that they be forwarded for logging, this does not always happen. In 2017/18 the PALS staff plan to walk around each ward on a daily basis to speak to ward staff and offer assistance. During this they will be asking for any compliments and thank you cards so that these can be logged.

10.2 **Fig 22. Compliments by service**



11. Conclusion

11.1 This year's complaints and PALS annual report highlights the significant progress that has been made across the organisation to respond to and, more importantly, to learn from the complaints and feedback we receive about our services. It is a number one quality priority for the trust to continue to improve the experience of our patients and ensure we improve the care and services we provide in response to the feedback we receive.

11.2 There will continue to be a focus on improving the way in which complaints are handled and responded to, both in terms of the response time and the quality of the investigation.

Tracey Carter
Chief Nurse

September 2017

Trust Board Meeting
05 October 2017

Title of the paper	**Strategy Update**
Agenda item	**12/52**
Lead Executive	**Helen Brown, Deputy Chief Executive**
Author	**Helen Brown**
Executive summary **(including resource implications)**	The report provides an update on the current position in relation to a range of longer term service changes and strategic developments. **Integrated Care Pathways:** Work continues across a range of specialties and pathways to redesign care models. Partner organisations were notified this week of the outcome of the community MSK tender with the outcome being that the contract has been awarded to a specialist MSK & Physiotherapy provider. The implications of this decision for WHHT are briefly summarised within the paper. **Acute transformation / estate redevelopment:** The main redevelopment and car parking SOCs are being reviewed by NHS Improvement. NHS Improvement have confirmed that the Trust may proceed to develop a full business case for the redevelopment of Watford Theatres as the total capital spend is within the Trust's delegated approval limits. Funding for the completion of the FBC is included within the Trust's ITFF loan application and only limited progress will be possible in advance of confirmation of loan funding being received. A programme board is being established to oversee the programme. The Trust continues to work with HVCCG and partner organisations to develop the proposed clinical model for Hemel Hempstead & Dacorum. A stakeholder event is scheduled for the 28th September. Trust clinicians are actively engaging in this work. **Royal Free London Group model:** A final draft work programme has been developed for review and approval via the Programme Board and WHHT / RFL Trust Boards in October and November. Executive leads across the two organisations are continuing to work through potential opportunities. Trust clinicians continue to actively engage in the clinical pathway group (CPG) reducing unwarranted clinical variation programme that is core to the group model.

Where the report has been previously discussed, i.e. Committee/Group	Updates on specific issues have been provided to TEC and relevant other forums.

Action required: *[please choose the option(s) below which is most appropriate and delete the others]*

- The Board is asked to note the report for information.

Link to Board Assurance Framework (BAF)

[Please indicate which Principal Risk this paper relates to by double clicking on the corresponding box]

- ☐ **PR1** Failure to provide safe, effective, high quality care
- ☐ **PR2** Failure to recruit to full establishments, retain and engage workforce
- ☒ **PR3** Current estate and infrastructure compromises the ability to deliver safe, responsive and efficient patient care
- ☐ **PR4a** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – IM&T
- ☐ **PR4b** Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care – Information and information governance
- ☐ **PR5a** Inability to deliver and maintain performance standards for Emergency Care
- ☐ **PR5b** Inability to delivery and maintain performance standards for Planned Care(including RTT, diagnostics and cancer)
- ☒ **PR7a** Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency programmes
- ☐ **PR7b** Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure
- ☐ **PR8** Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation.
- ☒ **PR9** Failure to deliver a long term strategy for the delivery of high quality, sustainable care
- ☐ **PR10** System pressures adversely impact on the delivery of the Trust's aims and objectives

PR6 – business continuity has been closed (incorporated into PR1)

Trust objectives

[Double click on the box to mark as appropriate]

- ☒ To deliver the best quality care for our patients
- ☐ To be a great place to work and learn
- ☐ To improve our finances
- ☒ To develop a strategy for the future

Benefits to patients/staff from this project/initiatives

Risks attached to this project/initiatives and how these will be managed

- Financial risks associated with pathway redesign – detailed mapping of the impact on income and opportunities to exit costs is being undertaken. A standardised methodology is being implemented.
- There is currently only limited identified funding to support the development costs of major capital projects (progressing from SOC to outline business case for main acute redevelopment project, development of the theatres FBC). Progress will be limited until a funding source has been secured. Where possible internal resource is being deployed to support these work programmes.

West Hertfordshire Hospitals NHS Trust

Agenda item: 12a/52

Trust Board Meeting – 05 October 2017

Strategy Update

Presented by: ***Helen Brown, Deputy Chief Executive***

1. **Your Care Your Future ~ integrated care and pathway re-design.**

The Trust continues to work with partners on the redesign of a range of planned and unplanned care pathways.

Service redesign processes can broadly be categorised under three sub types:

- Services being formally recommissioned by the CCG via a competitive open market procurement process (e.g. musculoskeletal community service, ophthalmology, ENT)
- Services being formally recommissioned by the CCG via local a 'multi-provider partnership collaborative' (MPPC) process. This process is based around all existing service providers coming together to jointly redesign services in response to a specification and activity envelope set out by the CCG (ie without open market procurement). In many cases early dialogue has taken place between HVCCG and provider organisations / clinicians to develop the proposed new model of care.
- Other service redesign opportunities arising from the joint HVCCG / WHHT 'QIPP' (quality, innovation, productivity and prevention) workstream.

WHHT has to date been asked to lead on the following (MPCC) pathways:

- Diabetes (NB this is a recent change from the original proposal for HCT to take the lead role within the collaborative for this pathway).
- Stroke (see update below)
- Dermatology
- Cardiology

WHHT continues to work with Hertfordshire Community Gynaecology Service (HCGS) on the development of a new community gynaecology service. The service will be led by HCGS who will subcontract with WHHT, RFH and L&D Hospitals for consultant led community gynaecology clinics. Detailed negotiations on sub contract arrangements are underway, as is work to remap the WHHT 'tier 4' clinic schedule and consultant job plans to take account of the impact of the new service model.

HVCCG recently ran an open market procurement process for a new community musculo-skeletal (MSK) service. The Trust, working with HCT, One Herts GP Federations and the Herts Valley Physio Group submitted a bid for this service. The partnership has been notified that its bid has been unsuccessful, the contract has

been awarded to a commercial provider specialising in MSK and physiotherapy services. This will have a limited direct impact on WHHT workforce – a small number of staff had been identified as potential for TUPE transfer but it is anticipated that there will be sufficient flexibility within the Trust establishment to offer alternative posts to all staff wishing to remain with WHHT. There will be a significantly greater impact on HCT and Herts Valley Physiotherapy Group. The new service is designed to reduce demand for rheumatology and orthopaedic outpatient appointments. The Trust will closely monitor referral rates and ensure that plans are in place to take down or redirect capacity as referral patterns change.

Work is currently underway to map the potential financial impact of all changes, pending final agreement with the CCG of the detailed contractual arrangements for each pathway.

In the main HVCCG is seeking to set a specified activity and finance envelope for the new pathways and put in place contractual arrangements with providers that transfer some or all of the risk for managing demand across to provider organisations through a lead provider or provider collaborative model. NHS Improvement have advised the Trust to adhere strictly to the national NHS acute contract which is based on a PBR tariff structure.

Once all aspects (service model, activity and financial envelopes, contractual arrangements) have been agreed in principle with HVCCG changes will be enacted through contract variations. Contract variations will be reported through the finance and investment committee (FIC), with formal approval via FIC and / or Trust Executive Committee (TEC) in line with delegated approval limits.

Brief updates on all active workstreams are provided in appendix one.

2. Stroke

HVCCG has confirmed that it would like WHHT to take the overall co-ordinating lead across a WHHT and HCT provider partnership for the delivery of an integrated stroke pathway.

As previously reported it is recognised that additional investment will be required for WHHT to make further progress towards the delivery of the full hyper-acute stroke service specification. HVCCG is currently benchmarking the costs of the rehabilitation elements of the pathway (rehabilitation beds at Langley House, Early supported discharge).

3. Vascular

E&NHT are leading the development of a vascular network for Hertfordshire and West Essex, with a hub at the Lister Hospital and ‘spokes’ at Watford General Hospital (WGH) and Princess Alexandra Hospital (PAH). A detailed business case will be developed for approval by all three Trust Boards prior to formal implementation of the new model commencing. The business case is expected to take 3-6 months to complete.

4. Your Care, Your Future - strategic outline case for the redevelopment of acute hospital services.

The main acute transformation / redevelopment SOC is currently being reviewed by NHS Improvement following the standard business case review process. Given the scale of investment required Department of Health review and approval will also be required. There is no firm timeline as yet for this review process to complete. The deputy CEO and Finance Director are actively liaising with NHS Improvement to ensure all queries are responded to in a timely way and to track progress through the approvals process.

An acute redevelopment programme board is being established to oversee the next phases of the programme. The first meeting is scheduled for October. A resourcing plan is being developed. A bid has been submitted via the STP capital process for funding to progress the outline business case (OBC), if this is unsuccessful the Trust will need to seek loan finance to support the development of the OBC. NHS Improvement have advised that no external financial support will be able to be accessed prior to approval of the SOC.

5. Hemel Hempstead strategic outline case (SOC)

As previously reported joint work is underway with HVCCG, WHHT clinical teams and other partners to develop in more detail the proposed clinical model for Hemel Hempstead & Dacorum. A stakeholder workshop is scheduled for the 28th September. This will inform the development of the SOC and estate options appraisal. A programme of stakeholder engagement and communications will continue throughout the development of the SOC.

6. Car Parking Strategic Outline Case

The Car Parking strategic outline case has been submitted to NHS Improvement for review and approval. The Trust has provided a comprehensive response to a series of clarification questions. Our understanding is that the SOC is now with the national NHS Improvement 'cash and capital' team for review prior to submission to the relevant NHS Improvement Committee for formal approval.

7. Watford Theatres redevelopment

NHS Improvement has confirmed that, given the total capital cost of the theatres redevelopment project is within Trust delegated approval limits, that the Trust can proceed to full business case (FBC).

The cost of developing the FBC (c. £750k) is included within the Trust's Internal Trust Financing Facility (ITFF) loan submission for 2017/18. Some capital funding has been identified as part of the 'ventilation works' priority one capital project to progress technical surveys and detailed design work; this will enable timely completion of the FBC once the remaining capital has been secured.

8. Pathology

Work continues with the Pathology team to strategically appraise options for the modernisation of the Trust's pathology service. This work will produce a SOC setting out the recommended preferred way forward. The SOC is scheduled to be completed for FIC and Board review in October / November 2017.

9. WHHT partnership working with the Royal Free Hospital

The next Programme Board meeting is scheduled for 17th October 2017. A final draft work programme has been developed for approval via the Programme Board at this meeting, following which it will be presented to the WHHT Board for review and approval.

10. Sustainability and Transformation Partnership (STP)

Highlights this month include:

- Work is underway to update the STP wide finance and activity analysis (due for completion in October)
- Clinicians are being recruited to join the STP 'clinical oversight group' to strengthen clinical engagement in the STP
- Good progress is being made in delivering cash releasing efficiencies through the medicines optimisation and procurement STP workstreams.

Helen Brown

Deputy Chief Executive

Agenda Item: 12/52 Appendix One – Pathway redesign update

Pathway	Type of pathway redesign	Key partners developing models	Development stage	Expected date of service commencement	Next key milestone
Community Musculoskeletal Service	Open market competitive tender 3years +2 contract	• A WHHT led service in partnership with Hertfordshire Community Trust, HertsOne GP Federation, Herts Valley Physio Group the current 17 AQP providers) & the Royal Free London NHS Foundation Trust (RFL). • Collectively we have called ourselves the Herts Musculoskeletal Collaborative (HMSKC)	• Invitation to Tender submitted 16/06/17. • Presentation & interviews completed 02/08/17. • Final outcome has been delayed, awaiting new timescale from CCG procurement team.	Currently pushed back by CCG to 08/01/18 and may be revised again depending on final timescales on preferred provider.	Outcome of procurement process and if awarded to the HMSKC Partnership, mobilisation plan enacted.
Community Dermatology	Multi Provider Partnership Collaborative (MPPC) 3years +2 contract (tbc)	• A WHHT led service in partnership with the two other incumbent providers, HertsOne GP Federation & Royal Free London NHS Foundation Trust (RFL).	• Teledermatology commenced on 01/09/17 as planned as a 6month pilot. • MPPC launch expected by CCG October 2017.	• 01/09/17 for Teledermatology • Full MPPC requested by HVCCG from December 2017 but to be agreed based on service scope.	Launch of MPPC (expected by CCG October 2017)
Community Gynaecology	Most Capable Provider 3 year contract	• Lead provider is Hertfordshire Community Gynaecology Practice owned by the Drs Kedia. Subcontracting with WHHT, RFL & Luton & Dunstable University Hospital.	• Finalisation of activity and finance and standard operating procedure as part of mobilisation. • Quality schedule and governance framework for the community service agreed	• 01/12/17 for triage. • Full service delivery from 08/01/17	Development of the subcontract between the lead provider and WHHT by end of October 2017
Community	Multi Provider	• Now to be a WHHT led	• Assurance document returned to	Original plan was for	Finalisation of service model

Diabetes	Partnership Collaborative (MPPC) 5year contract	service in partnership with Hertfordshire Community Trust and HertsOne GP Federation	HVCCG 21/07/17. • Awaiting confirmation by HVCCG of proposed service model and associated contract variation	Oct 2017 new date to be agreed and confirmed but will be this calendar year	with CCG and associated contract variation
	National Diabetes Treatment and care programme. 2 years funding with only 1st year confirmed	• As with the MPPC arrangement but a separate contract	• MOU with national programme agreed. Working groups for service delivery in place	From October 2017 (staged delivery of programme)	• Foot group to agree start date of service based on recruitment of team. • EDEN diabetes training programme commences Oct 2017
Integrated Community and Secondary Care Respiratory Service for Herts Valleys	Service led redesign ahead of Multi Provider Partnership Collaborative (MPPC) planned for Oct 2019	• WHHT in collaboration with Central London Community Healthcare (CLCH)	• Phase 1A - Development of Respiratory Hot Clinics to support prompt assessment of acutely unwell patients, minimise need for admission and facilitate safe early discharge, ensure appropriate follow up on the right clinical pathway	November 2017	Finalisation of clinical model and development of contractual arrangement
			• Phase 1B - Referral management including referrals filtered by disease specific pathways, advice and guidance and advice and guidance plus (includes virtual consultation and investigations)	April 2018	Finalisation of clinical model, agreement on preferred electronic system to support
			• Phase II -Develop and implement the full integrated acute and community model for Respiratory Services	April 2019	Development of Integrated Respiratory Service Specification and Pathways by April 2018

Lower GI Telephone Assessment Clinic (TAC)	Service led redesign	WHHT	• Implementation of nurse led telephone assessment clinic (TAC) service enabling 'straight to test' for 2ww patients	To be finalised but will be this calendar year	Finalisation of tariff for service with HVCCG and staff recruitment
Integrated Heart Failure Service (to include Cardiac Rehabilitation)	Multi Provider Partnership Collaborative (MPPC)	HVCCG requesting a WHHT led model in partnership with HCT	• Letter of intent issued to WHHT. Awaiting scope of service with finance and activity information from HVCCG	To be agreed	HVCCG to identify activity and assumptions for inclusion
FIRST (Facilitating Integrated Re-enablement to Support Transition)	Service redesign with a block contract to test a care model before moving to a bundle based approach	WHHT commissioning HCT to provide the service	• Pilot service in place, further evaluation being completed. • Service specification developed by WHHT in partnership with HCT & the Integrated Discharge team	In delivery as a pilot	Agree future service model and associated funding streams.

Agenda Item: 13/52

Report to:	Finance and Investment Committee
Title of Report:	Finance and Investment Assurance Report to Trust Board
Date of meeting:	3 October 2017
Recommendation:	For information and assurance
Chairperson:	John Brougham
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Finance and Investment Committee at its meeting on 28 September 2017
Background	The Committee meets monthly and provides assurance on:

Scheduled reports from all Trust operational committees with a finance and information technology brief according to an established work programme.

Financial Performance

i. I&E Deficit

The Committee reviewed the actual performance in the month and year to date, and focussed on the challenging action plans in place to deliver the budgeted deficit for the year.

The deficit in August of £5.2m was £1.7m worse than forecast in July and £5.1m worse than budget, resulting in a year to date deficit of £20.5m, £6.7m worse than budget and above the year end deficit budget of £15.0m. The Committee was concerned at the deterioration from the latest forecast for the month, mainly due to lower elective revenues than expected, and reviewed the latest projections for the year, focussing on cost reduction actions and plans, and revenue risks.

Following a detailed review of CIPs, which are £3.2m year to date, the Committee concluded that although not yet fully underpinned the original budget of £13.7m for the year, whilst still very challenging, is achievable. However there was now no confidence in the ability of achieving the full

year extra stretch CIP target of £8.2m, making total CIPs £21.9m. 6.5% of planned revenues.

The plans to reduce the levels of pay and non pay costs, which are above budget year to date by £1.9m and £1.4m respectively, were reviewed. The Committee commended the 32% reduction in agency costs in the first five months compared to the same period last year to date, and noted that the full year should be well inside the NHSI control total of £24.4m. However it was recognised that further work needs to be done to reduce the rate of both pay and non pay costs, and the action plans and progress will be reviewed again at the October Committee.

The Committee reviewed the revenue risks, including QIPPs, which once agreed will require cost reductions to match reduced revenues, and CQUINs. QIPP plans with HVCCG are still not finalised and will be reviewed again at the October Committee.

The Committee was not assured that the Trust could realistically offset the increase in deficit from the £8.2m CIP stretch, the £2.1m unbudgeted payment to HVCCG relating to last year's penalty and control total performance, and the loss in STF funding resulting from the failure to achieve this year's deficit and A&E performance targets.

The Committee recommends a paper is presented to part 2 of the October Board on the forecast deficit for the year, and the actions and associated risks to deliver the lowest practical deficit taking account of patient safety and the issues above.

ii. Back Office Savings.
Progress on back office savings plans was discussed and the Committee asked for a detailed paper on actions at the next meeting.

iii. Capital Expenditure/Funding
Capital spend in August brought year to date spend to £1.7m. The Committee was assured that the forward commitment of spend was being carefully managed to ensure that the existing NHS approval of £6.7m would not be breached. The Committee was updated on the approval process for the remaining £16.3 planned spend in the full year budget of £23.0m. The Committee noted that the Trust had been successful in achieving £1m of A&E funding from the Department of Health, and was further

encouraged by the recommendation of the Project Appraisal Unit of NHSE to NHSI that all but £0.8m of the remaining budget should be approved. If this recommendation was fully approved, it would result in full year spend approval of £22.2m. The Committee remain concerned as we enter the second half year that even if approval is imminent timescales are unlikely to enable all the £22.2m to be incurred this year, and asked for an update at next month's Committee on NHSI approval, projected spend and the status of carry forward approval into 2018/19.

iv. Revenue Funding

Funding of net revenue spend is subject to monthly approval and following review the Committee recommends ratification by the Board of a £1.4m loan to cover funding requirements in September.

The Committee discussed non payment by HVCCG of £3.2m of invoices to date which is impacting the ability to pay creditors on time. The Committee noted that the issue has been escalated to NHSI and asked for an update at the next meeting.

Service Line Reporting

The Committee reviewed the latest status on providing patient level costing in the Trust. As part of an ongoing NHSI review of costing processes in acute Trust providers, EY carried out a review of 2015/16 as part of a national contract. Their report rated WHHT as having partial assurance, and raised a number of recommendations to improve, which the Trust has accepted. Key to the recommendations is to establish a high level strategic costing steering group, chaired by a senior clinician ensuring that recommended actions are implemented to deliver the planned improvements in both costing processes and governance, for the Trust to be compliant with national standards from 2018/19.

The Committee welcomed the report and recommendations to accelerate the Trust's production of reliable patient level costing and asked for a quarterly update on delivering the report's recommendations.

ICT infrastructure programme update

The Committee reviewed a paper on the progress of the infrastructure improvement plan. It was noted that the target of achieving 80% roll out of devices by mid August had been

achieved, and is on target for achieving 90% by the end of September.

The Committee noted that despite remedial work being carried out, significant issues continue to be experienced with the data transmission speeds and performance of the wide area network (WAN). High level discussions continue with the prime contractor and their WAN supplier to urgently resolve these issues which is critical to the success of the whole programme. The Committee requested an update in October, and if not resolved, the options available to ensure that they are.

The Committee was informed that an IT security risk manager has been recruited and is working to reduce the Trust's risk of cyber attacks, with an in-depth risk review being presented to the Committee in October.

Corporate Risk Register

The Committee received an update on risks under its remit on the CRR. There were no recommended changes since the August meeting, with 12 risks in total, 7 in ICT and 5 in Finance.

The Committee asked that a paper be presented at the October meeting covering the actions in place, and associated risks, of complying with the changes in data protection legislation which come into force in May 2018

ED Reconfiguration

The Committee reviewed the plans, approved by the Executive Committee, to make optimum use of the £1m A&E capex approval from DoH. This has allowed the Trust to trigger a number of improvements to the pathway through A&E for patients and clinical teams, including a new 10 bed Clinical Decision Unit, which will result in improvements in increased patient privacy and dignity, improved patient flow, and reduction in waiting times.

This is one of the key initiatives to close the gap from the current ED 4 hour year to date performance, which averages 83%, to the standard of 95% by the first quarter of 2018/19, and is expected to deliver between 3% and 5% of the required improvement.

The Committee was assured that this investment is essential to achieving the standard and is cost neutral in terms of income and expenditure. The Committee recommends the paper on

the investment is presented to Part 1 of the Trust Board in October for ratification.

Procurement Update

The Committee received an update on key procurement developments and achievements to date. These included delivering £0.7m of CIPs in the first five months, with a projection of £2.6m for the year, and increased collaboration across Trusts in Hertfordshire, Bedfordshire and West Essex exploring procurement opportunities resulting from standardised equipment and a greater economy of scale.

The Committee was assured that good progress is being made in standardising clinical supplies in WHHT, and will be updated on progress from the wider collaboration in December.

Sale of Land

The Committee reviewed the proposed sale of a one metre strip of land on the St Albans site which abuts 16 properties in Goldsmith Way. The Committee supported proceeding with the sale and recommended the paper is presented to Part 2 of the October Board for approval.

Risks to refer to risk register

None

Issues to escalate

The Committee recommends the following:

To Part 1 of the October Trust Board for ratification:

i. The interim NHS revenue support loan of £1.4m to cover funding requirements in September

ii. A paper on the ED reconfiguration project

To Part 2 of the October Trust Board for review:

iii. A paper on the recovery actions, associated risks, and likelihood of meeting the full year deficit target

To Part 2 of the October Trust Board for approval:

iv. A paper on the sale of a small parcel of land at the St Albans site

Attendance record

Attended
John Brougham, Non-Executive Director (Chair)
Don Richards, Chief Financial Officer
Helen Brown, Director of Strategy & Corporate Affairs
Katie Fisher, Chief Executive
Mike van der Watt, Medical Director
Prof. Steve Barnett, WHHT Chair
Sally Tucker, Chief Operating Officer
Sean Gilchrist, Associate Director of ICT
Soheb Rafiq, Head of Financial Management
Tim Duggleby, Head of Strategic Development & Compliance for item 16)
Tom Drabble, Patients' representative
Svetlana Opacic, Interim Head of Procurement (for item 15)

Apologies
Lisa Emery, Chief Information Officer
Freddie Banks, Associate Medical Director for Clinical Strategy
Jeremy Livingstone, Divisional Director, Surgery, Anaesthetics & Cancer
Lesley Headland, Chair of Staffside
Kevin Howell, Director of Environment
Phil Townsend, Non-Executive Director
Stephen Dunham, Assistant Director of Finance & Commercial Development

Clerk
Clare Ransom, Executive Assistant

Agenda item: 14/52

Report to:	**Trust Board**
Title of Report:	**Assurance report from Clinical Outcomes and Effectiveness Committee**
Date of meeting:	**05 October 2017**
Recommendation:	**For information and assurance**
Chairperson:	**Ginny Edwards, Chair**
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Clinical Outcomes and Effectiveness Committee at its meeting on 28 September 2017
Background	The Committee meets bi monthly and provides assurance to the Board on: • Safe and effective patient care • Prevention, early intervention, recovery and rehabilitation • Ensure that the Trusts responsibility for infection control is effectively fulfilled • Promoting a culture of learning and continuous improvement. • Measure change using clinical outcome measures to monitor the impact of the services provided by the Trust.
Business undertaken	**<u>Integrated Performance Report (IPR)</u>** The Committee received and reviewed the IPR and was assured that appropriate actions were being taken to maintain and improve performance across a range of measures. In particular, the Committee discussed assurance on harm free care, Nil CDI cases in reporting period, sustained mortality position and measuring the number of complainants called within three days of receipt of complaint. The committee noted that areas requiring improvement was 'Harm Free Care' as measured through the monthly safety thermometer was below the target of 95%. Actual harms from catheter & new UTI's and new VTE's is above the national average with falls and pressure ulcers in line or below the national average. Performance

of harm free care is improved in comparison to this period in previous years. The Trust is working with the CCG to develop a criteria for assessing avoidable and unavoidable mixed sex breaches in ITU.

Clinical Audit and National Institute of Clinical Excellence (NICE) Annual Report 2017/18 Q1

The Committee reviewed the report relating to clinical audit. The Committee received assurance in the report as audits had been brought up to date and action plans and papers had been produced for guidance and learning. The status of the audits were shown at amber and green. Assurance was given to the Committee that the Bed Safety Rail audit in the appendix although overdue had been completed and the analysis was being undertaken and will be available in the next report..

Trauma Unit Peer Review 2017

The Committee noted that a formal Peer Review of the Major Trauma at Watford General Hospital. Occurred annually. The report outlined areas of Good Practice and it was noted the new Trauma Co-ordinator role had been established with anecdotal evidence of early benefit. The Committee were assured that where there were areas of concerns, actions had been put in place and were be being reviewed by the unscheduled care division. The Committee asked for the training of staff to be added as one of the key actions. Outcomes would be brought back to the Committee in January 18.

National Guidance on Learning from Deaths – Implementation update

The Committee noted the report and the updated action plan. They noted it was monitored through the Trust Mortality review Group (MRG). The Committee were satisfied that each action was agreed and ratified at the MRG. The policy has been published on the intranet and internet and will be reviewed in 12 months.

Local Safety Standards for Invasive Procedures (LocSSIPs) Work Programme Update

The Committee received a report and reviewed the risks associated to it. The Committee were assured the Trust was complying with the National Safety Standards for Invasive Procedures through the development implementation and ongoing review of LocSSIPs.

MBBRACE – UK Perinatal Mortality Surveillance Report

The Committee were given a presentation and noted the key achievements and the key targets identified for improvement.

Key achievements:

- Lower than the national average for neonatal mortality and extended perinatal rates

- Within 10% of the average (but higher) for units of similar size and complexity
- Data completeness overall was extremely good (15/18 sections = 100% complete)
- Data completeness more than 95% for the outstanding 3 sections (improvement from previous report)
- Post-mortems offered to 100% of stillbirths and neonatal mortality cases

Key targets identified for improvement:

- Stillbirth review: Statistics for stillbirths must be improved
- Neonatal death: Neonatal mortality statistics need to be improved
- Data to be collected for placental histology
- 100% Data completeness reviewed by local MBRRACE team (exception report)

The Committee was assured that planned actions were in place to further improve, however the committee did seek assurance from the division on reorganising consultant job plans and requested a plan on how this would happen to come to the next committee meeting.

Quality Strategy Update

The Committee received an update on the development of a quality strategy. Key items to note are:

The management consultants who have been commissioned to work with the Trust have started work on phase one. They would be engaging with senior leaders and key quality representatives. Feedback from staff engagement sessions will be used to generate the final quality strategy.

To support the implementation and delivery of the Quality Strategy the Trust would be working with world renowned organisations that have well tested quality improvement science methodologies. The first draft is expected for the November committee.

COE Committee risk register to include risks at 15

The Committee had one risk with a score of 15 and above assigned to it. The Committee reviewed this risk and was assured that appropriate actions were in place to manage it.

BAF Action Tracker 2017-18

It was noted that actions had been updated and one milestone had been changed.

BAF – review principal risk

The Committee reviewed the principal risks and agreed that it shoud recommend principal risk 5B to move to Amber/Red due to the risk around RTT performance. The committee agreed to review them in full once the CQC report had been released.

Risks to refer to risk register	
Issues to escalate to Board	Increased focus on the emergency standards and work underway to support this target. The work undertaken in Maternity and MBBRACE data The Committee agreed to change PR5B Elective Care (including RTT, diagnostics and cancer) to Amber/Red
Attendance	John Brougham, Non-Executive Director Tracey Carter, Chief Nurse & DIPC Mike van der Watt, Medical Director Jane Shentall, Director of Performance Anna Wood, Associate Medical Director of Clinical Standards and audit Ajitha Jayaratnam, Deputy Divisional Director Medicine Jackie Birch, Head of Risk, Assurance and Compliance Paula King, Head of Nursing SAC Angela White, Head of Nursing Unscheduled Care Linda Tarry, Executive Assistant to Chief Nurse (minutes)
In attendance for Specific Items	Renton L'Heureux, Paediatric Consultant

West Hertfordshire Hospitals NHS Trust

Agenda item: 15/52

Report to:	Trust Board
Title of Report:	Charitable Funds Committee Assurance Report to Board
Date of meeting:	05 October 2017
Recommendation:	For discussion
Chairperson:	Ginny Edwards, Non-Executive Director

Purpose

The report summarises the assurances received, approvals, recommendations and decisions made by the Charitable Funds Committee at its meeting on 28 September 2017.

Background

The Committee meets quarterly and provides assurance to the Board:

- that robust processes are in place to manage charitable funds and to ensure they are implemented;
- that donated funds are utilised in a way that takes into account any stipulations set out by donors and ensure best value is obtained from the funds donated;
- that further donations are being encouraged;
- that systems comply with regulation and governance of NHS Charities.

Business undertaken

Delivery of the Charity Strategy

The committee discussed a number of proposed recommendations:-

Whilst decisions are pending relating to the strategic direction of the charity it was recommended not to recruit a head of charity or head of fundraising at this time. The committee approved the recommendation that administration support to manage correspondence and progress and support fundraising be sought via admin bank on a part time basis for three months. This would be within the current available financial envelope.

A list of key governance tasks was presented and accepted and it was agreed that some further work was required to improve governance. A number of key tasks were required to enable this work to take place and the committee approved the recommendation that an external agency be employed to undertake the work for a maximum of three months. This would be within the current available financial envelope assigned for the head of charity role.

It was also agreed to continue the interim arrangements in the finance team.

Update on work with the Royal Free Charity
The committee discussed future options for the West Herts Hospitals Charity and agreed that a scoping document for an options appraisal should be put together, looking at:-

1. Affiliation with other partners (to include STP options as well as RFL)
2. Remain as is
3. Become an independent charity

The committee agreed that this piece of work should be undertaken by an external agency as an independent report and presented to the committee at its next meeting in November.

Annual Accounts
The annual accounts were received and were recommended to the Corporate Trustees for approval. It was acknowledged that the correct governance process had not been followed and the accounts had been printed prior to formal approval. It was noted that a statement from an independent auditor was not included in the annual report. The committee was reassured by the finance team that the independent audit had taken place and that no issues of concern had been raised.

Overview of funds
The committee received a report on the funds held by the charity and the performance of the investments. It was assured that the investments were performing well and were being well managed. The committee also received an update on new income, grants and donations.

The committee was provided with an update on the investment management tender process. The tender was considered and the preferred supplier will be recommended to the Corporate Trustee in the private session of the Board.

Overview of donations
A major donation of £98k had been received, £10k of which was to be ring-fenced for children's services. This money had been assigned to the Carers' Support Team and, in doing this, the League of Friends had agreed to release the £10k that it had pledged towards this £20k project.

It was agreed that £48k of the donation would be used to support health and wellbeing projects.

Request for funds
A request for charitable funds to support the expenditure for a visit by staff to Intermountain HQ was considered. After careful consideration, it was agreed that the visit would be for the benefit of all patients served by the Trust and therefore deemed appropriate. The committee concluded that individuals attending the visit should initially seek funding or part funding from their individual service funds. Any residual outstanding amount would be funded via legacy funds.

Escalation to the Corporate Trustee

- The annual accounts recommended for approval
- Options appraisal on the future of the charity
- Overview of funds
- Outcome of a tender process for investment advisor. The preferred supplied to be recommended to the Corporate Trustee in the private session of the meeting

Attendance record

Ginny Edwards, Non-Executive Director
Paul Cartwright, Non-Executive Director
Tracey Carter, Chief Nurse
Don Richards, Chief Financial Officer
Louise Halfpenny, Director of Communications
Paul da Gama, Director of Human Resources
Sandhya Patel, Financial accountant (Charitable Funds)
Leigh Franklin, Assistant Trust Secretary (notes)

West Herts Hospitals Charity

where your generosity is the difference

Annual report & financial statements

2016/17

Registered charity number 1052210 (England)

Contents

Cover photo:
Top left: Starfish team

Registered Charity Number 1052210 (England) https://www.westhertshospitals.nhs.uk/about/fundraising.asp

Jonathan Rennison
Chair of the Charitable Funds Committee

Making a difference with help from our friends

Foreword

The Corporate Trustee of West Hertfordshire Hospitals NHS Trust (WHHT) presents the annual report for the West Herts Hospitals Charity (WHHC) together with the financial statements for the year ended 31 March 2017.

This annual report and accounts have been prepared in accordance with Part VI of the Charities Act 1993 (as amended by the Charities Act 2006) and the Charities (Accounts & Reports) Regulations 2008 which provide the legal foundation for the recommendations made in the Statement of Recommended Practice Charities SORP 2015 (FRS102).

Report from the Chair of the Charitable Funds Committee

The past year has focused on building firm foundations for growth. We have seen income grow by 55%, reversing a four-year trend. This has involved hard work from our charity team and huge help from our friends – our patients, their families and carers, our staff at all three hospitals and also our partner charities and other supporters. All of these people have gone the extra mile by donating money, taking part in challenge events and starting new initiatives to help us become a stronger charity, able to support more people and improve the care they receive.

One of the reasons that we have been able to grow income has been having dedicated resource within the charity to support fundraising. Last year we took the decision to invest in a head of charity to help us improve our fundraising and to provide support to staff, patients and their families and friends who were fundraising for us. This role has been pivotal in the growth we have experienced and it has laid strong foundations for further growth.

There are too many friends of the charity to mention them all here so I will just highlight a few to illustrate how they have made all the difference to the support that the charity can provide to our hospitals to continually enhance the experience of our patients and our staff.

Last year the Woodland neonatal unit highlighted the need for improvements to their environment to provide even better care to the babies that they care for, as well as providing more support to the parents. Dr Sankara Narayanan came up with the idea of doing the Three Peaks Challenge – climbing Ben Nevis, Scafell Pike and Snowdon in 24 hours. I made the mistake of having a meeting with Sankara while he was organising this event and found myself also recruited to take part! His passion and commitment to the unit and providing the best care

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possible won me over. Sankara brought together a team of 14 people and after a very, very long day climbing we raised a total of £7,270 for the neonatal unit – not bad going for 24 hours work!

The staff at all three of our hospitals work tirelessly to fulfil the vision of West Herts Hospitals NHS Trust; *the very best care for every patient, every day*. They also strive to provide support and advice to the friends, families and carers of patients. Hospital staff are often unsung heroes who brush aside praise, saying that they are just doing their job. This belies the importance of what they do, the challenges that they face on a daily basis and how their kindness and commitment impacts on patients.

The charity has sought to provide support for them by supporting staff health and wellbeing activities. In the past year, the Charitable Fund's Committee made a grant of £56,000 to staff health and wellbeing activities, and we plan to continue to support these activities in the coming years.

The League of Friends has continued to be a supportive friend to the charity and the Trust. We have a strong relationship with the League of Friends and we work increasingly closely to ensure that funds are used in the best possible way to support our hospitals. The League of Friends has provided over £48,000 in funding and £35,000 in pledges in the past year to support a range of activities, including training equipment for maternity staff, a significant contribution to our discharge lounge to increase its capacity, the refurbishment of Elizabeth ward and a range of equipment including new couches for outpatients.

We are absolutely delighted to have the League of Friends as a partner and supporter and we look forward to working with them further to deliver even more improvements.

The carers' support team (CST) is a fast-growing success story. This excellent scheme, started by Suzanne Boon, has gone from strength to strength in providing much-needed support to parents and carers. It is a volunteer-led programme that uses highly skilled and passionate volunteers to provide parents and carers with information, advice and emotional support when their child is in hospital. The CST provides a friendly face during this difficult time. Suzanne has been a great friend to the charity by securing over £4,500 for the CST. Her commitment, drive and energy never cease to impress me and each year she surpasses herself by raising even more money for this excellent project. In the next year, we will work more closely with Suzanne to support her fundraising work and to learn from her experience of setting up the CST in order to grow specialised volunteering roles elsewhere within the Trust.

Another active supporter of the Charity and Trust is the Michael Green Foundation. Each year the Michael Green Foundation supports our diabetes services to reach more people and to help them to make changes in their lives so that they can manage and control their diabetes better. In the past year, staff from Information and Finance completed a 10km challenge race to raise funds for the Michael Green Foundation. In the same period, the Michael Green Foundation donated £12,000 to pay for a specialist diabetes dietitian employed in partnership with the Trust and for equipment for the metabolic unit.

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In addition to these larger projects and fundraising initiatives, there are also many other smaller things that the charity has supported at ward level. Many wards and teams have charitable funds they can access for important activities – from recognising and appreciating staff through to helping to improve the environment for patients. These charitable funds help to make changes throughout our hospitals. Without the support of our friends, we would not have these funds, and so I express our heartfelt thanks to everyone who has supported us in the past year.

In the year ahead we have lots more work to do. We now have a strategy for the charity that sets its course for being more proactive. Central to this is the need to continue improving our systems and processes to make fundraising easier as well as ensuring that the funds we hold are well managed and wisely spent.

Our priority for the next year will be to maintain income growth. To do this, we will need the support of our staff, patients, their families, friends and carers. We will continue to work with partner charities and we will look for new support from corporate partners. We will be developing new branding for the charity to raise our profile across our hospitals and communities. This will help to grow support for the charity.

Additionally, we want to work closely with the Trust to identify clearly defined volunteering roles that can make all the difference to the experience of our patients. We will fundraise to support this work.

We look forward to working with all our supporters in the coming year to identify new projects and to proactively fundraise to ensure that we can continue to make all the difference to our patients.

Jonathan Rennison

Chair of the Charitable Funds Committee

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Here are some of our

There are too many to name but here are a few:

Elizabeth Checkley
neonatal nurse SCBU
Easter cake sale and tombola, neonatal unit, breast pumps

Suzanne Boon
volunteer coordinator
Annual coffee and cake sale £445

Amanda Williams
housekeeper
cake sale Children's Emergency department

Dr Robert Brenner
donated over £4,000 of DVLA fees to the neurology fund

Emma Bord
who ran the Royal Parks half marathon for us last autumn, **raising over £1,315 for the Woodland neonatal unit and particularly the 'ladies in transitional care' who supported her baby daughter Lola**

Staff completed the **Three Peaks Challenge** raising **£7,270**

Bollywood Nights was organised and supported by the Woodland neonatal team who raised **£2,146**

Left to right - Mariama Clark, Mavis and Norman Tyrwhitt (from the League of Friends) at the discharge lounge opening

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fundraising heroes

Marilyn Taylor

children's services administrator and street fundraising team – Starfish Ward
£499

League of Friends

Cllr Rabi Martins (middle) cuts the ribbon to open the **simulation suite** with Norman and Mavis Tyrwhitt from the League of Friends.

The Michael Green Foundation Charity

founder, Joanne Green with Professor Steve Barnett, Chairman.

The impact of the charity on patient welfare

WHHC is committed to patient welfare and it aims to ensure that patients have a good experience and feel that they are treated as kindly as possible. In order to achieve this, grants have been made for purchases and projects across the NHS Trust.

Two grants of £12,000 (6 months to 30 September and 6 months to 31 March) were made to support the 'Kissing it Better' project. This project, delivered within Watford General Hospital by an external charity, works with volunteers from the wider community to provide company, stimulation and support to patients, especially those who are in hospital for extended periods. With an ambition to deliver holistic care and to 'bring the outside in' Kissing It Better has well established relationships within local communities, schools and colleges. Project elements include pet and art therapies on the wards, weekly singing performances, delivering gifts around the hospital and speaking to patients, carers and staff. This programme links with the National Citizen Service for volunteers aged 15 - 17, around 200 of whom have taken part in the above activities.

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Funds donated by the League of Friends were used to enable the continued delivery of 'The Rose Project' which supports patients at the end of their lives and the people who care for them. The project offers subtle and bespoke interventions to ensure that those patients and the families who are grieving for them receive respectful and meaningful support.

WHHC also understands the importance of the physical environment in delivering patient care and so using charity funds to improve the immediate physical environment has been important.

In September 2016 The League of Friends pledged support to develop a new discharge lounge for patients at Watford General Hospital. This new space has a more domestic and less clinical feel than other parts of the hospital. Patients who are well enough to leave hospital but are waiting for transport or medication can now wait comfortably in the discharge lounge. This is more comfortable for them – far better than being on a busy ward – and it has the important benefit to the trust of freeing up a hospital bed. There is a wall mounted TV, radio, books, magazines and access to refreshments. The support from the League has enabled the creation of two trolley spaces, meaning that the lounge can now accommodate patients who are not able to be seated. Up to 50 patients a day use the lounge.

Medical equipment

Charitable funds have been used for the purchase of equipment including two special incubators for the Woodland neonatal unit. These intensive care incubators (£45,000) are used for the care of pre-term babies.

WHHC was also fortunate to receive a donation of £30,000 raised by Herts Against Cancer through the Raindrops on Roses charitable retail enterprise www.raindropsonroses.org.uk. This enabled the purchase of endoscopes and associated equipment for the endoscopy unit.

£33,000 of charitable funds were spent on medical equipment including £12,000 on the Woodland neonatal unit for two specialist baby control monitors, a lab freezer and an illumination device. This device allows babies veins to be seen clearly which is important when intravenous medication is required. This was funded by the advertisers of the Babies on Board magazine. Funds were also spent from the WG Moore legacy fund to purchase a reverse osmosis unit and renal dialysis chair for the renal unit.

Furniture and fittings

Charitable funds were used for a £15,000 refurbishment and refitting of the urology doctors' offices, the relatives' room in Elizabeth ward (funded by the League of Friends) and the kitchen on Starfish (children's) ward. And the Watford metabolic fund was used to soundproof a clinic room. In order to make the hospital setting more pleasant, artwork was purchased for the A&E waiting room and the newly expanded endoscopy unit. Furniture was purchased as follows: paediatrics – task chairs, ophthalmology – two low-line two-seater chairs, diabetes – medical chair and as part of the Elizabeth ward refurbishment, lockable bedside cabinets

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were purchased by the League of Friends. As part of the commitment to supporting carers, Woodland neonatal unit used donations to purchase a double bed and the CST spent charitable funds on sleeper chairs for parents and other carers for when they stay overnight.

Computer equipment

Charitable funds were used to enable the installation of computers in the multidisciplinary team room on the Dick Edmonds stroke unit and for a project to improve the network and provide computer and accessories in the doctors' room of the colorectal cancer unit.

The impact of the charity on staff welfare

Following the success of the staff welfare and development project in 2015/16, the charitable funds committee agreed a further grant of £56,000 for this work (project costs £38,000 to date). The project, commenced in May 2016, **has brought significant impact with 578 staff benefitting from 672 hours of support** delivered through a number of project elements including **mental health 'first aid'**, **managing stress**, **emotional resilience**, **mindfulness**, **15 minute health MOTs**, **20 minute relaxation sessions** and **weight management courses**.

Impact on staff was tremendous with **95% feeling that the project benefitted them** and **92% feeding back that they had been helped to make lifestyle changes**. This positive feedback was put in context at the end of last year when **91% of staff reported that they felt WHHT takes positive action on health and wellbeing**. £7,000 of charitable funds were spent on Christmas celebrations for staff and as part of this commitment to staff health and wellbeing, funds were used to enable the hire of a health kiosk – with cholesterol and blood testing.

In order to train and retain our excellent staff, £55,000 of charitable funding was used to pay for **course expenses for staff from 35 units across the trust**. **Three staff from coronary care attended an update conference on delivering training and development for healthcare professionals** and **two members of paediatric staff attended conferences**. Donations from the kidney fund and Gurney bequest fund **were used to offset course fees associated with masters degrees** and **funding was donated from the orthopaedics**, **breast services** and **diabetes charitable funds for course/ conference fees**.

Charitable funds were used to **improve the physical environment for staff including the refurbishment of the female changing rooms in the colorectal cancer unit**.

Registered Charity Number 1052210 (England) https://www.westhertshospitals.nhs.uk/about/fundraising.asp

Managing charitable funds

We are currently managing (via a group of individual fundholders and fund managers who have defined delegated levels of financial authority) 142 funds of various sizes. Reducing the number of funds is part of our strategic objective of managing funds more effectively. A decision was taken in September to open no new funds and to manage the closure of smaller funds. This year 16 funds have been prepared for closure or for balance transfers to general funds and five have been combined into three. Fundholders have been encouraged to work collaboratively and develop projects which address shared need. Fundholders have also chosen to share resources with funds being transferred between the Watford metabolic and diabetic funds where there has been a strategic benefit – e.g. bespoke training for staff.

Donations to the general purpose fund have increased from £1,605 last year to £4,708 this year – in line with plans to increase non-designated funding. Work has progressed to provide frontline staff with an alternative designation when being offered donations. The idea that patients/donors trust WHHT for their health needs and therefore can equally trust them to choose the best purpose for donated funds is beginning to get some traction within both the charity and the NHS Trust. There is an increased sense that it is inequitable for donations to be solely for visible frontline functions when there are so many 'behind-the-scenes' staff and services that contribute to patient care. The impetus is for funds to be received on behalf of the whole charity rather than individual funds.

Fundraising

The charity has continued to encourage and support fundraising during the year and various events have helped to raise its profile. Fundraisers have continued to use the online facilities provided by JustGiving or Virgin Money Giving. There were 16 campaigns to help boost the funds of the Woodland neonatal unit, the intensive care unit, paediatrics department and others. £23,000 has been donated through JustGiving, showing significant growth over 2015/16 (£11,000). Nearly 700 donations have been made through the portal over the year – nearly two a day.

Challenge events

The charity has had runners in the Virgin London Marathon, the British 10k and the Royal Parks Half Marathon with further events planned for 2017/18. Two community groups undertook gruelling challenges:
The Boys and Girls Nursery completed the Tough Mudder challenge raising £3,405 from 110 donors – reflecting an astonishing level of support for the charity. And, as mentioned in the foreword from the Chair of the Charitable Funds Committee, Dr Sankara Narayanan led a team of 14 through the Three Peaks Challenge, raising £7,270 for the neonatal unit. Those raising funds through the online portals reach a very wide audience with friends, work and business connections all supporting their efforts.

Registered Charity Number 1052210 (England) https://www.westhertshospitals.nhs.uk/about/fundraising.asp

How you can support us

Make a donation

Please send us a cheque made out to 'West Herts Hospitals Charity' and send it to Watford General Hospital, Vicarage Road, Watford, Hertfordshire WD18 0HB.

Donate via our website at:

https://www.westhertshospitals.nhs.uk/about/fundraising.asp

or https://www.justgiving.com/westhertfordshirenhs

Call us on 01923 436177 and ask for Fundraising or email us at westhertscharity@whht.nhs.uk

Events

Join one of our events, or organise your own with our support.

In memory of a loved one

Set up an "in memoriam" page (in memory) of your loved one at

https://www.justgiving.com/westhertfordshirenhs

or contact us for funeral service donation envelopes

Support us through your company

Adopt us as your charity of the year, encourage your staff to volunteer for us, talk to us about how we could work together to help meet your corporate social responsibility agenda.

Support our Appeals

- Visit the website at http://www.westhertshospitals.nhs.uk/about/fundraising.asp for more details
- Leave a gift in your will
- Contact us for information on how to make a provision in your will for our charity
- Become a volunteer fundraiser
- Join our group of brilliant fundraisers – ring us on 01923 436177 For any help and information in relation to West Hertfordshire Hospitals Charity, please write to WHHC, Willow House, Watford General Hospital (full address above), call 01923 244366 ext 8177 or email westhertscharity@whht.nhs.uk

Registered Charity Number 1052210 (England) https://www.westhertshospitals.nhs.uk/about/fundraising.asp

Financial review

Balance Sheet

Overview

The total net assets of WHHC as at 31 March 2017 were £1,028,000 (2016: £1,134,000). This represents a slowing down in the rate that reserves are used – from 2016: £156,000 to 2017: £106,000.

Income £237,000 has increased by 55% (2016: £153,000) due to improved management of fundraising activity. This reverses a trend started in Financial year (FY) 2012/13. There were significant gains in income in donations and legacies £183,000 (2016: £103,000). Other fundraising activities £22,000 (2016 £19,000) and investment income £32,000 (2016 £31,000) also showed improvement.

Expenditure (£467,000) has also increased (2016: £255,000). Expenditure on activities to benefit patients and staff (charitable activities) (£385,000) has increased significantly (2016: £243,000). The running costs of the charity (£82,000) increased following the appointment of the head of charity (2016: £12,000).

Investments

The valuation of the charity's portfolio stands at £820,000 (2016: £995,000). In the accounts, returns on investment are allocated on a pro rata basis to unrestricted (including designated) and restricted funds.

£290,000 was drawn down to reimburse West Hertfordshire Hospitals NHS Trust for expenditure incurred by the charity over the course of the previous year.

Debtors

As at 31 March 2017 total debtors were £55,000. £7,000 income accrued related to the fourth quarter dividends and interest from the charity's investments of (2016: £7,000) and £47,000 pledged by the League of Friends.

Cash

As at the 31 March 2016 the charity was holding £405,000 in cash (2015: £319,000).

Creditors

The amount owed by WHHC was £252,000 (2016: £187,000). This related to an outstanding reimbursement due to West Hertfordshire Hospitals NHS Trust for charitable activities. During the year, £290,000, was drawn down from the charity's portfolio and was used to reduce the liability.

In addition, the League of Friends made pledges of £35,000 for which invoices have to be supplied before the funding can be drawn down.

Registered Charity Number 1052210 (England) https://www.westhertshospitals.nhs.uk/about/fundraising.asp

Statement of Financial Activities (SoFA)

1 April 2016 to 31 March 2017

Incoming Resources

Total incoming resources were £237,000 (2016: £153,000) which included voluntary income of £183,000 (2016:£103,000), activities for generating funds of £22,000 (2016: £19,000) and investment income of £32,000 (2016: £31,000).

Voluntary Income (£183,000) (2016: £103,000)

Voluntary income includes donations from other charitable organisations including trusts and grant giving bodies (£95,000) churches and schools £7,000 (2016: £28,000), private companies 17,000 (2016: £22,000), Trust employees and community events £7,000 (2016: £9,000) and other individual donations, £31,000 (2016: £33,000), from our patients, their relatives, their friends. Legacies and in-memoriam donations accounted for income of £20,000. Transactional income from e.g. DVLA and staff courses totalled £5,000. Income was significantly up on last year.

Activities for generating funds were £22,000 (2016: £19,000).

This includes income from those who have fundraised on our behalf – online fundraisers, via the JustGiving and other portals.

Investment income £32,000 (2016: £31,000)

This incudes our investment portfolio, managed by Investec Wealth and Management Ltd. This earned the charity £31,000 and the remainder, £1,000 came from the charity's bank accounts.

Resources expended

Total resources expended were £467,000 (2016: £255,000).

This consisted of charitable activities £385,000 and activities for generating funds £82,000.

Charitable activities £385,000 (2016: £243,000)

Charitable activities include expenditure incurred by the charity in undertaking activities that further its charitable aims of improving patient and staff experience and welfare, as follows:

Investing in improved outcomes for our patients £248,000 (2016: £69,000)

Expenditure on patients £63,000 (2016:23,000) includes funds used for the direct benefit of patients, including comforts. Patients also benefit from the use of charitable funds to purchase medical equipment £33,000 (2016: £18,000). Overall expenditure under these headings has increased from £41,000 in 2016 to £96,000 in 2017.

We have also tracked expenditure which tracks our efforts to create a better experience for our patients. This includes expenditure on capital equipment £80,000 (2016: £5,000) and on furniture and fittings £72,000 (2016: £23,000) Overall expenditure under these headings has increased from £28,000 in 2016 to £152,000 in 2017.

Investing in staff development and welfare
£96,000 (2016: £122,000)

Expenditure on staff welfare £21,000 (2016 £56,000) has dipped on last year. This is to do with the phasing on expenditure on the flagship staff health and wellbeing activities project which has significant expenditure committed but not yet incurred. However expenditure on staff training (course expenses) £55,000 (2016: £54,000), general training and equipment for staff benefit £16,000 (2016: £14,000) and computer equipment £4,000 (2016: £3,000) has increased from £71,000 in 2016 to £75,000 in 2017.

The cost of running WHHC £124,000 (2016: £58,000)

This includes administration (support costs) £36,000 (2016: £42,000), audit £6,000 (2016: £4,000) and fundraising costs £73,000 (2016: £1,000). The latter reflects the appointment of the head of charity and costs associated with the purchase of a trust and grant management database and funding to pump-prime charitable activities. The salary of the head of charity is disclosed within fundraising costs and is currently charged to the unrestricted general fund. West Hertfordshire Hospitals NHS Trust employs a charitable fund accountant on a full-time basis and the salary costs of that employee are re-charged to the charity.

Investment management fees are £9,000 (2016: £11,000) WHHC's investment managers, Investec Asset Management, charge a quarterly fee based on the value of the portfolio. Please refer to section on investment objectives on page 16 for details of how these charges are calculated.

Significant changes

On Thursday 4 May 2017 the Corporate Trustee agreed two key documents which define the objects, strategic aims and context for WHHC. These documents – discretionary resources policy and development strategy for WHHC – represent a key milestone in the journey to move the charity to be a proactive and effective partner for WHHT.

- **Strategic Objective 1**

Increase WHHC income by identifying and developing a range of projects and campaigns

- **Strategic Objective 2**

Improve the charity's effectiveness by managing existing and potential discretionary resources through the Charities Steering Group (CSG) which will bring together a group of stakeholders (from both inside and outside the Trust)

- **Strategic Objective 3**

Enable WHHC to become the charity of choice amongst staff, patients and the wider community

- **Strategic Objective 4**

Becoming the best charity we can.

Registered Charity Number 1052210 (England) https://www.westhertshospitals.nhs.uk/about/fundraising.asp

Investment performance

The performance data for this year is as follows:

31 March 2017	31 March 2016	(%)
Investec Market value	Investec market value	Capital return*
£819,826	£ 994,554	17.46 (2016: 4.62)
FTSE 100	FTSE 100	
7322.92	6,174.90	18.59 (2016: 8.83)

The yield on investment was 3.41% in FY17 (2.63% in FY16)

*The capital return is calculated by taking the movement of the portfolio in the year and dividing it by the value of the investment portfolio at the beginning of the year. FTSE 100 performance is at (18.59%) in comparison to the charitable fund portfolio return of (17.46%).

Structure, governance and management

The Corporate Trustee

Responsibility for charitable funds rests entirely with the Corporate Trustee which is the sole Trustee of WHHC. The Corporate Trustee comprises the voting members of the NHS Trust board acting collectively.

The Corporate Trustee has overarching responsibility for the strategy for the charity, the approach to fundraising, investment, expenditure and approval procedures associated with the use of discretionary resources, including but not limited to existing charitable funds. The Corporate Trustee is responsible for the establishment of the Charitable Funds Committee (CFC), to which it delegates specific powers. The Corporate Trustee manages the relationship between the NHS Trust and the CFC and authorises the use of outside legal or other independent professional advice.

Corporate Trustee	
The charitable funds are administered by a sole corporate trustee namely the voting members of the West Hertfordshire Hospitals NHS Trust Board acting collectively. Members of the corporate trustee are shown below as at 31 March 2017:	
Executive	**Non-Executive**
Katie Fisher (Chief Executive)	Professor Steve Barnett (Chair)
Helen Brown (Deputy Chief Executive)	Jonathan Rennison (Senior Independent Director, Non-Executive Director)
Professor Tracey Carter (Chief Nurse and Director of Infection Prevention & Control)	Paul Cartwright (Non-Executive Director)
Don Richards (Chief Financial Officer)	Virginia Edwards (Freedom to Speak Up Guardian, Non-Executive Director)
Michael van der Watt (Medical Director)	John Brougham (Non-Executive Director)
	Phil Townsend (Vice Chair, Non-Executive Director)

Registered Charity Number 1052210 (England) https://www.westhertshospitals.nhs.uk/about/fundraising.asp

Charitable Funds Committee

Acting for the Corporate Trustee, the purpose of the Charitable Funds Committee is as follows:

- To ensure there are robust processes in place to manage discretionary resources, including charitable funds, and to ensure these processes are implemented
- To monitor the disposition of discretionary resources, to ensure funds held on Trust are utilised in a way that takes into account any stipulations set out by donors and ensures best value is obtained from the funds donated
- To promote greater awareness of WHHC to encourage donations, particularly through communicating the benefits that have been realised through disposition of the funds
- To proactively fundraise and secure discretionary resources for WHHC, in order to support charitable activities and purposes within West Herts Hospitals NHS Trust.

Investment policy

The charity's investment objective is to maximise growth over the long term whilst protecting the real value of the funds and maintaining a reasonable level of income. The appointed investment managers have, at the discretion of the Corporate Trustee, unrestricted powers in accordance with the Trustees Act 2000, with the exception that there will be no investment in companies that have a significant investment in tobacco or alcohol.

The investment managers, Investec Wealth & Investment, report quarterly to the CFC regarding historic performance. The report explains all investment movements i.e. purchases, sales, market movement etc. All financial transactions are supported by contract notes. There is a quarterly management charge which is based on 0.8% of the portfolio valuation and that is deducted direct from the portfolio cash holding.

Reserves policy

The reserves currently stand at £1,028,000. Of these reserves £820,000 is being used to support the investment objective of the charity while £208,000 relates to the net current assets. The reserve comprises funds held by the charity which have been accumulated over time. Note 9 of the accounts states the purposes of these funds.

Alongside the investment objective the Corporate Trustee is committed to apply the income of the charity within a 'reasonable time' of receiving it. This policy applies to restricted and unrestricted (designated) funds. The focus on timely expenditure of funds, together with the investment objective places a requirement on fundholders and fund managers to work with WHHC to develop spending plans and forecasts for expenditure.

The reserves policy has been considered and it has been agreed that the reserves will be sufficient to fund six month's of expenditure including a cash holding of 90 days expenditure at a minimum.

Registered Charity Number 1052210 (England) https://www.westhertshospitals.nhs.uk/about/fundraising.asp

Risk management

The CFC on behalf of the Corporate Trustee ensures that WHHC has met its obligations for risk management as set out in the terms of reference. It has established a framework for risk identification and has examined the strategic and operational risks that the charity faces. The CFC regularly reviews these risks and takes action to mitigate and monitor them. The investment strategy is currently being reviewed in line with the revised level of risk appetite agreed by the Corporate Trustee.

Structure

The umbrella charity was established by a Declaration of Trust dated 12 December 1995. The aim of this charity is to provide monies wholly or mainly for the services of WHHT, drawing together a group of subsidiary funds which particularly benefit St Albans and Hemel Hempstead hospitals.

There are five subsidiary funds each with different objectives relating to the illustration. They are:

1. St Albans City Hospital General Fund provides funds for any charitable purpose relating to the National Health Service, wholly or mainly for the St Albans City Hospital.

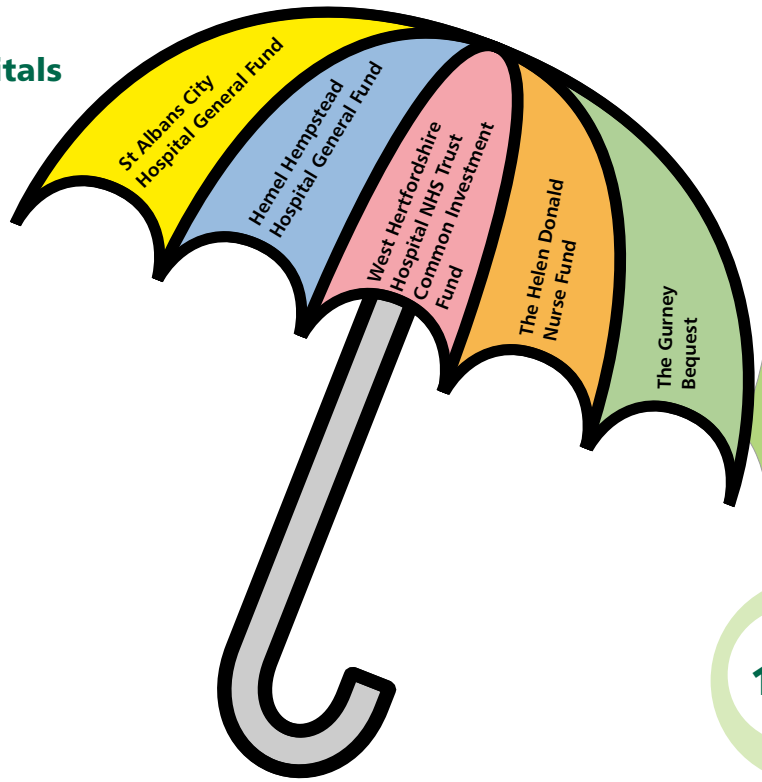
2. Hemel Hempstead Hospital General Fund provides funds for any charitable purpose relating to the National Health Service, wholly or mainly for the Hemel Hempstead Hospital.

3. The Helen Donald Nurse Fund provides funds for the relief of sickness by the funding of a part-time staff nurse at the Hemel Hempstead Hospital and providing benefits for patients who are or have been treated at the St Albans and Hemel Hempstead hospitals.

4. The Gurney Bequest provides funds for any purpose relating to the postgraduate centre at the Hemel Hempstead Hospital.

5. West Hertfordshire Hospitals NHS Trust Common Investment Fund established on 2 March 2001 protects the real value of the portfolio whilst maintaining a reasonable level of income.

WHHC comprises 142 individual funds.



Registered Charity Number 1052210 (England) https://www.westhertshospitals.nhs.uk/about/fundraising.asp

Legal and administrative details

Registered charity number: 1052210

Registered charity name: West Hertfordshire Hospitals NHS Trust Charity
Bank: Lloyds, 67 High Street, Watford, Herts WD17 2DU

Registered charity address: c/o West Hertfordshire Hospitals NHS Trust, Watford General Hospital, 60 Vicarage Road, Watford, Hertfordshire WD18 0HB

Independent Examiner: Grant Thornton UK LLP, Melton Street, London NW1 2EP

Legal status: WHHC is constituted under a Declaration of Trust dated 12 December 1995

Solicitors: Capsticks, 77-83 Upper Richmond Road, London SW15 2TT

Investment managers: Investec Wealth & Investment, 2 Gresham Street, London EC2V 7QN.

Financial statements

Statement of the Corporate Trustee's responsibilities

The Corporate Trustee is responsible for:

Keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the funds held on trust and to enable it to ensure that the accounts comply with the requirements of the Charities Act 1993.

Establishing and monitoring a system of internal control; and establishing arrangements for the prevention and detection of fraud and corruption.

The Corporate Trustee is required under the Charities Act 1993 to prepare accounts for each financial year. In preparing those accounts, the Corporate Trustee is required to:

- Apply on a consistent basis accounting policies laid down by the Charities Act 1993
- Make judgments and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Corporate Trustee confirms that, as far as it is aware, there is no relevant audit information of which the Charity's auditors are unaware and that it has taken all reasonable steps to ensure that this is the case.

The Corporate Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out from page 20 have been compiled from and are in accordance with the financial records maintained by the Corporate Trustee.

For and on behalf of the West Hertfordshire Hospitals NHS Trust

Professor Steve Barnett
Chair of the Corporate Trustee

Statement of Financial Activities for the year ended 31 March 2017

	Note	2016-17 Unrestricted Funds £000	2016-17 Restricted Funds £000	2016-17 Total Funds £000	2015-16 Unrestricted Funds £000	2015-16 Restricted Funds £000	2015-16 Total Funds £000
Income and endowments from:							
Donations and legacies	2.1	120	63	183	62	41	103
Other activities	2.2	8	14	22	9	10	19
Investment income	2.3	23	9	32	23	8	31
Total income and endowments		151	86	237	94	59	153
Expenditure on:							
Raising funds		(79)	(3)	(82)	(9)	(3)	(12)
Charitable activities		(231)	(154)	(385)	(196)	(47)	(243)
Total expenditure	3	(310)	(157)	(467)	(205)	(50)	(255)
Gains/(losses) on Investment assets	4	107	17	124	(31)	(23)	(54)
Net income/(expenditure)		(52)	(54)	(106)	(142)	(14)	(156)
Gross transfer between funds		0	0	0	1	(1)	0
Net movement in funds		(52)	(54)	(106)	(141)	(15)	(156)
Reconciliation of funds:							
Fund balances brought forward		872	262	1,134	1,013	277	1,290
Fund balances carried forward		820	208	1,028	872	262	1,134

The notes at pages 5 to 12 form part of this account.

Balance sheet as at 31 March 2017 Balance sheet as at 31 March 2016

	Notes	2017 Unrestricted Funds £000	2017 Restricted Funds £000	2017 Total at 31 March £000	2016 Unrestricted Funds £000	2016 Restricted Funds £000	2016 Total at 31 March £000
Fixed assets							
Investments	5	654	166	820	766	229	995
Total fixed assets		654	166	820	766	229	995
Current assets							
Debtors	6	44	11	55	5	2	7
Cash at bank	7	323	82	405	245	74	319
Total current assets		367	93	460	250	76	326
Creditors: amounts falling due within one year	8	(201)	(51)	(252)	(144)	(43)	(187)
Net current asssets/(liabilities)		166	42	208	106	33	139
Total assets less current liabilities		820	208	1,028	872	262	1,134
Total net assets		820	208	1,028	872	262	1,134
Funds of the charity							
Income funds:							
Restricted	9.1	0	208	208	0	262	262
Unrestricted	9.2	820	0	820	872	0	872
Total funds		820	208	1,028	872	262	1,134

The notes at pages 5 to 12 form part of this account.

Signed

Professor Steve Barnett
Chair of the Corporate Trustee

Charitable Trust Account – West Hertfordshire Hospitals Charity 2016/2017

Statement of cash flows for the year ending 31 March 2017	Note	Total Funds 16/17	Total Funds 15/16
Net cash provided/(used in) operating activities		(245)	(441)
Cash flows from investing activities:			
Dividends & Interest from investments	2.3	32	31
Proceeds from sale of investments	5	889	483
Purchases of investments	5	(590)	(122)
Net cash provided/(used in) investing activities		331	392
Change in cash and cash equivalents in the reporting period		86	(49)
Cash and cash equivalents at the beginning of the reporting period		319	368
Cash and cash equivalents at the end of the reporting period	7	405	319

		Total Funds 16/17	Total Funds 15/16
Net income/(expenditure) for 2016/2017 as per SOFA		(106)	(156)
Adjustments for :			
(Gains)/losses on investments	4	(124)	54
Dividends and interest	2.3	(32)	(31)
(Increase)/decrease in debtors	6	(48)	2
Increase/(decrease) in creditors	8	65	(310)
Net cash provided by (used in) operating activities		(245)	(441)

Notes to the accounts

Accounting concepts and policies

1

1.1 Basis of preparation

The financial statements have been prepared under the historic cost convention, as modified for the revaluation of certain investments, and also in accordance with applicable United Kingdom accounting standards and the Statement of Recommended Practice 'Accounting and Reporting by Charities' by the Charities Commissioners in 2015 (FRS102).

1.2 Going concern

The Corporate Trustee are aware of material uncertainties that have cast significant doubt about West Hertfordshire Hospitals NHS Trust's ability to continue as a going concern. However they have recevied assurances from the NHS Board that the services currently provided by the Trust will continue to be provided for the forseeable future.

1.3 Financial instruments

The Charity has opted to account for financial instruments in line with with IAS 39.
See notes 8(a) and 8(b) for further details.

Financial assets

Financial assets are recognised when the Charity becomes party to the financial instrument contract or in this case when the income is probable. Financial assets are de-recognised when the contractual rights have expired or the asset has beentransferred. Financial assets are initially recognised at fair value.

Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Charity becomes party to the contractual provisions of the financial instrument.

Financial liabilities are de-recognised when the liablity has been paid or expired.

1.4 Reconciliation with previous generally accepted accounting practice

In preparing these accounts, the Corporate Trustee have considered whether any restatement of comparatives were required to comply with FRS 102. In the case of the Charity there are no changes in accounting policy which affect total retained funds at 1 April 2015 or 2016 or net income for 2015/16. No restatement required although there are changes in the analysis of governance costs.
Governance costs have been separately analysed on the face of the statement of financial activities, these are now classified as support costs and apportioned between fund raising activities and charitable activities.

1.5 Income and endowments

a) All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

i) Entitlement – arises when a particular resource is receivable or the Charity's right becomes legally enforceable.

ii) Probability – when receipt of any income becomes probable.

iii) Measurement – when the monetary value of the incoming resources can be measured with sufficient reliability.

b) Boundary of recognition of income
Incoming resources reflected in these accounts reflect those resources which have satisfied the conditions applied to the boundary of recognition of income.
This boundary has been established as the cashiers office of the Trust.

Accounting concepts and policies 1

1.6 Expenditure
The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

a) Raising funds
The cost of generating funds is the cost associated with generating income for the funds held on trust. This will include the costs associated with the investment manager's fees, Head of Fundraising and other administration costs.

b) Charitable activities
Costs of charities activities comprise all costs incurred in the pursuit of the charitable objectives and include Governance costs which are accounted for on an accruals basis and are recharges from West Hertfordshire Hospitals NHS Trust covering audit fees and accounting services. They are apportioned over all of the funds based on the average fund balance.
Grants made by the League of Friends are now reported within charitable funds with effect from 1 October 2016.

c) Allocating costs by activity
All administration costs being the other staff costs and audit fees will be apportioned to Raising Funds and Charitable Activities based on time spent on each activity.

Notes to the accounts

Accounting concepts and policies

1

1.6 Expenditure

The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

a) Raising funds

The cost of generating funds is the cost associated with generating income for the funds held on trust. This will include the costs associated with the investment manager's fees, Head of Fundraising and other administration costs.

b) Charitable activities

Costs of charities activities comprise all costs incurred in the pursuit of the charitable objectives and include governance costs which are accounted for on an accruals basis and are recharges from West Hertfordshire Hospitals NHS Trust covering audit fees and accounting services. They are apportioned over all of the funds based on the average fund balance.

Grants made by the League of Friends are now reported within charitable funds with effect from 1 October 2016.

c) Allocating costs by activity

All administration costs being the other staff costs and audit fees will be apportioned to Raising Funds and Charitable Activities based on time spent on each activity.

Accounting concepts and policies

1.7 Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund.

Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds.

Other funds which are not legally restricted and the Corporate Trustee has chosen to earmark for set purposes are classified as designated funds. The major funds held within these categories are disclosed in notes 9.1 and 9.2.

1.8 Investment properties

Donated properties received are normally disposed of as soon as practicable, and the proceeds are included in the statement of financial activities as an incoming resource.

1.9 Fixed asset investments

Fixed asset Investments are shown at market value.

Quoted stocks and shares are included in the balance sheet at mid-market price, ex-dividend.

Other fixed asset investments are included at the Corporate Trustee's best estimate of market price.

1.10 Debtors
Debtors are amounts owed to the Charity. They are measured on their recoverable amount.

1.11 Cash
Cash at bank and in hand is held to meet the day-to-day running costs of the charity as they fall due.

1.12 Creditors
Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt. They are recognised as soon as there is a legal or constructive obligation to make payment to a third party.

1.13 Realised gains and losses
All gains and losses are taken to the Statement of Financial Activities as they arise.Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.14 Pooling scheme
An official pooling scheme is operated for investments relating to the funds of the West Hertfordshire Hospitals NHS Trust Common Investment Fund. This scheme was registered with the Charity Commission on 2 March 2001.

1.15 Irrecoverable VAT
Irrecoverable VAT is charged against the category of resources expended for which it is incurred.

1.16 Related party transactions
None of the trustees or members of the West Hertfordshire Hospitals NHS board or parties related to them has undertaken any transactions with, or received any benefits from the charity in payment or kind. The trustees received no honoraria or emoluments in the year.
All creditors and accruals, see note 8, are with the West Hertfordshire Hospitals NHS Trust Included in which is a figure that relates to capital equipment items, categorised as such because the cost is in excess of £5,000. The figures are noted below.

Name of related party	Relationship to charity	Nature of Transaction	2016/17 £ 000	2015/16 £ 000
West Hertfordshire Hospitals NHS Trust	Corporate Trustee	Contribution to the NHS	80	5

Income and endowments

2

2.1 Donations and legacies

		Unrestricted Funds 2017 £000	Restricted Funds 2017 £000	Total Funds 20107 £000	Unrestricted Funds 2016 £000	Restricted Funds 2016 £000	Total Funds 2016 £000
A	Donations	110	63	173	61	41	102
B	Legacies	10	0	10	1	0	1
	Total	120	63	183	62	41	103

2.2 Other trading activities

		Unrestricted Funds 2017 £000	Restricted Funds 2017 £000	Total Funds 2017 £000	Unrestricted Funds 2016 £000	Restricted Funds 2016 £000	Total Funds 2016 £000
A	Three Peaks Challenge	0	7	7	0	0	0
B	Bollywood Nights event	0	3	3	0	0	0
C	Other	8	4	12	9	10	19
	Events from various fund raising	8	14	22	9	10	19

2.3 Investment income

	Unrestricted Funds 2017 £000	Restricted Funds 2017 £000	Total Funds 2017 £000	Unrestricted Funds 2016 £000	Restricted Funds 2016 £000	Total Funds 2016 £000
Investec – dividends/interest	22	9	31	22	8	30
Citibank interest	1	0	1	1	0	1
Total	23	9	32	23	8	31

Expenditure

3 Charitable

	Raising activities 2017 £000	Total Funds 2017 £000	Charitable Funds 2017 £000	Raising activities 2016 £000	Total Funds 2016 £000	Funds 2016 £000
Furniture and fittings	72	0	72	28	0	28
Medical equipment	33	0	33	18	0	18
Capital equipment	80	0	80	5	0	5
Patient welfare	56	0	56	11	0	11
Staff welfare	27	0	27	64	0	64
Staff training	16	0	16	14	0	14
Course expense and equipment	55	0	55	54	0	54
Computer equipment	4	0	4	3	0	3
Investment fees	0	9	9	0	11	11
Fundraising costs – see Note 3.1 (i)	0	73	73	0	1	1
Administration – see Note 3.1(ii)	36	0	36	42	0	42
Staff costs – see Note 3.1 (iii)	0	0	0	0	0	0
Audit – see Note 3.3	6	0	6	4	0	4
Total	385	82	467	243	12	255

3.1 Staff Costs

There are no staff costs this year or in any previous years. However staff are employed by West Hertfordshire Hospitals NHS Trust and recharged to the Charity as detailed below;
(i) the salary of the Head of Fundraising is disclosed within fundraising costs and is currently charged to the unrestricted General fund.
(ii) the salary of the Charitable Funds Acccountant is disclosed as part of the administration costs and that cost is apportioned over all of the charitable funds.

(iii) the salary of three members of staff are disclosed within charitable activities and the cost is recharged to the League of Friends.

3.2 Trustees remuneration, benefits and expenses

None of the corporate trustees were paid any remuneration or expenses in return for their services.

3.3 Auditors remuneration

The external auditors remuneration of £4K (2016 £4k) related solely to independent review with no additional work being undertaken. Internal audit fees totalled £2k (2016 £0K).

Gains/(losses) on investment assets — 4

	Unrestricted Funds 2017 £000	Restricted Funds 2017 £000	Total Funds 2017 £000	Unrestricted Funds 2016 £000	Restricted Funds 2016 £000	Funds Total 2016 £000
Unrealised gains/(losses)	(12)	(32)	(44)	(79)	(42)	(121)
Realised gains/(losses)	119	49	168	48	19	67
	107	17	124	(31)	(23)	(54)

Analysis of fixed asset investments — 5

	Held in UK £000	Total 2017 £000	Total 2016 £000
Market value at 31 March :			
Investments listed on Stock Exchange	788	788	963
Cash held as part of the portfolio	32	32	32
Total	820	820	995

Analysis of investment portfolio

Investment portfolio	Total 2017 £000	Total 2016 £000
Market value at 31 March	995	1,410
Less: disposals at carrying value	(889)	(483)
Add: acquisitions at cost	590	122
Net profit on revaluation	124	(54)
Market value at 31 March	820	995
Historic cost at 31 March	716	847

Analysis of debtors 6

Amounts falling due within one year:	Total 2017 £000	Total 2016 £000
Debtors	55	7
Total debtors	55	7

Total debtors includes accrued investment income (£7k) and a funding pledge from the League of Friends (£47k)

Analysis of cash 7

	Total 2017 £000	Total 2016 £000
Cash at bank	405	319
Total cash at bank	405	319
Analysis of cash		
Lloyds current account	4	3
Lloyds call account	3	7
NatWest Bank	398	309
Total	405	319

Analysis of creditors 8

Amounts falling due within one year:	Total 2017 £000	Total 2016 £000
Creditors	195	176
Accruals	57	11
Total creditors	252	187

Creditors in both 2016/2017 and 2015/16 relate to amounts due to West Hertfordshire Hospitals NHS Trust.

Financial instrument 8a Financial assets

	At fair value through receipts and payments 2017 £000	Receivables 2017 £000	Total 2017 £000	Total 2016 £000
Investments	820		820	995
Debtors		55	55	7
Cash at bank and in hand		405	405	319
Total financial assets	820	460	1,280	1,321

8b Financial liabilities

	2017 £000	Payables 2017 £000	Total 2017 £000	Total 2016 £000
Creditors		195	195	176
Accruals		57	57	11
Total financial liabilities	0	252	252	187
Total Funds	820	208	1,028	1,134

Analysis of funds 9

9.1 Restricted funds

		Balance 31 March 2016 £000	Incoming resources 2017 £000	Resources expended 2017 £000	Transfers 2017 £000	Gains and losses 2017 £000	Balance 31 March 2017 £000
	Material funds						
A	SCBU	67	20	(63)	0	12	36
B	Breast cancer appeal	44	2	(10)	0	8	44
C	WG Moore legacy	32	1	(2)	0	2	33
D	Kidney	31	3	(5)	0	2	31
E	Acute stroke unit	18	2	(11)	0	1	10
F	Oncology	14	2	(4)	0	1	13
G	Respiratory	15	0		0	1	15
H	Chemical pathology	13	1		0	0	13
I	League of Friends	0	48	(39)	0	0	9
	Others (9)	28	7	(21)	0	(10)	4
	Total (18)	262	86	(157)	0	17	208

Details of material funds – restricted funds

	Name of fund	Brief description of the nature and purpose of each fund
A	SCBU	Special care baby unit equipment/training
B	Breast cancer appeal	Raising funds for cancer care
C	WG Moore Legacy	Renal dialysis machines
D	Kidney	Dialysis unit patient care and staff training
E	Acute stroke unit	Care of stroke patients
F	Oncology	Cancer treatment
G	Respiratory	Lung cancer care
H	Chemical pathology	Testing of cultures and other investigations
I	League of Friends	Patient welfare

9.2 Unrestricted funds

		Balance 31 March 2016 £000	Incoming Resources 2017 £000	Resources Expended 2017 £000	Transfers 2017 £000	Gains and Losses 2017 £000	Balance 31 March 2017 £000
	Material funds						
A	West Herts General	209	18	(120)	0	0	107
B	Colorectal cancer	67	2	(34)	0	2	37
C	Watford Metabolic	67	8	(11)	(10)	4	58
D	Haematology	67	7	(4)	0	4	74
E	Gurney Bequest	57	2	(13)	0	2	48
F	Clinical biochemistry	48	2	(4)	0	2	48
G	Neurology	35	6	(3)	0	2	40
H	Patients experience	15	6		0	2	22
	Others (116)	307	100	(120)	10	89	386
	Total (124)	872	151	(310)	0	107	820

Details of material funds – unrestricted funds

	Name of fund	Brief description of the nature and purpose of each fund
A	West Herts General	Trust wide equipment
B	Colorectal cancer	Cancer treatment and research
C	Watford metabolic	Metabolic research fund including clinical trials
D	Haematology	Treatment of patients with blood disorders
E	Gurney Bequest	Medical education,training and equipment
F	Clinical biochemistry	Education and training
G	Neurology	Education and training
H	Patients Experience	Patients comforts

Connected organisations 10

Name, nature of connection, description of activities undertaken and details of any qualifications expressed by their auditors	2016-17		2015-16	
	Turnover of Connected Organisation £000	Operating deficit of Connected Organisation £000	Turnover of Connected Organisation £000	Operating deficit of Connected Organisation £000
West Hertfordshire Hospitals NHS Trust Board is the charity's Corporate Trustee.	322,643	(25,955)	299,769	(37,025)

Note: The operating (deficit)/surplus of West Hertfordshire Hospitals NHS Trust is after adjusting for impairment and depreciation on donated assets in excess of donated income.

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Agenda item: 20/52

TRUST BOARD MEETING IN PUBLIC
AGENDA

02 November 2017 at 9.30am – 12.00noon

Terrace Executive Meeting Room, Spice of Life Restaurant, Watford Hospital

Apologies should be conveyed to the Trust Secretary, Jean Hickman on jean.hickman@whht.nhs.uk or call 01923 436 283

Item ref	Title	Objective	Previously presented	Lead	Paper or verbal
01/53	**Opening and welcome**	To note	N/A	Chair	Verbal
02/53	**Patient experience presentation**	To receive	N/A	Chief Nurse	Presentation
OPENING					
03/53	**Apologies for absence**	To note	N/A	Chair	Verbal
04/53	**Conflicts of interests**	To note	N/A	Chair	Paper
05/53	**Minutes of the meeting held on 05 October 2017**	For approval	N/A	Chair	Paper
06/53	**Board action log from 05 October 2017 and previous meetings and decision log**	To note	N/A	Chair	Paper
07/53	**Chair's report**	To note	N/A	Chair	Paper
08/53	**Chief Executive's report**	To note	N/A	Chief Executive	Paper
PERFORMANCE					
09/53	**Integrated performance report – month 6**	To note	Trust Executive Committee	Chief Operating Officer	Paper
SAFE EFFECTIVE CARE (BAF RISK 1)					
10/53	**Quality improvement plan update**	For information	Trust Executive Committee	Chief Nurse	Paper
11/53	**Nursing and midwifery and allied health professional strategy update**	For information	Safety and Compliance	Chief Nurse	Paper
12/53	**Annual establishment review - maternity**	For information	Safety and Compliance	Chief Nurse	Paper
13/53	**Bi-annual safeguarding report**	For information	Safety and Compliance	Chief Nurse	Paper
14/53	**Learning from Deaths Update**	For information	Clinical Outcomes and Effectiveness Committee	Medical Director	Paper

RETAIN AND ENGAGE WORKFORCE (BAF RISK 2)					
15/53	**Emergency Department Skills Mix review**	For information		Chief Nurse	Paper
16/53	**Guardian of safe working update**	For information	Patient & staff experience committee	Director of Human Resources	Paper
SUSTAIN KEY EXTERNAL STAKEHOLDER RELATIONS AND COMMUNICATIONS (BAF RISK 8)					
17/53	**Approval of stakeholder engagement strategy**	For approval		Deputy Chief Executive	Paper
DELIVER A LONG TERM STRATEGY(BAF RISK 9)					
18/53	**Strategy update – month 7**	To note	Trust Executive Committee	Deputy Chief Executive	Paper
19/53	**Estates strategy update**	To note	Trust Executive Committee	Deputy Chief Executive	Paper
20/53	**Work programme for the Royal Free partnership**	To note	Trust Executive Committee	Deputy Chief Executive	Paper
21/53	**Strategic outline business case for pathology service**	For information	Trust Executive Committee	Chief Financial Officer	Paper
22/53	**General data protection review (GDPR) – update**	For information	Trust Executive Committee	Chief Information Officer	Paper
GOVERNANCE					
23/53	**Summary report on corporate risk register**	For information/ assurance	Trust Executive Committee	Deputy Chief Executive	Paper
24/53	**Board assurance framework update**	For information	Trust Executive Committee	Deputy Chief Executive	Paper
25/53	**Board and committee dates for forthcoming financial year**	For information		Deputy Chief Executive	Paper
26/53	**Update of standing financial instructions, standing orders and scheme of delegation**	To note	Trust Executive Committee	Chief Financial Officer/ Deputy Chief Executive	Paper
COMMITTEE REPORTS					
27/53	**Assurance report from Finance and Investment Committee**	For information and assurance	Finance and Investment Committee	Committee Chair/ Chief Financial Officer	Paper
28/53	**Assurance report from Audit Committee**	For information and assurance	Audit Committee	Committee Chair/Chief Financial Officer	Paper
29/53	**Assurance report from the Patient and staff experience committee**	For information and assurance	Patient & staff experience committee	Committee Chair/Director of Human Resources	Paper
30/53	**Assurance report from Safety and compliance**	For information and assurance	Safety and Compliance	Committee Chair/ Medical Director	Paper

ANY OTHER BUSINESS					
31/53	**Any other business previously notified to the Chairman**	N/A	N/A	Chair	Verbal
QUESTION TIME					
32/53	**Questions from Hertfordshire Healthwatch**	To receive	N/A	Chair	Verbal
33/53	**Questions from our patients and members of the public**	To receive	N/A	Chair	Verbal
ADMINISTRATION					
34/53	**Draft agenda for next board meeting**	To approve	N/A	Chair	Paper
35/53	**Date of the next board meeting in public:** 07 December 2017, Terrace Executive Meeting Room, Watford Hospital	To note	N/A	Chair	Verbal